Statement of
Rosemary D. Marcuss
Assistant Director
Tax Analysis Division
Congressional Budget Office

before the
Committee on Finance
United States Senate

March 26, 1987

NOTICE
This statement is not available for public release until it is delivered at 10 a.m. (EST) on Thursday, March 26, 1987.

The Congress is considering proposals that would expand Medicare coverage and set a maximum on the amount that an enrollee could spend out-of-pocket for health services covered by the program. Most proposals would also provide for new trust fund revenues that would offset the added program outlays.

At your request, my remarks are limited to the financing of catastrophic insurance benefits under Medicare. After outlining the way Medicare is currently financed, this statement focuses on three topics:

- The issues that must be resolved in financing new benefits,
- Some illustrative financing options and their revenue potential, and
- The relative burden of payments under these alternatives for families at different income levels.

BACKGROUND

Established in 1965, Medicare will insure about 29 million elderly and 3 million disabled Americans in 1988. The Hospital Insurance (HI) portion of Medicare--which provides inpatient hospital, skilled nursing, and home health services--is financed largely from payroll taxes, currently set at 1.45 percent of covered wages from both employers and employees. The Supplementary Medical Insurance (SMI) portion--which provides physician,

hospital outpatient, laboratory, and other services--is financed largely by federal general revenues and enrollee premiums, currently set at $17.90 per month. Only 8 percent of Medicare receipts come from current enrollees, while 92 percent come from general taxpayers and wage earners, as shown in Table 1.

TABLE 1. SOURCES OF INCOME FOR THE MEDICARE TRUST FUNDS, FISCAL YEAR 1988

Trust Fund/Income Source	Income	
	Billions of dollars	Percent of total
Total	101.4	100
Hospital Insurance		
Payroll taxes	61.7	61
Interest	4.6	5
Other	0.9	1
Supplementary Medical Insurance		
Enrollee premiums	8.0	8
Transfers from general revenues	25.4	25
Interest	0.8	1

SOURCE: Congressional Budget Office baseline for fiscal year 1988.

Medicare leaves "gaps" in its coverage of hospital and physician services, including deductibles, coinsurance, and limits on covered hospital days. To protect against large out-of-pocket costs that might arise because of these gaps, a market in private supplementary insurance--"medigap" policies-has developed. Like all private insurance, the premiums paid for these policies finance both health care benefits and the marketing and administrative costs of the insurance; the nonmedical portion of the cost typically ranges from 15 percent to 35 percent of the premium paid by the elderly. Medigap insurance covered about 45 percent of the elderly in 1967. By 1984, more than 70 percent of the elderly had medigap coverage. Medicaid fills the same gaps in coverage for an additional 10 percent of low-income elderly, making almost 80 percent of the elderly covered for such costs.

About 20 percent of the elderly, or about 6 million enrollees, have no supplementary coverage to protect them against high out-of-pocket expenses for services covered by Medicare. These people--who tend to be older, in poorer health, and of lower income than those with medigap insurance--may be of particular concern to the Congress as it considers changes in Medicare's benefits to provide coverage against catastrophic expenses.

ISSUES IN FINANCING NEW MEDICARE BENEFITS

If the Congress decides to expand Medicare benefits to provide coverage against catastrophic expenses, it could choose among a range of sources of additional trust fund revenue to finance the added outlays. The choice among sources of revenue raises several issues:

- Who should pay?
- How should these payments be collected? and
- How can unintended side effects be kept to a minimum?

Who Should Pay?

In considering who should pay, the Congress must first determine both the mix of payments from general taxpayers and current program beneficiaries and how payments might be related to the incomes of those who pay. Raising a given amount of revenue from many taxpayers would lead to a lower incremental contribution per person. Furthermore, increased payroll taxes could be viewed as a contribution by workers toward their own future benefits.

On the other hand, raising trust fund revenues by increasing payments of current enrollees would place the responsibility on those who would benefit directly from the increased Medicare coverage. Because many enrollees have medigap policies, their additional contributions would be offset by savings on their private insurance premiums, since those policies would be modified to reflect the expansion of benefits under Medicare. Moreover, the elderly may be capable of financing a modest increase in benefits, since their income over the last two decades has risen relative to the income of the nonelderly.

The issues before the Congress concern not only the relative contributions of general taxpayers and current enrollees, but also whether or not payments should be based on ability to pay. For example, if the new benefits were financed by the payroll tax, the increase might be distributed in proportion to current payroll taxes, or it might be targeted toward those with the highest wages who currently pay taxes on only part of their earnings. Although an increase in the payroll tax rate would spread the cost of expanded coverage over all 75 million families with earnings, workers already face a payroll tax increase next January. Eliminating the maximum on taxable earnings subject to the payroll tax ($45,300 in 1988) would limit

the tax increase to families with the greatest ability to pay but would place a large burden on these families.

Similarly, if additional payments are limited to current enrollees, the Medicare premium might be increased for all enrollees or, alternatively, payments might be related to income. Raising the premium for all enrollees would be consistent with the view that since benefits do not vary systematically by income, neither should payments. On the other hand, equal per capita payments would collect a larger share of income from low-income enrollees than from those with higher incomes. Furthermore, since benefits to the average current Medicare enrollee far exceed the value of past contributions, some observers argue that the subsidy to higher-income enrollees is already too great relative to their ability to pay.

How Should these Payments be Collected?

The choice of financing mechanisms also raises issues of administrative feasibility and cost. If additional payments are to come from general taxpayers, a number of current revenue sources--including the payroll tax, the personal income tax, and selective excise taxes--could be increased or altered with relatively minor administrative costs. These tax sources offer a range of options in relating payments to ability to pay.

At present, the only source of payments from Medicare enrollees is the SMI premium. If the Congress wishes to increase enrollee payments in a way that is related to the income of the enrollee, it could not use the SMI premium as a vehicle because the Medicare program does not collect information on income as part of its eligibility process. Establishing a system for collecting and verifying income data for 32 million enrollees would be very costly.

Options that take advantage of income data already collected by the Social Security Administration and the Internal Revenue Service (IRS) would be more feasible administratively. The drawbacks to these two sources are that they use an incomplete definition of income and, especially in the case of IRS data, exclude many Medicare enrollees. About half of Medicare enrollees do not file tax returns--for the most part, because Social Security benefits are not taxable for most recipients. In 1988, individuals with less than $5,900 and couples with less than $10,100 in income from taxable sources will owe no income taxes regardless of the size of their Social Security benefits.

How Can Unintended Side Effects be Kept to a Minimum?

A final issue in choosing financing mechanisms is to minimize side effects. For example, if the expanded Medicare benefits were to be financed solely through higher premiums based on enrollee income, the payments required of high-income enrollees could exceed the value of their Medicare benefits. Payments of this magnitude could represent an unfair burden to these enrollees. Some current enrollees, when faced by this prospect, might in fact drop out of Medicare and either seek private insurance or go without insurance. To keep this unintended effect to a minimum, the income-related payment per enrollee could be limited--for example, to an amount that would be less than the insurance value of Medicare benefits.

SOME ILLUSTRATIVE FINANCING OPTIONS

The Congressional Budget Office's (CBO's) preliminary estimate of the benefits under the catastrophic insurance plan proposed by Department of Health and Human Services Secretary Bowen is about $2 billion in 1988. Other proposals would involve considerably greater benefits. The remainder of my statement will illustrate a range of financing options by discussing two alternatives for increasing payroll taxes and four alternatives that

would affect only current enrollees. Table 2 gives a brief description of each option and shows approximately how much revenue it could raise. An expansion of Medicare benefits could be financed with these or other options, used alone or in combination. Some of the options do not raise enough revenue to finance current proposals on their own. A combination of options may be necessary to achieve a desired mix of financing between all taxpayers and current enrollees, or between enrollees of different income levels. The revenue amounts in the table do not represent official budget estimates for any specific proposal. The income tax estimates are calendar year tax liabilities.

CBO has examined two means of increasing payroll taxes. One would be to raise the current Hospital Insurance payroll tax rate by 0.10 percent--from 1.45 percent to 1.55 percent--for both the employee and the employer. This increase would add $3.9 billion in revenue for 1988. An alternative would be to raise the maximum amount of wages on which the HI portion of the payroll tax must be paid. In 1988, the taxable maximum is projected to be $45,300. Eliminating the cap (that is, making total wage, salary, or self-employment income for each worker taxable) would yield about $5.6 billion in revenue in 1988.

TABLE 2. EXAMPLES OF FINANCING SOURCES AND THEIR REVENUE POTENTIAL, 1988 a/

Financing Source	Approximate Revenue Potential (In billions of dollars)
Payroll Tax Options	
Increase the Hospital Insurance Payroll Tax Rate from 1.45 Percent to 1.55 Percent	3.9
Eliminate the Maximum on Taxable Earnings ($45,300 in 1988) for Calculating the Hospital Insurance Payroll Tax	5.6
Options that Affect Current Medicare Enrollees Only	
Impose a Premium on All Current Enrollees	
$5 per month	1.8
$10 per month	3.6
Impose a Fee Based on the Level of Social Security Benefits	
1 percent of benefits	1.6
2 percent of benefits	3.3
Impose a Surcharge on the Taxable Income of All Current Enrollees	
1 percent up to the value of new benefits b/	0.9
2 percent up to the value of new benefits b/	1.1
5 percent up to the value of new benefits b/	1.2
1 percent up to the SMI subsidy value c/	1.9
2 percent up to the SMI subsidy value c/	3.4
5 percent up to the SMI subsidy value c/	6.1
Include a Portion of the Actuarial Value of Medicare in Adjusted Gross Income d/	
Include 50 percent of the actuarial value of HI	2.4
Include 75 percent of the actuarial value of SMI	2.2
Include 50 percent of the actuarial value of HI and 75 percent of the actuarial value of SMI	4.8

SOURCE: Preliminary Congressional Budget Office estimates.

a. Calendar year; assumes full implementation on January 1, 1988.
b. Assumes that new benefits average $100 per enrollee.
c. The SMI subsidy value--that is, the value of SMI benefits in excess of premiums paid--is projected to be $845 per enrollee in 1988.
d. The actuarial value of Medicare benefits is defined as total benefit payments divided by total enrollees--that is, average benefits.

The remaining options would affect only current Medicare enrollees. The first alternative would be to impose a premium on all current enrollees. A premium increase of $5 per month would net the government $1.8 billion in 1988. An increase of $10 would raise twice as much.

One way to base payments on income might be to use Social Security benefits to represent ability to pay. Supplementary Medical Insurance premiums are now collected by the Social Security Administration, so it would be feasible to collect a fee based on the level of Social Security benefits. If all Medicare enrollees were charged a fee equal to 2 percent of their Social Security benefits, about $3 billion would be raised.

Alternatively, income-related options could use the individual income tax system to raise additional revenue from current Medicare enrollees. One set of options would apply a surcharge to their taxable income. The first of these options would impose a surcharge of 1 percent of taxable income, but would limit each enrollee's liability to the average cost of the new benefits. If the new Medicare benefits cost $100 per year for each beneficiary, this option would generate about $1 billion of the $3 billion total cost. Raising the surcharge rate above 1 percent would bring in

relatively little additional revenue, because many taxpayers would pay the maximum $100 surcharge with even a 1 percent tax. By design, no beneficiary would pay more than his or her share of the costs, and many beneficiaries would pay nothing because their taxable income would be too low. Consequently, these options would have to be combined with some additional revenue sources in order to be self-financing.

The other surcharge options would allow the surcharge paid by an individual to be as high as the total subsidy value of SMI. For current enrollees with high incomes, these surcharges would result in payments that exceed their new benefits. In 1988, the subsidy value under current law would be $845. Revenues would increase by $1.9 billion with a 1 percent surcharge. A 5 percent surcharge would generate about $6.1 billion. 1/

The final set of options would require Medicare enrollees to include part of the actuarial value of their benefits in adjusted gross income (AGI) for purposes of the individual income tax. Including 50 percent of the

1. The maximum tax could be raised to include part of the actuarial value of the Hospital Insurance portion of Medicare. For example, including half of HI would add an additional $0.1 billion with a 1 percent surcharge, $0.4 billion with a 2 percent surcharge, and $2.0 billion with a 5 percent surcharge.

actuarial value of Hospital Insurance benefits provided under current law would generate about $2.4 billion in 1988. Including 75 percent of the current law value of SMI benefits would generate about $2.2 billion. 2/Revenue would increase by $4.8 billion if both parts of Medicare were made partially taxable. 3/ Revenues from these options would be somewhat higher if the value of new benefits were made taxable also.

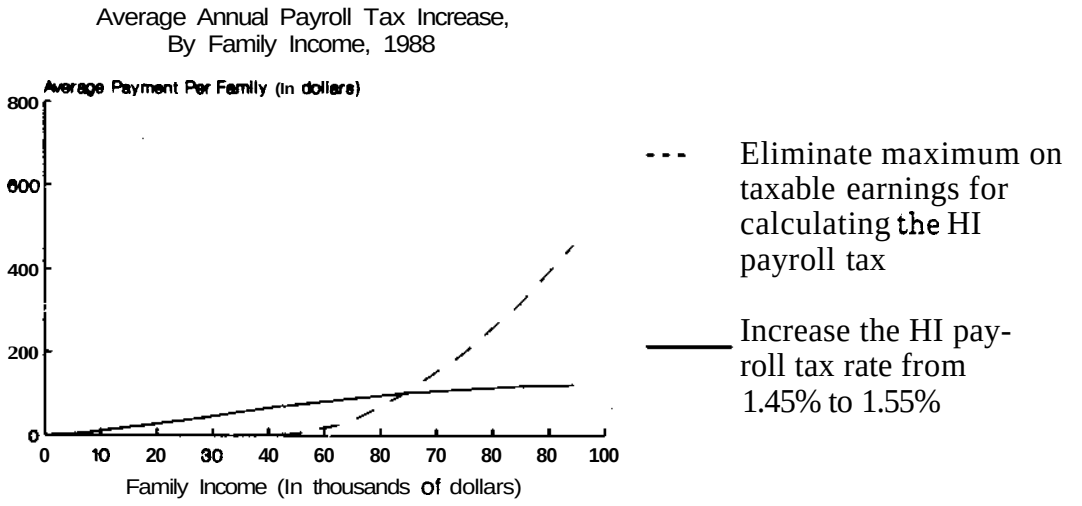
DISTRIBUTION OF PAYMENTS BY FAMILY INCOME

The illustrative options presented here would collect different amounts from people at different income levels. Figures 1 and 2 show the probable patterns of average annual payments by family income level for options affecting wage earners and for options affecting current enrollees, respectively. Family income is the total annual cash income (including realized capital gains) for all related persons living in the same household.

2. It is sometimes argued that Medicare's HI benefits are 50 percent earned as a result of an enrollee's past payroll tax contributions and 50 percent subsidized through past employer payments. Medicare's SMI benefits are partly financed by current enrollee premiums, which represent about 25 percent of program costs, and are 75 percent subsidized by transfers from general revenues.

3. The inclusion of both HI and SMI would raise more revenue than the sum of their separate yields, because any expansion of adjusted gross income moves families onto the tax rolls and into higher tax brackets.

FIGURE 1. AVERAGE ANNUAL PAYROLL TAX PAYMENT, BY FAMILY INCOME, 1988



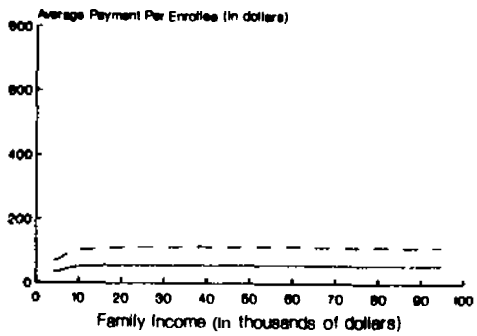
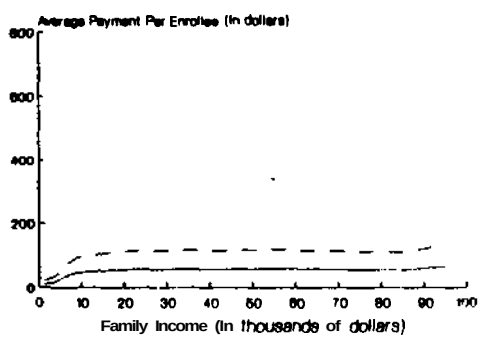
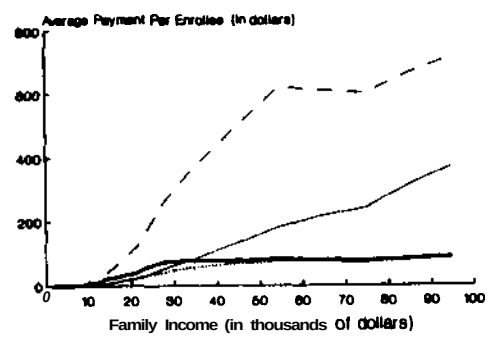
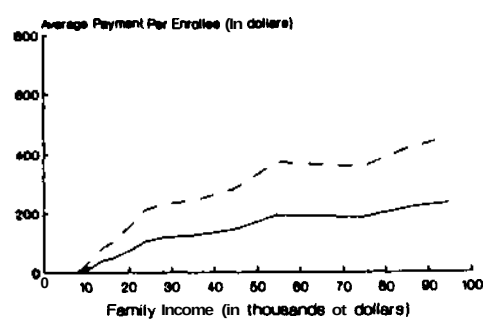
SOURCE: Preliminary Congressional Budget Office estimates.

Figure 1 compares two payroll tax options that would affect wage earners. A small increase in the current tax--represented by the solid line-would cost an average of nearly $60 per family (one-half from employees and one-half from employers) for about 75 million families. Although in 1988 each worker will stop paying payroll taxes when his or her earnings reach $45,300, average payments would continue to rise for families with incomes above that level because many of those families earn less than the

ceiling. Also, families with more than one worker would, in effect, face a higher ceiling. In contrast, the elimination of the taxable earnings ceiling--represented by the broken line--would leave all of the nearly 80 percent of families with incomes below $45,300 unaffected, but would collect rapidly growing amounts from families at incomes above that level. The average payment per family among all those families paying the new taxes would be $800 per year; among those with incomes above $100,000, it would be $1,700 per year.

Figure 2 shows the same type of information for financing options that would affect only current enrollees. Each panel represents one of the four generic options-premiums, fees on Social Security benefits, surcharges on enrollees' taxable income, and making some Medicare benefits subject to income taxation-while the different lines in each panel display the effects of variants on these options. The lines represent average increases in payments for current enrollees, including those whose increase is zero. The average increase for enrollees who do pay more may be much higher than the average payment shown here.

FIGURE 2: ILLUSTRATIVE PAYMENTS FROM CURRENT MEDICARE ENROLLEES

	Option	Percent of Enrollees Affected	Average Payment Per Enrollee
A Average Annual Premium. By Family Income. 1988 	--- $10 per month premium	88	106
	—— $5 per month premium	88	53
B. Average Annual Social Security Fee. By Family Income. 1088 	--- 2% fee on Social Security benefit	86	101
	—— 1% fee on Social Security benefit	86	55
C. Average Annual Taxable income Surcharge, By Family Income, 1988 	--- 5% surcharge up to subsidy value of total SMI benefit	45	192
	—— 1% surcharge up to subsidy value of total SMI benefit	45	60
	▬▬ 5% surcharge up to subsidy value of new benefits	45	40
	... 1% surcharge up to subsidy value of new benefits	45	28
D Average Annual Income Tax Increase From Counting Some Medicare Benefits as Taxable Income, By Family Income, 1988 	--- Include 50% of actuarial value ofHI and 75% of SMI in AGI	52	152
	—— Include 50% of actuarial value ofHI in AGI	48	76

SOURCE: Preliminary Congressional Budget Office estimates.

Premiums and fees related to Social Security benefits generally would not vary with income (see Panels A and B in Figure 2). The two approaches based on the income tax would leave enrollees with the lowest income unaffected but would collect increasing amounts as income rises to levels at which the maximum tax would be reached (see Panels C and D). In looking at these illustrations, it is important to keep in mind that 54 percent of current enrollees have incomes below $20,000 and only 11 percent have incomes of $50,000 or more.

Panel A of Figure 2 shows the effect of two possible premium increases by level of income. Because Medicaid pays the premium for many enrollees at low levels of income, the average payment is low. At levels of income above $15,000, most enrollees would pay their own premiums, with little variation in the average payment.

Panel B shows the effect of two possible options in which the payment would be a fraction of an enrollee's Social Security benefit. The pattern of payments is quite similar to that in Panel A, but the average payments for the Social Security options are somewhat lower for families with incomes below $10,000.

Panel C shows the effect of four possible surcharges on taxable income. Most families with incomes below $10,000 would be unaffected by all of these options because they have no taxable income. The bottom two curves represent surcharges capped at the subsidy value of new benefits--$100 in this example. Average payments with a 5 percent surcharge rise faster than average payments with a 1 percent surcharge, but the two payments merge at about the $50,000 income level, where most enrollees would pay the maximum surcharge at either tax rate.

The top two curves in Panel C represent surcharges that can be as high as $845 per enrollee. Again, payments with a 5 percent surcharge rise faster than the 1 percent surcharge. Average payments from a 5 percent surcharge with an $845 cap quickly rise above average payments with a $100 cap, because only $2,000 of taxable income is necessary to hit a $100 maximum tax with a 5 percent tax rate. Average payments for both 1 percent surcharges are the same up to family income of about $20,000.

The final panel represents the effect of including the actuarial value of Medicare in adjusted gross income. These options affect enrollees at somewhat lower levels of income than the surcharge options because some

enrollees who have no taxable income under current law would owe taxes under these options. Although these tax options show a stronger relationship between average payments and family income than some other options, there is a good deal of variation in actual payments at each family income level. The variation arises because families with the same total income may have quite different amounts of taxable income.

CONCLUSION

If the Congress chooses to expand Medicare benefits to reduce the risk of catastrophic out-of-pocket costs, it must resolve many issues when selecting from among alternative sources of financing for these benefits. The most general choice involves how the additional payments would be divided among general taxpayers, wage earners, and current enrollees. In addition, there is a choice of whether or not payments should be related to ability to pay. The options analyzed separately here provide a range of possible resolutions of these issues. Moreover, a financing package that would depend on a mix of options could provide distributions of total payments that would fall within the range of those shown here.