SCALING MEDICARE BENEFITS TO INCOME

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Scaling Medicare benefits to income--often described as "means-testing"--implemented through increased cost-sharing for higher-income individuals could reduce federal outlays while protecting elderly and disabled enrollees who are least able to afford increased medical costs.[1] Since Medicare benefits are currently available to all enrollees regardless of income level, increased cost-sharing without means-testing would affect those at all income levels.

Medicare currently requires beneficiaries to contribute to the costs of covered services through premiums for Supplementary Medical Insurance (SMI), and through coinsurance (a percentage of each charge) and deductibles under both SMI and Hospital Insurance (HI). SMI coinsurance applies to all covered physician and other provider charges (except home health). HI assesses coinsurance only after 60 days of short-stay hospitalization or 20 days in a skilled nursing facility. Costs of the premiums, coinsurance, and deductibles for an average elderly Medicare enrollee are expected to be $505 in 1984. These costs represent less than one-third of all out-of-pocket costs for elderly Medicare enrollees, however, since a large portion of medical expenses--outpatient drugs and much nursing home care, for example--are not covered by Medicare. Moreover, Medicare-related cost-sharing can be very high for those in poor health. For example, the approximately 11 percent of beneficiaries with Medicare reimbursements in excess of $5,000 are expected to have Medicare cost-sharing expenses averaging $1,675 in 1984.

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1. Means-tests often are applied to other resources in addition to income. The terms "means testing" and "income testing" will be used interchangeably.

Relief from these costs is available to many low-income Medicare beneficiaries who also participate in Medicaid. For the low-income enrollees outside that program and for moderate-income enrollees, however, increases in Medicare-related cost-sharing might be burdensome.

THE RATIONALE FOR MEANS-TESTING MEDICARE BENEFITS

If benefits under Medicare are restructured to reduce federal outlays, some form of means-testing might enable higher savings while ensuring more protection for those with modest incomes than if cuts were instituted across the board. For example, hospital coinsurance could be raised on the early days of a hospital stay and the rate made even larger for those with higher incomes. Increasing beneficiary liability on average by $500 per year might be considered unacceptable for elderly or disabled beneficiaries with low incomes, but more reasonable for those whose incomes are, say, $20,000 per year or more.

Moreover, some changes might be viewed as providing additional protection to low-income individuals rather than as denying coverage to high income enrollees. For example, increased hospital or physician coinsurance could be combined with a "cap" or limit on the out-of-pocket liability of low-income beneficiaries. This would constitute a form of income-testing--and one that might allow the coinsurance changes to be greater, since low-income persons would receive some protection against catastrophic expenditures.

A number of approaches could be used, including:

- o Scaling SMI premiums to income;
- o Changing the coinsurance or amount of services covered to reduce benefits for those at higher incomes; or
- o Placing an upper bound on Medicare out-of-pocket liability which would increase with income.

The next section discusses some of the general issues regarding means-testing. Then after a brief discussion of how changes in cost-sharing may also affect use of medical services, each of these types of options is examined in more detail.

GENERAL CONCERNS ABOUT MEANS-TESTING

Regardless of the specific option, a number of broad questions arise when considering introducing some form of means-testing for Medicare. The first, whether means-testing is appropriate for Medicare, may dominate any discussion. In addition, a number of practical concerns arise in the context of relating benefits to income. The costs of administering any income test would depend upon how those practical concerns are treated in any specific option.

Medicare: A Benefit or A Social Insurance Program?

One of the primary concerns in evaluating means-testing as an option for Medicare is the question of whether this program is to be viewed as a benefit or an insurance program. If it is purely a social insurance program, many would argue that benefits should be available equally to all eligible enrollees since such eligibility is tied to those with Social Security coverage who have paid into that system for many years.

The structure of Medicare, however, implies that it may not be a pure social insurance program. After an initial period of blanket coverage for the elderly, entitlement to Hospital Insurance (HI) benefits is now restricted to individuals eligible for Social Security. Social Security taxes now place a contribution equal to 2.6 percent of taxable payroll in the Medicare trust fund that is earmarked for HI benefits.[2] These contributions have only been made since 1966, however, and payment of benefits to the aged and disabled currently enrolled in Medicare far outstrip the actuarial value of their contributions into the system. Although each year new beneficiaries have a longer history of contributions, the rate of return on such payments under the current program is projected to remain very high. For example, an elderly couple each reaching age 65 in 1982, of whom one spouse had average covered earnings over the 1966-1982 period, would have paid in $2,200. The present value of their future lifetime benefits is projected to be $63,000--28.6 times the contribution.[3]

SMI has less claim to being social insurance, particularly for the elderly. This program receives no payroll tax contributions and any elderly person is allowed to participate, regardless of Social Security eligibility. SMI premiums currently pay for only 25 percent of program costs. SMI could, therefore, be considered purely a benefit program.

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2. The 2.6 percent is the combined employer-employee contribution. For self-employed individuals, the figure is 1.3 percent in 1983.

3. This estimate is based on 1982 Alternative II-B assumptions as contained in the Annual Report of the Board of Trustees of the HI trust fund. The return to a couple both working would be lower. Moreover, contributions will rise over time as people pay in for longer than the 17 years in this example.

Problems with Income-Testing

Aside from the general criticism that income-testing would change the nature of Medicare, many of the other objections to such an option center on the practical problems associated with implementing it. Perhaps the most difficult are the need to define and measure resources appropriately and then to develop a viable formula for applying income-testing. Most of these issues are common to all means-tested programs, however, so they do not necessarily preclude the use of income-testing under Medicare.

Defining Resources. Since the goal of income-testing is to distinguish among beneficiaries according to their ability to bear a greater share of medical costs, it would be necessary to use a measure of "means" that captures economic resources available to beneficiaries. The usual measure for such well-being is income--defined as periodic payments to individuals in the form of wages, salaries, interest, dividends, rent, pensions, annuities, and cash benefits such as Supplemental Security Income (SSI) or Social Security. This measure of income would capture most of the flows of resources into a household during the year. It might not, however, reflect ability to purchase medical care for families that differ in a number of other respects.

One important source of ability to purchase medical care not included in income would be the asset holdings of a family in the form of savings, stocks, or ownership of a home. Such assets are particularly important for the elderly compared with the general population--more than 70 percent of the elderly own homes and over two-thirds of them have income from liquid

assets. Families with equal levels of income might have very different levels of assets--and hence different resources from which to draw to purchase medical care. Moreover, even for those with similar dollar amounts of asset holdings, the form of the assets might matter. A $100,000 fully owned home is less liquid than $100,000 in a savings account. It might be necessary to use a separate asset test in conjunction with the income test.

In addition, families with equal incomes and assets might not be alike in terms of the demands, both medical and otherwise, placed on their resources. Families of different size face different expenditures for food and housing. Moreover, for an elderly couple, large medical bills for one spouse are more difficult to pay if the other also has high medical expenses.

Measuring Resources. Incorporating additional dimensions to the definition of "means" would not necessarily represent a viable approach for measuring resources, since each complication would add to the intrusiveness and ex-pense of means-testing. The simpler the definition, the more likely that the means test could be uniformly applied--and the more likely that it would fail to distinguish well among those with different abilities to pay medical bills.

The goal of a simple definition of economic well-being would best be met by a measure that corresponds to other commonly used definitions. For example, income reported for tax purposes to the Internal Revenue Service is such a measure, although it varies substantially from a comprehensive measure of income. In the case of the elderly and disabled, the largest

source of difference is likely to be Social Security and other transfer payments or pension benefits, which are excluded from taxable income. This exclusion substantially understates income for Medicare beneficiaries; indeed, some of the aged do not file federal income tax forms since they owe no tax--their incomes other than Social Security is lower than the standard deductions and exemptions.

An income test could be developed based on adjusted gross income from the tax form or perhaps adjusted gross income plus Social Security and other untaxed income. Another possibility is to use the more complicated reporting required for participation in SSI. Any measure that would be chosen, however, would be unlikely to reflect accurately the ability of some portion of the elderly and disabled to finance medical care. For example, using adjusted gross income from the income tax system plus cash transfer payments--thereby ignoring much of the contribution of assets--would subject persons with higher levels of wealth to the same liability for medical costs as someone with an equal level of income but no assets.[4] Moreover, any measure would likely have to be based on the previous year's income, again distorting the current resources available to some beneficiaries.

Establishing the Structure for an Income Test. Income tests (such as for Medicaid) may operate by establishing a dollar level, below which benefits are available and above which they are not. In other cases, the cutoff point is phased in to avoid problems with discontinuity in benefits

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4. Assets such as real property that is not sold in any year would be ignored as would more liquid assets such as tax-free bonds, for example.

around the cutoff. For example, income-testing through such cutoffs would likely lead to a change in Medicare's deductible or coinsurance amounts. Alternatively, a cap or limit on total liability could be imposed differentially depending upon income level.

The simplest approach would be to use only one or two cutoff points, although this would necessarily create discrepancies in coverage between those just above and those just below an arbitrary cutoff. If the difference in benefit coverage is great, individuals with high expenses but incomes just above the cutoff could end up worse off than persons just below the threshold. Using several cutoffs could allow slower gradations of benefits and avoid some of these problems. A further refinement would be to set the cutoff as a percentage of the defined level of resources, so that it would vary continuously.

On the other hand, with only one or two cutoffs, an income test could be further simplified by making it voluntary. That is, persons could be subject to the highest level of cost-sharing or limit unless they applied for a lower rate, which would require verification of income (and perhaps assets) below a certain limit. In this way, only persons applying for the preferential rate would have to be certified. Individuals with resources above the established limits (or who choose not to apply) would not need to reveal their incomes. Even if a phase-in were used--for example, slowly raising the liability limit above the initial income cutoff--this voluntary approach could still be maintained.

In fact, such a scheme could be implemented outside the Medicare program entirely, technically avoiding the issue of income-testing Medicare benefits. Medicaid currently provides protection for very low-income individuals. In some states, such aid is available for the medically needy as well as those eligible for other welfare programs. The medically needy are defined as those who become eligible as a result of high medical expenses (and low income). The medically needy portion of that program could be expanded to include moderate-income elderly and disabled persons, although such an approach would require a number of complicated changes.[5]

Finally, the level of any cutoffs would also be important since there would be a tradeoff between protecting beneficiaries from burdensome liabilities and reducing the cost of the program. If the first cutoff was set relatively high, say, at $25,000 of income, the use of a means test might be less controversial. Since many of the elderly and disabled have relatively low incomes, however, a high cutoff would also reduce the federal savings generated. For example, it is projected that by 1983 only 32 percent of the elderly will be in families with incomes over $20,000. Moreover, use of medical care is lower on average for those in the highest income categories so that any savings generated would be less than proportional to the size of the affected group.

Administrative Issues. The approach used to address each of the problems just described would affect the complexity of the required

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5. For example, states vary considerably in the type of benefits covered. Moreover, coverage of the medically needy is optional.

administrative structure from various income-testing options. Two additional administrative functions would need to be added to Medicare: certification of income eligibility and coordination of the particular change in Medicare benefits.

It might be feasible to use existing administrative groups--for example, through the Internal Revenue Service or the Supplemental Security Income portion of Social Security--to manage the certification of income or resources. If the structure was simple and participation voluntary, the administrative costs would likely be relatively small.

Another important administrative issue relates to the specific form of the benefit structure change. If the income test would mean lower coinsurance on beneficiaries, for example, Medicare intermediaries (for HI) or carriers (for SMI) who process claims would have to participate in the implementation. In contrast, if only SMI premiums were affected, the implementation could be much simpler. Finally, if differing limits on liability were imposed, carriers and intermediaries could be avoided, but it would be necessary to have an administrative structure to verify that the limits on cost-sharing had been met. This would be particularly cumbersome in the case of a limit on combined HI and SMI cost-sharing since such coordination is not now undertaken.

INCOME-TESTING, COST-SHARING, AND CHANGES IN HEALTH CARE USE

Some options for introducing income-testing would involve increased cost-sharing that would lead to changes in behavior on the part of

beneficiaries. For example, if income-testing is introduced through higher coinsurance on beneficiaries above a certain income level, outlay savings would be generated from both greater payments by patients and potentially lower use of medical services in response to the higher implicit "price" of care.[6] This latter, indirect source of savings would not result in higher costs to beneficiaries, although the impact of reduced medical care use on the health status of beneficiaries is unknown.

The impact on use of services would, however, be less than is implied by looking only at any change in Medicare coverage. The existence of private supplemental, or "Medigap," coverage--which usually pays Medicare deductible amounts and coinsurance--tends to keep the price of medical care at or near zero, thus negating the incentives to lower medical care use. If these cost-sharing changes are confined to high-income beneficiaries, the effect of private insurance will be particularly strong since such individuals are more likely to have purchased supplemental coverage. Controls could be placed on Medigap coverage to limit its offsetting effects, however. For example, a premium tax could be assessed against that portion of supplemental policies directed at Medicare coinsurance and deductibles.

SPECIFIC OPTIONS

The options described here are meant to be illustrative of how means-testing could be introduced into Medicare. Family household income for 1984 is used in all the estimates. This measure includes earnings, pensions,

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6. "Price" in this context refers to the amount beneficiaries must pay. This is generally indicated by the deductible amount and coinsurance.

cash transfer payments, and interest, rent, and dividends. No adjustments are made for family size. Only one specific option is estimated to illustrate the general strategies, although as discussed above, a large number of variations within each option would be possible. In general, the income cutoff used for these examples is $20,000. Higher income cutoff levels would greatly reduce outlay savings; lower ones would increase them.

SMI Premium

An increase in SMI premiums would increase costs to all Medicare enrollees in the affected income group. Unlike higher deductibles and more coinsurance, which would result in variation in cost-sharing liability within a particular income group depending on the actual use of medical care, costs of higher SMI premiums would be evenly spread (and consequently more predictable). SMI premiums could be increased in several stages for those at various income levels--or they could be set at a percentage of income so that they would vary continuously with income.

The option estimated here would (on January 1, 1984) increase premiums to 35 percent of the average incurred costs of an elderly beneficiary for those with incomes between $20,000 and $30,000 and to 50 percent for those with incomes above that level. The premium would remain unchanged at 25 percent for those with incomes below $20,000. The income limits would be indexed to rise over time with increases in the Consumer Price Index. The amounts paid by each income group would also increase with the per capita rise in Medicare SMI reimbursements. Outlay

savings for fiscal years 1984, 1985, and 1986 would total $4.1 billion (see Table 1).

TABLE 1. FEDERAL SAVINGS FROM INCOME-TESTED OPTIONS FOR MEDICARE

Option	1984	1985	1986	3-Year Total
SMI Premium Increase[a]	0.9	1.3	1.9	4.1
SMI Coinsurance Increase[b]	0.1	0.1	0.1	0.3
HI Coinsurance Increase with Limit on Total Cost-Sharing[b]	0.1	0.2	0.2	0.5

a. These figures reflect revenue increases from higher premiums.

b. These figures reflect outlay reductions.

Medicare subsidies for SMI were originally intended to pay only half of the costs of the program, so this change would reflect a return to the original intent for those with incomes in excess of $30,000. Moreover, the annual cost of these premiums would rise by only about $235 by 1986 over what they are estimated to be under current law, so that no one individual would face an extraordinarily large increase in liability.

On the other hand, since total outlay savings would come from the premium increases, such a change is unlikely to encourage more prudent use of medical care (which could in turn generate additional savings). Only options in which the costs to beneficiaries would vary with medical care use would generate these indirect savings.

Coinsurance

The terms of coinsurance on ambulatory services and hospitalization could also be varied by income. This could involve increasing the level of coinsurance (for example, under SMI which is almost fully comprehensive) or expanding the areas in which coinsurance is applied (for example, to hospital care which has only limited coinsurance under current law) for those at higher income levels.

For example, persons with incomes over $20,000 could be subjected to 25 percent SMI coinsurance (instead of the current 20 percent level). Three-year savings from this option would be $0.3 billion.[7]

Unlike a large increase in the deductible, all beneficiaries would remain eligible for Medicare benefits--albeit with a greater degree of SMI cost-sharing for those with higher incomes. Moreover, increased SMI coinsurance--unless fully offset by private supplemental coverage--might result in some outlay savings from reduced ambulatory care, and even hospital care (since hospital use tends to fall when physician visits decline).

On the other hand, increased liability from this coinsurance change would be particularly costly for those with high medical use, resulting in an uneven burden among those subject to the higher rate. With no catastrophic protection, those in the worst health would bear the greatest burden. Higher cost-sharing for some beneficiaries might encourage doctors to

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7. No hospital coinsurance option is discussed here. In the next section, however, hospital coinsurance is combined with a cap on Medicare liability.

refuse assignment for those patients since persons subject to higher cost-sharing could also be viewed as able to afford added physician's charges (beyond the allowed charge) as well.

Limits on Medicare Liability

Placing limits on Medicare-related liability of enrollees in conjunction with other increases in cost-sharing would reduce the outlay savings from any one change but would increase the protection of those within any one income category. This limit could be varied by income level of the enrollee; that is, the higher-income beneficiary would pay more of the costs of covered services before reaching the limit on liability.

The specific option estimated here is based on increased hospital coinsurance, which would begin on the second day of a hospital stay and would charge patients 10 percent of the HI deductible amount--about $35--for each additional hospital day. A two-tiered limit on all HI and SMI premium, deductible, and coinsurance payments would be used--persons with incomes below $20,000 would pay no more than $1,500 per year, whereas the limit would be $3,000 for those with incomes in excess of $21,500. For those with family incomes between $20,000 and $21,500, the liability limit would rise (above $1,500) by $1 for every $1 increase in income in excess of $20,000. This combination of increased hospital coinsurance and limit on liability would generate three-year outlay savings of $0.5 billion.

A major advantage of this option is that although higher-income individuals would be liable, on average, for greater cost-sharing, they would

also receive a new benefit in the form of a cap on Medicare liability. Also, coinsurance on SMI would be particularly likely to lower use of ambulatory services (unless enrollees fully offset this increase through higher private insurance).

Unlike the other options discussed here, however, enrollees with incomes under $20,000 who use hospital care would face increased liability from hospital coinsurance, unless they were already over the $1,500 limit. Liability changes (both up and down) would vary considerably across the enrollee population. Only about one-fourth of Medicare beneficiaries have periods of hospitalization in any one year, and of that group only a small percentage are hospitalized for more than 30 days.

A Comparison of the Specific Options

The three options discussed here are intended to illustrate various approaches rather than provide an exhaustive list. As examples, they each have strengths and weaknesses that can be compared.

Changes in the SMI premium would mean that the increased costs paid by beneficiaries would be most evenly distributed within the various income categories, while the beneficiary liability changes in the last option--which combined greater hospital coinsurance with a differential cap on patient liability--would have the most unequal impact. Since increased hospital coinsurance could discourage use of hospital care, however, it might nonetheless be preferred to the SMI premium change.

Finally, the degree of intrusiveness of income-testing and related administrative costs might be a major concern in choosing among the options. As discussed earlier, the fewer the number of income cutoffs involved, the less instrusive the required testing of resources. Options such as the combined limit on cost-sharing liability would require less than 8 percent of beneficiaries to submit to a means test in order to qualify for preferential treatment.[8] On the other hand, the SMI premium option has the advantage of not involving reimbursement determinations, therefore excluding carriers, intermediaries, and even providers from both knowing of and distinguishing between enrollees with different levels of resources.

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8. Only the small portion of beneficiaries reaching the limit in any year and with qualifying incomes would need to submit to a means-test.