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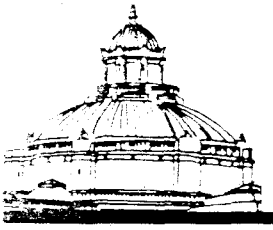
CATASTROPHIC HEALTH INSURANCE: COMPARISON OF THE MAJOR PROVISIONS OF THE "MEDICARE CATASTROPHIC PROTECTION ACT OF 1987" (H.R. 2470, as passed by the House July 22, 1987) and the "MEDICARE CATASTROPHIC LOSS PREVENTION ACT OF 1987" (S. 1127, as reported by the Senate Finance Committee, July 27, 1987)

Jennifer O'Sullivan
Specialist in Social Legislation
Education and Public Welfare Division



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CATASTROPHIC HEALTH INSURANCE: COMPARISON OF THE MAJOR PROVISIONS OF THE "MEDICARE CATASTROPHIC PROTECTION ACT OF 1987" (H.R. 2470, as passed by the House July 22, 1987) and the "MEDICARE CATASTROPHIC LOSS PREVENTION ACT OF 1987" (S. 1127, as reported by the Senate Finance Committee, July 27, 1987)

CURRENT LAW	H.R. 2470	S. 1127
I. BENEFITS		
A. INPATIENT HOSPITAL SERVICES		
1. Coverage Covers up to 90 days of inpatient hospital care per spell of illness plus up to 60 lifetime reserve days.	1. Coverage Covers unlimited number of days and eliminates spell of illness concept.	1. Coverage Similar provision, except limited to persons who enroll in Part B.
2. Deductible Applies one deductible per spell of illness ($520 in 1987).	2. Deductible Applies one deductible per calendar year. A new deductible would not apply if hospitalization began in previous calendar year.	2. Deductible Similar provision, except limited to persons who enroll in Part B. Deductible would not apply in January if hospitalization (for which beneficiary paid a deductible) began the previous December.
3. Coinsurance Applies daily coinsurance charge (1/4 of inpatient hospital deductible) for days 61-90 in a spell of illness and daily coinsurance charge (1/2 of inpatient hospital deductible) for lifetime reserve days.	3. Coinsurance Eliminates coinsurance charges.	3. Coinsurance Similar provision, except limited to persons who enroll in Part B.
B. SKILLED NURSING FACILITY (SNF) SERVICES		
1. Coverage Covers up to 100 days per spell of illness following a hopsital stay.	1. Coverage Covers up to 150 days per calendar year and eliminates prior hospitalization requirement.	1. Coverage Similar provision, except limited to persons who enroll in Part B.

2. Coinsurance Applies daily coinsurance charge (1/8 of inpatient hospital deductible) for days 21-100.	2. Coinsurance Applies daily coinsurance charge, equal to 20% of national average per diem reasonable cost, to days 1-7.	2. Coinsurance Applies daily coinsurance charge equal to 15% of national average per diem reasonable cost to days 1-10. Limited to persons who enroll in Part B.
C. HOSPICE SERVICES Provides that a beneficiary who is terminally ill may elect to receive hospice services for two 90 day periods and one 30 day period for a total of 210 days.	Entitles beneficiary to extension beyond the 210 day limit if he or she is recertified as terminally ill.	Identical provision.
D. HOME HEALTH BENEFITS Covers home health services if services are required because the individual is homebound and requires skilled nursing care on an intermittent basis or physical or speech therapy. "Intermittent" is defined in guidelines as permitting daily skilled nursing visits for up to two or three weeks; daily is defined as 5, 6, or 7 days a week.	Defines daily as 7 days a week. Specifies that daily care may be provided for up to 35 days, except an extension could be granted in unusual circumstances based on a physician's certification.	Clarifies that daily care means 7 days/week. Provides that such care may be provided up to 21 days. Extends the period up to 45 days, for beneficiaries enrolled in Part B, if the beneficiary was discharged from a hospital or skilled nursing facility within 30 days prior to beginning home health care. In addition, includes in law the current program policy relating to the definition of homebound.
E. OUTPATIENT MENTAL HEALTH SERVICES Pays 50% of reasonable charge (up to $250/year) for outpatient services.	Increases payment limit to $1,000/year.	No provision.

F. RESPITE SERVICES		
No provision	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. Specifies that a chronically dependent person is one who is unable to perform at least two activities of daily living. If necessary, the number of hours would be reduced in 1991, to assure no premium increase of greater than 20%. Benefit expires December 31,1991. Requires studies of: 1) alternative out-of-home services for chronically dependent persons; and 2) in_home care.	No provision.
G. EFFECTIVE DATES	Generally applies in 1988. Elimination of 3-day prior hospitalization requirement and changes in home health and outpatient mental health benefits effective January 1, 1989. Respite benefit effective for the 3-year period beginning January 1, 1989.	Generally applies to items and services furnished after December 31, 1987. Clarification of homebound requirement for home health services and hospice provision effective on enactment.

II. CATASTROPHIC LIMIT No provision.	1. Amount Establishes an annual limit on beneficiary out-of-pocket expenses for covered Part B services (including no more than $250 of reimburseable outpatient mental health expenses.) Specifies that the limit is $1,043 in 1989. Indexes the annual increase to the Social Security cost-of-living (COLA) adjustment.	1. Amount Establishes a limit on beneficiary out-of-pocket expenses in connection with covered services under Parts A and B. Specifies that the limit is $1,700 in 1988 (with only expenses incurred after July 1,1988 counted for that year). Indexes the annual increase to the Social Security cost-of-living adjustment. Counts beneficiary expenses for the following noncovered services in determining whether a beneficiary meets the cap: expenses for immunosuppressive drugs furnished after the first year following a transplant and periodic mammograms and colorectal exams.
	2. Notice Requires carriers to notify beneficiaries when they have reached the limit. The notice is to be in a form which may be presented to their physicians and would encourage such physicians not to balance bill these patients.	2. Notice No provision.

III. PRESCRIPTION DRUGS Excludes coverage for outpatient prescription drugs except for immunosuppressive drugs furnished during the first year following a Medicare-covered organ transplant. Covers vaccinations against pneumococcal pneumonia and hepatitis B and those directly related to the direct treatment of an injury or direct exposure to a disease.	A. Catastrophic Program 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%. Effective for drugs dispensed on or after January 1, 1989.	No provision.

B. Payment Limits Establishes payment limits. For single source drugs (where generics are not available), the limit is the average wholesale price plus an administrative allowance. For multiple source drugs (where generics are available), the limit is 50% of the brand name reference price (average wholesale price for 1/87, indexed by CPI) plus an administrative allowance. Specifies that where generics are available, payment is based on the generic limit unless the physician indicates in handwriting that a brand name drug is medically necessary.	No provision.

C. Participating Pharmacy Establishes a participating pharmacy program for pharmacies who agree to: not refuse to dispense covered drug items in stock to beneficiaries; not to charge more than they charge the general public; keep patient records for beneficiaries, assist them in determining whether they have met the catastrophic limit and submit documentation to carriers; and, effective 1/1/92, submit bills to Medicare electronically, unless requirement waived by Secretary.	No provision
D. Prescription Drug Payment Review Commission Establishes Commission to make recommendations by March of each year on payment methods.	No provision
E. Studies Requires the Secretary to conduct a beneficiary drug cost survey by 3/1/89. Requires Secretary to conduct a number of additional studies on issues related to outpatient drug coverage.	E. Study Provides for a study and report by the Institute of Medicine on prescription drugs that might be covered under Medicare or counted toward the catastrophic cap. Requires report to include recommendations with respect to payment limits. Final report due within one year of enactment.

IV. FINANCING

A. Part B Premium

Provides that Part B is financed through: 1) beneficiary premiums which are set at 25% of estimated program costs for the aged; and 2) general revenues. Beginning in 1989, the annual increase in the premium may not exceed the increase in the COLA.

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.

A. Part B Premium

Provides for the addition of a catastrophic coverage premium amount to the premium amount otherwise calculated. This additional amount is set at $4.00 in 1988 and increased in future years by the increase in the per capita actuarial costs of catastrophic benefits under Parts A and B. (In 1989 the amount is set as if the benefit were in effect for the entire year). The additional premium would apply beginning in February 1988. For years after 1988, individual beneficiaries are held harmless so the premium increase could not exceed the actual COLA increase in their social security benefit.

B. Supplemental Premium

No provision.

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1. Imposition

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.

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Imposes a supplemental premium, administered through the income tax system, on each person who receives Part B coverage and has Federal tax liability in excess of $150.

2. Initial Amount Provides that in 1988, the premium is imposed on persons with an AGI over $6,000. Persons with an AGI of $6,001 would pay a $10 a year premium; the premium amount would increase by approximately $10 per $143 of AGI. Persons with an AGI of $14,167 or more would pay the maximum amount of $580. For joint returns, the premium amount for each spouse would be based on 1/2 the couple's joint AGI.	2. Initial Amount Provides that in 1988, the yearly premium equals the product of the following: a) premium rate ($1.02 in 1988; individual's tax liability divided by $150 (rounded down to the nearest whole number); and c) number of months individual enrolled in Part B. Maximum premium is $800 in 1988. For joint returns, the premium is determined as if the spouses were one individual; the maximum is the sum of the limits that would apply to each spouse if determined separately.

3. Indexing Specifies that 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.	3. Indexing Specifies that beginning in 1989, the premium rate is to be adjusted to reflect change in actuarial comprehensive catastrophic benefit amount. Requires the Secretary, beginning in 1993, to increase the premium rate and the catastrophic coverage premium to the extent needed so that revenues equal benefits. Specifies that maximu premium is $850 in 1989; $900 in 1990; $950 in 1991; and $1,000 in 1992. For subsequent years, the maximum premium is in effect, 65% of the excess value of the basic Part B coverage and catastrophic coverage over the premiums (excluding the supplemental premiums) charged for such coverage.

V. MEDICARE SUPPLEMENTAL POLICIES Requires Medicare supplemental policies to meet minimum standards before they can be marketed as Medigap policies. The standards are contained in a model state program approved by the National Association of Insurance Commissioners (NAIC).	V. MEDICARE SUPPLEMENTAL POLICIES Requires Secretary to report to Congress, within 150 days after enactment, changes that should be made in standards and loss ratios for certification of Medicare supplemental policies taking into consideration the amendments provided in this bill and any other pertinent legislation enacted in the first session of the 100th Congress and any recommendations developed by the NAIC. Requires Medigap policies in effect on 1/1/88 to send a letter by 1/31/88 to their policyholders entitled to Medicare explaining improved benefits and how improvements affect policies and premiums. Requires Medigap policies to submit their advertising to the State insurance commission for review for compliance with State law. Prohibits from 1/88 - 12/88, imposition of current Federal penalties (for selling policies to Medicare beneficiaries which substantially duplicate health benefits to which they are otherwise entitled) for exisitng Medicare supplemental policies which duplicate only the benefits changed by this bill.	V. MEDICARE SUPPLEMENTAL POLICIES Provides that if the NAIC revises the existing standards for Medigap policies within 90 days after enactment, then those standards will apply as the standards for certification, beginning one year later. If the NAIC does not revise the standards within 90 days, requires the Secretary to issue Federal model standards within 90 days to become effective one year later. Requires a uniform 30 day free look period for all Medigap policies, whether sold by agents or by mail. Requires States which have approved certification programs to adopt reporting forms developed by the NAIC in order to collect information on actual loss ratios. Requires the Secretary to inform beneficiaries about laws that prohibit certain marketing sales abuses.

VI. MEDICAID PROVISIONS

A. Coverage of Aged and Disabled Persons Below Federal Poverty Line Permits States to cover under Medicaid aged and disabled persons with incomes up to a State-established level up to 100% of the Federal poverty line. A State can offer either the Medicaid benefit package or alternatively just cover the Medicare cost sharing charges.	A. Coverage of Aged and Disabled Persons Below Federal Poverty Line Mandates States to pay Medicare cost-sharing charges for all aged and disabled persons below the poverty line. With respect to the drug deductible, a State could either reimburse for incurred charges below the deductible or offer the same drug coverage (up to the deductible) as offered to other beneficiaries.	A. Coverage of Aged and Disabled Persons Below Federal Poverty Line Requires States to use Medicaid savings attributable to Medicare catastrophic benefit for either or both of the following: 1)paying for Medicare cost-sharing charges for persons below poverty line; or 2) increasing the maintenance needs allowance applicable for the community spouse of institutionalized individuals.

B. SPOUSAL IMPOVERISHMENT Establishes certain rules for determining income and resources, including what amounts are included or disregarded and how the income and resources of an individual's spouse are counted. An institutionalized individual with a spouse in the community is permitted to keep an amount for the maintenance needs of his spouse; however, this amount is set at welfare levels. As a result of Medicaid rules, both for determining eligibility and in the treatment of income after eligibility has been established, the community-based spouse may become impoverished; this is referred to as spousal impoverishment.	B. SPOUSAL IMPOVERSIHMENT Specifies that in determining eligibility, half of the income would be attributable to each spouse. Provides for a one-time determination of resources, with half attributable to each spouse; specifies that the institutionalized spouse may transfer to the community spouse the amount necessary to bring the community spouse's share up to $12,000. If the community spouse's share is over $48,000, the excess is to be attributed to the institutionalized spouse. Permits the community-based spouse to keep an amount equal to 150% of the poverty line plus half the couple's income over that amount not to exceed $1,500. Establishes a uniform national policy on transfer of assets.	B. SPOUSAL IMPOVERISHMENT See "A" above.

Both H.R.2170 and S.1127 contain a number of additional provisions which are not sumarized in this document.