

# Issue Brief

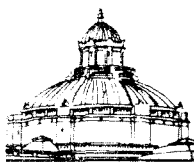
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**CATASTROPHIC HEALTH INSURANCE: MEDICARE**

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by

**Jennifer O'Sullivan**

**Education and Public Welfare Division**

**Congressional Research Service**

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## CATASTROPHIC HEALTH INSURANCE: MEDICARE

SUMMARY

Catastrophic medical costs are broadly defined as large unpredictable health care expenses; these are usually associated with a major illness or serious injury. The absence of catastrophic health insurance protection for the elderly has been the subject of concern for several years. A number of proposals have been offered to expand protection for the aged through the existing Medicare program. Most of the proposals which have been offered would place an upper limit on beneficiary liability for Medicare deductibles and coinsurance; they would also remove the limit on covered inpatient hospital days. Some proposals would also attempt to provide protection against some of the costs currently not covered under Medicare (for example, prescription drugs). Few of the proposals include long-term institutional care expenditures in the benefit package; these costs, which are potentially the largest health-related expenditures facing the elderly are not covered by Medicare and are rarely covered under private health insurance plans.

The Administration submitted a proposal to Congress in February 1987, that would offer catastrophic protection for persons covered by Medicare. The additional costs would be financed by a monthly beneficiary premium (added to the current Medicare Part B premium) estimated by the Administration at \$4.92 in 1988). The proposal contained no recommendations pertaining to coverage of costs not associated with covered Medicare services or to coverage of catastrophic costs for the population as a whole.

On July 22, 1987, the House passed the "Medicare Catastrophic Protection Act of 1987", H.R. 2470. For persons voluntarily enrolling in Part B, the bill limits beneficiary cost-sharing for covered Part B services. For all beneficiaries, the bill removes coinsurance and durational limits for hospital services; modifies the skilled nursing facility benefit; and expands benefits for hospice, home health and outpatient mental health care. H.R. 2470 also creates a separate catastrophic prescription drug benefit for the aged. The bill would be financed through a combination of an income-related premium for those beneficiaries with tax liability and an increase in the Part B premium.

On July 27, 1987, the Senate Finance Committee reported S. 1127 which provides catastrophic protection for beneficiaries voluntarily enrolling in Part B by limiting beneficiary cost-sharing liability, removing coinsurance and durational limits for covered hospital services and modifying the skilled nursing facility benefit. It also improves coverage for home health and hospice care for all beneficiaries. Financing would be through a combination of an income-related premium for those with tax liability and an increase in the Part B premium. (The calculations differ considerably from those in H.R. 2470).

## ISSUE DEFINITION

Catastrophic medical costs are broadly defined as large unpredictable health care expenses; these are usually associated with a major illness or serious injury. Two methods are commonly employed to determine whether an individual's medical expenses are catastrophic in nature. The first standard measures, over a specific period of time, total out-of-pocket expenditures (i.e., expenditures not met by insurance or public programs) and defines anything over a specified amount, e.g. \$2,000 or \$4,000, as catastrophic. The second standard is based on out-of-pocket expenditures that are large relative to an individual's income, e.g. expenses over 5% or 10% of annual income.

The absence of protection against catastrophic health costs, particularly for the elderly, has been the subject of congressional concern for several years. A number of proposals have been offered that would provide protection against at least some of these costs.

## BACKGROUND AND ANALYSIS

### **Incidence of Catastrophic Expenses**

The Department of Health and Human Services (DHHS) has defined "catastrophic expenses" using a combination of these methods. It specifies a threshold amount below which no expense level is considered catastrophic regardless of income; a percentage of income figure is then added to that amount to yield the threshold above which expenditures are considered catastrophic. Using varying thresholds and percentage of income figures, DHHS estimated the incidence of catastrophic out-of-pocket expenditures in 1987 (based on 1977 data). For the population under age 65 or families headed by a person under age 65, the incidence ranges from 2.4 million to 6.2 million persons, or 1.2% to 3.2% of this population group. For the aged or families headed by a person over age 65, the range is 0.9 to 2.1 million persons, or 3.5% to 8.1 percent.

### **Insurance Coverage for Catastrophic Expenses**

The characteristics of health insurance coverage for the over age 65 population differs from that for younger age groups. Almost the entire aged population (between 95% and 96 percent, or 29 million persons) are covered under Medicare; in addition, the program covers 3 million disabled persons. Medicare's benefits, which are the same throughout the country, are targeted toward meeting the acute health care needs of the elderly. Medicare places no upper limit on out-of-pocket costs paid by beneficiaries either in connection with covered program services or for all out-of-pocket health care expenses. The Medicare program itself therefore contains no catastrophic coverage provisions.

The combination of cost-sharing charges for covered Medicare services (see TABLE 1) coupled with the potential for high out-of-pocket payments for uncovered services has led the majority of Medicare beneficiaries to purchase private insurance coverage to supplement the program's benefit

package. This protection, frequently referred to as Medigap coverage, is purchased by an estimated 65% of Medicare enrollees. The principal protection offered by the majority of these policies is coverage of Medicare's deductibles and coinsurance charges. Some Medigap policies cover a limited number of additional services not covered by Medicare such as prescription drugs. Few policies offer protection against the costs of long-term institutional care -- potentially the most costly service item.

In 1980, legislation was enacted that provided standards for policies marketed as Medigap insurance. The legislation incorporated by reference the Medigap standards contained in a model regulatory program developed by the National Association of Insurance Commissioners (NAIC). If a State has adopted laws and/or regulations at least as stringent as those of the NAIC, policies regulated by the State are deemed to meet Federal requirements. Currently 46 States, the District of Columbia, and Puerto Rico meet these requirements.

Some low-income aged and disabled Medicare beneficiaries are also covered by the Federal-State Medicaid program. (This program also covers other low-income population groups including families with dependent children). However, many aged beneficiaries do not become eligible for Medicaid benefits until after they become institutionalized and reduce their incomes and resources to the Medicaid standard through their expenditures on health care. Persons covered by Medicaid are effectively protected against the costs associated with covered program services.

Approximately 20% of the Medicare population has no other health insurance coverage. According to DHHS, this figure includes over 2 million poor and 6 million near poor elderly not covered by Medicaid.

### **Current System Issues**

#### **Acute Care Focus of Medicare - Coverage Gaps**

The original Medicare program was designed to meet the acute health care needs of the elderly. The acute care focus is evidenced in the benefit design of the Hospital Insurance (Part A) program and Supplementary Medical Insurance (Part B) program.

Fairly extensive coverage is provided for short-term hospital stays under Part A. Coverage for long-term hospital stays is less adequate. These long stays are subject to significant coinsurance charges; further, a beneficiary may potentially exhaust all benefits (see TABLE 1). However, a very small percentage exceed 60 days of hospital care in a spell of illness. (A spell of illness is defined as beginning when a beneficiary enters a hospital and ending when he or she has not been an inpatient in a hospital or SNF for 60 days). An even smaller percentage exhaust their lifetime reserve days.

Beneficiaries enrolled in Part B pay a monthly premium (\$17.90 a month in 1987). They are also liable for certain charges in connection with their use of physicians and other services covered under the program (see TABLE 1). All beneficiaries are liable for the \$75 deductible and

20% coinsurance charges. In addition, where a physician or other provider does not accept "assignment" (i.e., agree to accept Medicare's determination of the "reasonable charge" amount as payment in full for covered services), the beneficiary is liable for the difference between Medicare's reasonable charge amount and the physician's actual charge. (This is sometimes referred to as the "balance billed" amount.)

**TABLE 1. Medicare: Summary of Benefits and Associated Beneficiary Cost-Sharing Charges, 1987**

<u>Coverage</u>	<u>Beneficiary Payments</u>
<u>Part A</u>	
Inpatient Hospital Services <u>a/</u>	
- Per spell of illness:	
-- First 60 days	\$520 deductible <u>b/</u>
-- 61st - 90th day	\$130 daily coinsurance <u>b/</u>
- 60 lifetime reserve days	\$260 daily coinsurance <u>b/</u>
Post-hospital SNF services	
- First 20 days	None
- 21st - 100th day	\$65 daily coinsurance <u>b/</u>
Home health services	None
Hospice services	Subject to durational limits and copayments for outpatient drugs and respite care
Blood	Cost of the first three pints
<u>Part B</u>	
Physicians' services and other medical services <u>a/</u>	1) \$75 deductible 2) 20% coinsurance 3) Amounts in excess of reasonable charges on unassigned claims (balance billing)
Blood	Cost of the first three pints

a/ Special limits apply with respect to inpatient services in a psychiatric hospital under Part A and outpatient psychiatric physician's services under Part B. Limits are also applied to annual program payments for physical therapy services provided by an independent practitioner.

b/ Part A deductible and coinsurance amounts are increased annually; coinsurance amounts are calculated as specified percentages of deductible.

Overall, Medicare covered 48.8% of the aged's health care costs in 1984. The program's benefit package excludes prescription drugs, routine eye examinations, eyeglasses, hearing aids, dental care, dentures, and most preventive care.

The major gap in the Medicare benefit package is coverage of long-term care services. Nursing home coverage is limited to short-term post-hospital stays in skilled nursing facilities (SNFs). As a result, Medicare covered only 2.1% of the nursing home costs of the aged in 1984. Home health care is covered only when a beneficiary can be shown to need intermittent skilled nursing care or physical or speech therapy. Many chronically ill persons do not need skilled care to remain in their homes but rather custodial care and assistance with daily routines; home health services for these persons are not covered by Medicare.

### **Beneficiary Liability**

The Congressional Budget Office estimates that liabilities for Medicare copayments will average \$456 in 1987; an additional \$105 represents average liability for balance billing charges by physicians. Thus total per capita liabilities in connection with covered services are an estimated \$561. However, the liability for Medicare cost-sharing charges is not distributed evenly throughout the population. Copayment liabilities are highest for those with inpatient stays and those with renal disease. For those with one inpatient stay, the average liability is \$1,335.

In addition to Medicare-related liabilities, beneficiaries are liable for additional health care costs. In 1984, total per capita spending by the aged for health care was \$4,202. Of this amount, \$1,059 (or 25.2% of the total) represented out-of-pocket payments by the elderly. These out-of-pocket figures do not include the additional amounts spent by the elderly for payment of Part B premiums or private insurance premiums. These figures are averages and may be higher or lower for individual beneficiaries depending on individual circumstances such as age, income level, incidence of acute illness, the presence of chronic conditions, and other insurance coverage.

### **Long-Term Care**

Medicare offers limited protection for the costs of nursing home care and almost no protection for the costs of custodial care services required by chronically ill persons over an extended time period. Nursing home care costs an estimated \$22,000 per person per year. In 1984, 50% of all nursing home expenses for the elderly were paid out-of-pocket. The Federal-State Medicaid program picked up 42% while Medicare covered only 2% of such expenses. Six percent came from a combination of other Government and private sources with 1% paid for by insurance. At the present time, few insurance companies (surveys estimate between 12 and 38) write more comprehensive long-term care insurance policies. There are considerable variations among these policies which cover an estimated 50,000 to 150,000 persons.

Since there is limited coverage of long-term care services under Medicare or most private insurance policies, Medicaid has become the primary source of third-party financing of long-term care services. Individuals can only gain coverage under Medicaid after they have reduced their incomes and resources to the State-established eligibility levels. Many elderly at risk of needing long-term care services face the prospect of impoverishing themselves to these welfare levels.

### **Types of Catastrophic Proposals**

Generally the proposals which have been offered to expand protection for the aged would build on the existing Medicare program. Most of the proposals which have been offered would place an upper limit on beneficiary liability for Medicare deductibles and coinsurance; they would also remove the limit on covered inpatient hospital days. Some proposals would also attempt to provide protection against some of the costs currently not covered under Medicare (for example, prescription drugs). Few of the proposals include long-term institutional care expenditures in the benefit package.

Those who favor offering catastrophic insurance coverage suggest that there are gaps in health care coverage of the elderly that are not being met. This is particularly so for the 20% of the Medicare population that has no supplementary coverage; most of these persons are poor and near-poor elderly that may be unable to afford Medigap insurance. Those who favor expanding the Federal role also note that an administrative structure is already in place to implement an expanded benefit. Those who oppose expanding the Federal role note that the majority of Medicare beneficiaries have supplementary coverage, primarily through Medigap policies. They suggest that efforts should be made to expand rather than supplant the role of the private sector.

One of the key concerns in designing a catastrophic plan is how the plan would be financed. The Administration plan, the House-passed bill and the bill reported by the Senate Finance Committee (see below) are budget neutral, i.e. no additional general revenue is required for the period for which the cost estimate is made. The Administration bill would spread the additional cost across all beneficiaries in the form of increased Part B premiums. The bills passed by the House and reported by the Senate Finance Committee would offer certain expansions in benefits in addition catastrophic coverage. Financing for these measures would be through a combination of an increase in the Part B premium and an income-related premium for the estimated 40% of beneficiaries with tax liability. (The calculations differ considerably between the House and Senate versions.) If approved, this would mark the first time that beneficiary payments for services would be tied to income.



### Administration Actions

In his February 1986 State of the Union Message, the President asked Secretary Otis Bowen of DHHS to examine the issue of catastrophic protection for all age groups (not just for the Medicare population) and report recommendations to him by the end of the year. Secretary Bowen transmitted the Department's Report to the President, "Catastrophic Illness Expenses", in November 1986. This report identified three major components of the catastrophic coverage problem, namely, acute catastrophic protection for the elderly, long-term care protection alternatives; and catastrophic protection for the general population. It identified the policy options for each component and presented preferred alternatives.

The report recommended placing an annual limit on each Medicare beneficiary's out-of-pocket expenses for all Part A and Part B deductibles and coinsurance. Part A coinsurance for inpatient hospital and covered SNF days would be eliminated and the maximum number of hospital deductibles would be set at two per year. Catastrophic coverage with a \$2,000 annual limit on deductibles and coinsurance would require an additional annual premium of \$59. This cost, i.e., \$4.92/month would be added to the Part B premium. The benefit would be fully funded by the premium and be indexed annually. The Secretary estimated that 1.4 million persons would incur program-related expenses in excess of \$2,000 in 1987.

The President submitted the Administration proposal on Feb. 24, 1987 (introduced as H.R.1245 and S.592). It incorporated the Medicare catastrophic coverage proposal recommended in the Bowen Report. It did not include any provisions relating to long-term care or coverage of acute catastrophic expenses of the non-elderly population.

### Congressional Action

#### House

On July 22, 1987, the House passed H.R. 2470, the Medicare Catastrophic Protection Act of 1987. This legislation was originally reported by the Ways and Means Committee. It was amended by the Energy and Commerce Committee which added a number of provisions including a catastrophic prescription drug benefit. The Ways and Means Committee subsequently reported a different version of the catastrophic drug benefit. A compromise package was introduced as H.R. 2941. The text of H.R. 2941 was substituted for the text of H.R. 2470 and passed the House as H.R. 2470. The major provisions of the bill are as follows:

**Inpatient Hospital Services.** Specifies a maximum of one hospital deductible per year and eliminates the durational limits, coinsurance charges, and spell of illness provisions.

**Skilled Nursing Facility Services.** Requires daily payments for the first seven days equal to the national average Medicare reasonable cost for SNF care (estimated at \$24/day in 1988);

eliminates coinsurance for 21st-100th days; adds coverage for up to 150 days and eliminates the prior hospitalization requirement effective Jan. 1, 1989.

**Home Health Services.** Transfers benefit to Part B program with no change in reimbursement policies; expands the "intermittent" skilled nursing care definition so that "daily" would be defined as up to 7 days a week for 35 days in any given period (instead of 5 days a week for up to 2 or 3 weeks).

**Outpatient Mental Health Service.** Raises the maximum payment from \$250 to \$1,000 per year.

**Limitation on Out-of-Pocket Part B Expenses.** Provides a \$1,043 catastrophic limit on Part B expenses in 1989 to be indexed by the COLA in future years; specifies that expenses counting toward the cap are the Part B deductible, Part B blood deductible, \$250 of reimbursable mental health expenses, and the 20% Part B coinsurance.

**Respite Services.** Covers up to 80 hours a year of in-home benefits for chronically dependent persons as a respite for unpaid individuals who live with and care for such persons. Benefit expires 12/31/91.

**Catastrophic Prescription Drug Benefit.** Establishes a separate catastrophic prescription drug program which would pay 80% of the costs of outpatient prescription drugs after a beneficiary had met the deductible. Sets the deductible at \$500 in 1989; sets the increase for 1990 and 1991 equal to the medical care component of the consumer price index (CPI). Specifies that the increase in future years would be tied to the increase in the covered outpatient drug index developed by the Secretary. Beginning in 1991, the deductible amount would be further increased, if necessary, to assure no premium increase of greater than 20 percent. Payment would equal the actual charge subject to specified limits with no additional cost-sharing by the beneficiary.

**Financing.** The additional benefits would be financed through modifications to the existing Part B premiums plus the addition of a supplemental premium.

**A. Part B Premium.** Provides for the following additions to the premium amount otherwise calculated: 1) an increase of \$1.00 in 1991 and \$1.30 in 1992; 2) an additional premium amount for the prescription drug benefit of \$2.30 in 1989; in subsequent years the amount is to equal 75% of costs of the benefit except that it may not exceed \$3.40 in 1990 nor increase by more than 20% in subsequent years; 3) an additional premium for in-home care benefit equal to 100% of the costs; it may not exceed \$0.30 in 1989, \$0.50 in 1990, nor increase by more than 20% in the subsequent year.

**B. Supplemental Premium.** Imposes a supplemental Medicare premium, administered through the income tax system, on each person entitled to Medicare Part A whose adjusted gross income (AGI) is over a specified amount. In 1988, the premium is imposed on persons with an AGI over \$6,000. The maximum premium in 1988 is \$580. In future years the amounts in the income categories would be increased by the cost of living adjustment used to adjust the income tax brackets. The premium amounts would be adjusted each year by the increase in the subsidized portion of Medicare and the prescription drug factor.

**Medicaid.** Requires Medicaid programs to pay Medicare cost sharing charges for all elderly and disabled below 100% of poverty line. In addition, the bill would require States to allow spouses of institutionalized persons to retain more income and assets for their maintenance needs.

**Medigap Policies.** Requires the Secretary, taking into consideration the recommendations of the National Association of Insurance Commissioners and the new catastrophic legislation, to report to Congress within 150 days of enactment on recommendations for change in Federal certification requirements. Companies issuing Medigap policies would be required to notify beneficiaries of improved Medicare coverage.

**Effective Dates.** Jan. 1, 1988 for Part A benefit changes; Jan. 1, 1989 for Part B benefit changes (including catastrophic limit) and the drug benefit; and taxable years ending after Dec. 31, 1987 for supplemental premium tax.

#### Senate

On July 27, 1987, the Senate Finance Committee reported S. 1127, the "Medicare Catastrophic Loss Prevention Act of 1987." The following is a summary of the major provisions:

**Catastrophic Plan.** All persons enrolling in Part B are automatically enrolled in the catastrophic insurance program. An annual limit of \$1,700 is placed on out-of-pocket expenses for Part A and Part B services; the cap is indexed by the COLA in future years. (Beneficiary expenses for the following items, which are not covered program services, count toward the cap: immunosuppressive drugs after the first year after a transplant and periodic mammography and colorectal exams.)

**Hospital and SNF benefits.** For persons enrolled in Part B, the durational limits and coinsurance charges are eliminated for hospital services and SNF coverage is extended to 150 days. Only one inpatient hospital deductible is required per year; the 3 day prior hospitalization requirement is eliminated for SNF services, and coinsurance (equal to 15% of national average cost per day) is charged for days 1-10 of SNF care. Current law provisions relating

to coverage of hospital and SNF services would apply to persons not enrolling in Part B.

**Home health and hospice care.** All beneficiaries would be entitled to up to 45 days of daily care if they have recently been in a hospital or SNF. Current law is clarified to assure all beneficiaries may receive up to 21 days of daily care. The 210 day limit on hospice care is eliminated for all beneficiaries.

**Drug Study.** The Institute of Medicine is to study possible coverage or catastrophic coverage of prescription drugs.

**Financing.** Catastrophic benefits are financed through a combination of an increase of \$4.00 in 1988 in the Part B premium (increased in future years by the per capita increase in actuarial costs) and an income-related supplemental premium for those with income tax liability. The maximum premium would be \$800 in 1988.

**Medicaid.** States must use Medicaid savings to expand coverage for low-income Medicare beneficiaries or support initiatives dealing with spousal impoverishment.

**Medigap.** Changes to model standards made within 90 days by National Association of Insurance Commissioners would be adopted. If changes not made within 90 days, the Secretary would issue revised standards to be effective one year later. The Secretary is required to provide information to consumers that will permit them to assess the value of Medigap policies to them and the relationship of such policies to Medicare coverage.

## LEGISLATION

### **H.R. 65 (Pepper)**

Medicare Part C: Catastrophic Health Insurance Act of 1987. Establishes a program to provide comprehensive services (including long-term care, prescription drugs, and elimination of current copayment requirements) to Medicare eligibles through prepaid health plans. Funds program through a combination of beneficiary premiums (subject to an income-related limit) and transfers of amounts which would otherwise have been expended under Medicare. Introduced Jan. 6, 1987; referred to Committees on Ways and Means, and Energy and Commerce.

### **H.R. 200 (Roybal)**

U.S. Health Program Act. Establishes U.S. Health program which provides catastrophic and basic health protection for all Americans (including current Medicare beneficiaries) regardless of age or income. Provides for funding from beneficiary coinsurance and copayments (with catastrophic limits), extension of hospital insurance taxes to all wages, continuation of Part B premium, excise taxes on wages, State contributions, increased cigarette taxes, and tax surcharge. Introduced Jan. 6, 1987; referred to Committees on Ways and Means, and Energy and Commerce.

**H.R. 406 (Roe)**

Establishes a national catastrophic illness insurance program under which the Federal Government, acting in cooperation with State insurance authorities and the private insurance industry, will reinsure and otherwise encourage the issuance of private health insurance policies which make adequate protection available to all Americans at a reasonable cost. Introduced Jan. 6, 1987; referred to Committee on Energy and Commerce.

**H.R. 678, H.R. 679, and H.R. 680 (Oakar)**

H.R. 678 adds an optional Medicare Part C, funded by a combination of beneficiary premiums and a portion of tobacco excise taxes, providing coverage for certain vision, hearing, and dental services and prescription drugs. H.R. 679 provides Medicare coverage for hospital-based comprehensive care programs. H.R. 680 authorizes a voluntary insurance option, paid by beneficiary premiums, for coverage of most Medicare cost-sharing charges and one annual preventive health care visit. Introduced Jan. 21, 1987; referred to Committees on Ways and Means, and Energy and Commerce.

**H.R. 784 (Bonker)**

Supplementary Medical Insurance Improvements Act of 1987. Amends Medicare Part B to provide two voluntary insurance options for Medicare beneficiaries to be paid for by beneficiary premiums. The first option would cover nearly all current Medicare cost-sharing requirements; the second option would cover outpatient prescription drugs for chronic illness. Introduced Jan. 28, 1987; referred to Committees on Ways and Means, and Energy and Commerce.

**H.R. 955 (Slaughter)**

Health Care Savings Account Act of 1987. Amends the Internal Revenue Code to allow individuals a credit against income tax for amounts contributed to a health care savings account and to amend Medicare to provide for a high deductible and protection against catastrophic medical care expenses for individuals who have established such accounts. Introduced Feb. 4, 1987; referred to Committees on Ways and Means, and Energy and Commerce.

**H.R. 1182 (Regula and Gallo)**

Health Services Act of 1987. Amends the Internal Revenue Code to allow individuals a deduction from gross income for contributions to a health services savings account; amends Medicare to establish a limited option for catastrophic care; and amends Medicaid to establish a public/private program to provide health services to the medically uninsured. Introduced Feb. 19, 1987; referred to Committees on Ways and Means and Energy and Commerce.

**H.R. 1245 (Mitchel et al.)/S. 592 (Dole et al.)**

Administration bill, Medicare Catastrophic Illness Coverage Act. Removes Part A coinsurance for inpatient hospital and covered SNF days and sets the maximum number of hospital deductibles at two per year. Places an annual limit - \$2,000 in 1988 - on each beneficiary's out-of-pocket expenses for all Part A and Part B deductibles and coinsurance. Provides that the full cost of the benefit would be added to the Part B premium and

indexed annually. H.R. 1245 introduced Feb. 25, 1987; referred to Committees on Energy and Commerce, and Ways and Means. S. 592 introduced Feb. 26, 1987; referred to Committee on Finance.

**H.R. 1760, H.R. 1761, and H.R. 1762 (Waxman and Stark)**

H.R. 1760 amends Medicaid to require States to provide for payment of Medicare premiums, deductibles and cost-sharing for Medicare beneficiaries with incomes below poverty. H.R. 1761 would make such coverage optional for beneficiaries below 150% of poverty. H.R. 1762 would permit States to cover under Medicaid prescription drugs for elderly persons with incomes up to 150% of poverty. Introduced Mar. 23, 1987; referred to Committee on Energy and Commerce.

**H.R. 1930 (Roybal and Garcia)**

Medicare and Medicaid Catastrophic Acute and Transitional Care Act. Provides for expanded acute and transitional coverage under a Federal Medigap Insurance program; expands Medicaid protection; and provides for funding through a combination of a Federal excise tax on cigarettes, Federal tax surcharge, and an add-on to the Part B premium. Introduced Apr. 2, 1987; referred to Committees on Ways and Means and Energy and Commerce.

**H.R. 2470 (Stark et al.)**

Medicare Catastrophic Protection Act of 1987. Limits the inpatient hospital deductible to one per year; eliminates the durational limits on and coinsurance charges for inpatient hospital services. Limits coinsurance charges for post-hospital SNF services to the first 7 days; provides that the coinsurance charge be set at a level equal to 20% of the estimated national average cost; and provides for 150 days of post-hospital SNF benefits per year. Establishes an annual out-of-pocket limit on beneficiary's payments for Part B deductibles and coinsurance at \$1,043 in 1989 with annual updates equal to the social security cost-of-living adjustment. Establishes a catastrophic prescription drug benefit. Clean bill introduced May 19, 1987; referred to Committees on Ways and Means and Energy and Commerce. (Reflects Ways and Means Committee markup of H.R. 1270 and H.R. 1271.) Reported by Ways and Means Committee May 22, 1987. Amended by Energy and Commerce Committee, June 17, 1987. Committee on Ways and Means approved free-standing drug amendment June 24, 1987. Clean bill (H.R. 2941) introduced July 15, 1987. Text of H.R. 2941 substituted for text of H.R. 2470; passed House as H.R. 2470 July 22, 1987.

**S. 210 (Kennedy)**

Amends the Public Health Service Act to provide voluntary catastrophic health insurance protection for aged and disabled to be financed by enrollee premiums. Payment would be made after an individual incurred \$2,000 in out-of-pocket expenses for reasonable costs or charges in connection with specified services (comparable to the Medicare benefit package). Introduced Jan. 6, 1987; referred to Committee on Labor and Human Resources.

**S. 454 (Sasser)**

Establishes a program to provide comprehensive services (including long-term care and elimination of current copayment requirements) to

Medicare eligibles through prepaid health plans. Funds program through a combination of beneficiary premiums (subject to an income-related limit) and transfers of amounts which would otherwise have been expended under Medicare. Introduced Feb. 4, 1987; referred to Committee on Finance.

**S. 754 (Dole et al.)**

Medicare Catastrophic Illness Coverage Act. Provides, for persons enrolled in Part B, for: an annual limit - \$1,800 in 1988 - on each beneficiary's out-of-pocket expenses for Part A and B deductibles and coinsurance, for elimination of inpatient hospital and SNF copayments, elimination of lifetime limits on inpatient hospital days, and only one hospital deductible in any one year. Provides that reasonable charges for immunosuppressive drugs for transplant patients can count toward the cap beginning in the second year. Finances program through actuarially sound Part B premium. Expands the home health benefit to 21 days of continuous care. Requires the Secretary to request from the Institute of Medicine a study to identify other prescription drugs which might count toward the cap. Introduced Mar. 17, 1987; referred to Committee on Finance.

**S. 1127 (Bentsen et al.)**

Medicare Catastrophic Loss Prevention Act. Provides, for persons enrolled in Part B, for: an annual limit -- \$1,700 in 1988 -- on each beneficiary's out-of-pocket expenses for the Part A deductible and coinsurance; elimination of inpatient hospital coinsurance and durational limits; a maximum of one inpatient hospital deductible per year; 150 days of SNF care per year; SNF coinsurance charges on first 10 days of care (but no more than 10 days a year); and revised calculation of SNF coinsurance charges. Finances coverage through: a) a \$4 monthly increase (indexed annually) in the Part B premium; and b) an income-related supplemental premium for persons with income tax liability. Expands home health and hospice coverage for all beneficiaries. Introduced May 5, 1987; referred to Committee on Finance. Reported July 27, 1987.

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- U.S. Congress. Special Committee on Aging. Catastrophic health care costs. Hearings, 100th Congress, 1st session. Jan. 26, 1987. (unpublished)
- U.S. Congress. House. Committee on Energy and Commerce. Medicare Catastrophic Protection Act of 1987. Report to Accompany H.R. 2470, July 1, 1987. Washington, U.S. Govt. Print. Off., 1987. (100th Congress, 1st session. House Report no. 100-105, part II).
- U.S. Congress. House. Committee on Ways and Means. Medicare Catastrophic Protection Act of 1987. Report to Accompany H.R. 2470, May 22, 1987. Washington, U.S. Govt. Print. Off., 1987. (100th Congress, 1st session. House Report no. 100-105, part I).
- U.S. Congress. Senate. Committee on Finance. Medicare Catastrophic Loss Prevention Act of 1987. Report to Accompany S. 1127, July 27, 1987. Washington, U.S. Govt. Print., Off., 1987. (100th Congress, 1st session. Senate Report no. 100-126).

#### CHRONOLOGY

- 07/27/87 --- Senate Finance Committee ordered reported S. 1127.
- 07/22/87 --- House passed H.R. 2470.
- 02/24/87 --- President submitted Message to Congress.
- 11/00/86 --- Secretary Bowen submitted report to the President.

#### FOR ADDITIONAL READING

- U.S. Congress. Committee on Ways and Means. Background Materials on Health Care Coverage and Expenses of the Medicare Population-- Including H.R.1280/H.R.1281, the Medicare Catastrophic Protection Acts of 1987 as Approved by the Subcommittee on Health, Committee on Ways and Means. Committee Print WMCP:100-10, 100th Cong. 1st session. Washington U.S. Gov. Print. Off., May 5, 1987.
- U.S. Congress. Message from the President of the United States. Proposed Legislation - "Medicare Catastrophic Illness Coverage Act". 100th Congress, 1st session. Feb. 24, 1987.  
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U.S. General Accounting Office. Medigap insurance: Law has increased protection against substandard and overpriced policies. Report to the Subcommittee on Health of the Committee on Ways and Means. October 1986.

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U.S. Department of Health and Human Services. Report to the President. Catastrophic illness expenses. November 1986.

U.S. Library of Congress. Congressional Research Service. Financing and delivery of long-term care services for the elderly, by Carol O'Shaughnessy, Richard Price, and Jeanne Griffith. [Washington] Feb. 24, 1987.

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----- Health insurance: proposals in the 99th Congress [by] Anne C. Stewart and Janet Pernice Lundy. [Washington] 1987. (Updated regularly)

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