

Comment on “Medicare Financing Reform: A New Medicare Premium”

JACK A. MEYER

*American Enterprise Institute for Public Policy Research,
Washington*

THE ANALYSIS OF KAREN DAVIS AND DIANE Rowland is careful, thoughtful, and comprehensive. Their provocative article combines a clear, concise explanation of the problems in financing Medicare with a bold proposal that is commensurate with the dimensions of these problems.

My chief concern with the Davis-Rowland proposal is that the authors seem to load the entire burden of financing the large projected shortfall in Medicare revenues onto the elderly, justifying this step by asserting that this burden is distributed fairly, *among* the elderly. Adopting what I believe to be an unduly narrow concept of equity, the authors contrast the fairness of their proposal—a single income-related premium covering Parts A and B of Medicare that could generate enough revenue to bring outlays and resources into line—only with a “straw man” version of beneficiary cost-sharing.

The result is that their analysis has a nice ring of “internal” equity to it (*within* the beneficiary group), but is plagued by a failure to address the larger or “external” equity question: How should the financial burden of meeting the health care needs of a growing elderly population be distributed *between* the elderly, as a group, and the nonelderly working population that is taxed to support these (and

other) needs? A related question is how the needs of the elderly should be balanced against the needs of other groups in society requiring public assistance, particularly nonelderly low-income households.

To address the worker/elderly balance issue, it is necessary to compare policy options involving both benefit reductions and tax increases. In the Davis-Rowland paper, tax options are listed, but quickly dismissed, each for a separate (and sometimes unconvincing) reason. The authors then settle on a "benefit change only" approach that is supported mainly by reciting the drawbacks of beneficiary cost-sharing.

Some of the limitations of the cost-sharing approach noted by the authors are valid concerns. They fail to mention, however, some of the potentially offsetting advantages of this approach. For example, a fair system of increased cost-sharing, by coupling modest daily contributions for routine hospital stays with catastrophic illness protection, could provide incentives for earlier release from a hospital which do not jeopardize health. The authors depict all utilization reductions as dangerous if they are triggered by a greater measure of cost-sharing. They also neglect to point out that greater cost-sharing, like the premium increases they favor, could be income-related, shielding the low-income elderly from excessive outlays. By contrasting their premium plan with the harshest version of a cost-sharing approach, the authors bias the choice, even within the restrictive parameters established by their conceptual framework.

The option of gauging cost-sharing to income would raise some troublesome administrative problems. Such legitimate concerns, however, are also pertinent to the Davis-Rowland proposal. Indeed, the authors brush over the administrative pitfalls of their proposal far too quickly. They are overly optimistic about the ease with which their premium plan could be implemented through the federal tax system.

Moreover, the complications with their use of a premium increase based on some measure of income (e.g., adjusted gross income, taxable income) go beyond the pure difficulty of administering such a plan. Their proposal raises basic conceptual issues as well. For example, basing the insured's contribution to his or her own insurance on any concept of taxable income may establish a criterion for contribution that departs significantly from the ability to pay. A substantial amount of the income of many people 65 years of age or older is not subject to federal taxation (e.g., most Social Security income, up to recently enacted limits). In addition, "income" itself is somewhat incomplete

as a measure of ability of the elderly to pay. Some elderly households have relatively modest income, but substantial assets.

I would combine the best features of the Davis-Rowland proposal with the best features of a cost-sharing approach, recognizing that the low-income elderly should be shielded from any additional burden, and even relieved somewhat from present cost-sharing responsibility. For example, the merger of Parts A and B of Medicare, along with the initiation of an ability-to-pay criterion, are admirable features of the Davis-Rowland proposal. I believe that these changes could be combined with both benefit redesign and tax increases for the employed, nonelderly population to form the basic elements of a fair, comprehensive reform package.

With proper safeguards, such economizing need not jeopardize the access to or quality of care; concerns about access and quality are legitimate, but there is a tendency to associate them only with market reforms. Both market and regulatory strategists, however, must wrestle with these troublesome issues.

Let me stress that benefit redesign should not be relied upon to raise a lot of money. It is basically a fairness measure. But a benefit redesign plan could be used to reinforce the payment system reforms, such as prospective payment recently enacted in Medicare; the current benefit structure flies directly in the face of the movement toward prospective payments.

While the government tries to discourage an extra, unneeded day in a hospital, it also contradictorily makes the cost of that extra day to the patient zero, except at unusually long lengths of stay, where cost-sharing should be off-limits. If patients began to make a small contribution toward each extra day in the hospital, the government would no longer have to ask beneficiaries to ante up for a major share of the hospital bill after the sixtieth day of a visit. A little bit of cost-sharing for short-term hospital stays could avoid the need for a lot of cost-sharing for longer term stays.

Contributions by recipients could be related to their resources in two ways under my approach. First, the expanded premium (Parts A and B combined) would be based on ability to pay, as Davis and Rowland propose. Second, the "stop-loss" provision of the benefit redesign plan would also be based on ability to pay. In other words, after a household had incurred out-of-pocket expenses for health care amounting to a particular proportion of income, such as 10 percent,

their exposure to further financial “losses” would be stopped. This type of plan was proposed by Martin Feldstein a decade ago.

Other Options

We need to ask what other options are available for meeting the growing gap between Medicare’s expected resources and its expected outlays. I agree with the authors that we should reform the payment system under Medicare so as to reduce the gap as much as possible without tax and benefit changes. For this purpose I would rely on measures such as benefit redesign and a voucher system. I am skeptical of the extent to which either extending limits established in the Tax Equity and Fiscal Responsibility Act or the new diagnosis-related group (DRG) payment system will actually dent the growth of outlays. But when all the payment system reform is tried, we will still have a sizable shortfall. A key virtue of the Davis-Rowland proposal is that it acknowledges the limitations of payment system reform as a means of reconciling outlays and revenues under Medicare.

The authors list these major alternatives to their premium increase plan: (1) higher payroll taxes; (2) alcohol and tobacco tax increases; (3) expanded use of general revenues; and (4) interfund borrowing. I believe that the first two of these options were too quickly dismissed and that a variation of the third option may have merit. I would not rely on interfund borrowing, which would jeopardize the fragile, long-term viability of Social Security.

The authors mention that increasing payroll taxes would be regressive. Such a judgment must hinge on a comparison with other options, including a status quo option that relies on cost-shifting by hospitals to transfer reimbursement cost to private payers. My research (Meyer 1983, 10–14) suggests that continuing to finance the shortfall through cost-shifting is less equitable than the alternatives of explicit taxation (payroll or income). Cost-shifting places a greater burden on working-class and lower-middle-income households than either the payroll tax or the income tax.

While a payroll tax increase is more regressive than a personal income tax increase paid by all households, a comparison with an income-related “tax” on premiums paid only by the elderly is less certain to favor the latter on grounds of equity. In any case, the

authors do not present evidence on the *relative* attractiveness of their preferred option on equity grounds.

Alcohol and tobacco tax increases were to be dealt with elsewhere and in another context, hence it had been suggested that they be beyond the scope of the paper; but Davis and Rowland should not have accepted this exclusion so readily. Taxes on some alcoholic beverages are higher than others, as a percentage of the purchase price, and a realignment of such taxes that raised revenues could make a contribution to the anticipated deficit in the Hospital Insurance trust fund. To the extent that higher taxes on tobacco and alcoholic beverages reduce excessive use, some favorable effects on health status and health costs could also be achieved.

I agree with the authors' concern about general revenue financing, which in today's fiscal environment translates into deficit financing. We can ill afford to meet the Medicare shortfall by expanding the federal deficit. I would not favor an income tax surcharge or an income tax *rate* increase for Medicare, but I would encourage a broadening of the federal income tax *base*, with a specified portion of the revenue increase earmarked for Medicare. A ceiling on the exclusion from employee taxable income of the employer contribution for health insurance is a place to start, but other subsidies could be capped as well, including the open-ended deductibility of mortgage interest and property taxes. In the congressional debate over financing health insurance for the unemployed, both a ceiling on the health care tax subsidy and a tightening of the income-averaging provisions of the federal tax code have been considered as revenue sources. Capping federal tax subsidies would also be a progressive way of providing some revenue to contribute to the shortfall in Medicare, assuming that the tax subsidies chosen are those benefitting primarily middle- and upper-income households.

The combination of benefit redesign and premium increases based on ability to pay will only take us so far in assuring Medicare's future. And they *should* take us only so far. Tax increases should take us the rest of the way, and this is the missing variable in the Davis-Rowland analysis. I prefer more progressive taxes, but maybe we need a blend of alternative revenue sources. We could make a series of adjustments in alcohol and tobacco taxes, payroll taxes, and federal tax subsidies, and raise a lot of money.

By broadening the personal income tax base and raising excise taxes,

we would supplement the type of change the authors urge and, in fact, lighten the burden of such change. Thus, the estimated 4 percent of income required of beneficiaries for premiums under their approach could be cut to 2 percent or so under my approach. Moreover, both subsidy caps and excise tax increases hold the potential for some favorable effects on cost escalation—we could get a double bang from these measures if they both raise revenues and lead to greater cost awareness.

Broadening the Focus of Analysis

The point I wish to emphasize is that while a premium increase may seem less unfair to the elderly than cost-sharing (particularly as the latter is depicted in the Davis-Rowland article), it may be *more* unfair than other options that involve a balanced package of benefit changes and revenue raising measures. Although tax subsidy caps or alcohol and tobacco tax increases would not, per se, provide enough funding to bridge the Medicare funding gap, if they are packaged with a modest payroll tax increase *and* benefit changes, the burden of meeting future obligations could be more equitably distributed.

The authors have not made a convincing case for ruling tax increases off limits. It could be argued that since there is going to be a much higher dependency ratio in the future, we must start now to “renegotiate the social contract.” The key idea here is to establish a way to signal *today’s* working population that they are going to have to shoulder more of their own health care costs ten, twenty, or thirty years from now because their children will not be able to shoulder the burden. This might argue for placing most (but not necessarily all) of the burden of meeting a *future* shortfall on the future elderly. But Davis and Rowland have not presented such a case for tilting the burden toward tomorrow’s elderly so as to protect tomorrow’s workers from an untenable tax burden.

My point here is not to insist on a 50–50 split of the burden, but to suggest that we *consciously decide* how the responsibility of providing for the health care needs of our future elderly population should be apportioned between future nonelderly workers and future beneficiaries.

Tax increases are not used in the Davis-Rowland proposal to make up any portion of the expected shortfall; that job goes to premiums

in their model, and this means that it goes entirely to the elderly. The authors tell us that the job goes *fairly* to the elderly, in the sense that well-to-do senior citizens pay relatively more for their coverage and the healthy elderly pay along with the sick. I share this preference, but stopping here ducks the larger issue and provides an overly narrow view of the well-off population. Note that the nonelderly wealthy escape scot-free under the Davis-Rowland model, and this is simply unfair to the elderly.

Of course we must avoid giving the elderly a totally free ride as we tighten our belts—their benefits should not be off-limits any more than those of other groups. But, the authors' approach would seem to go toward the other extreme—loading the full burden of the funding gap on nonpoor recipients.

We should follow the lesson of the Social Security compromise of March 1983. Whatever its limitations, it worked because it balanced the legitimate interests of our senior citizens with the legitimate interests of taxpayers. Each group gave up something. Recipients now have their Social Security benefits taxed at the margin, and recipients in the next century face a small increase in the retirement age. Taxpayers were subjected to an acceleration in payroll tax increases and other measures. We need an analogue of this balance in Medicare.

A Larger Perspective

The problems anticipated in Medicare financing are a microcosm of the crisis in the total federal budget. We not only have an underfunded Medicare program—we have an under-funded federal government. In view of the commitments we have made to a broad spectrum of government beneficiaries and to our national security requirements, we are an undertaxed society. This is not a plea for a tax increase, but a call for reducing the federal deficit to a more manageable, safe share of our economy. No portion of the budget should be exempt from trimming. But, federal outlays are driven by four major spending categories: national defense; Social Security; health care; and interest on the debt itself—and it will be very difficult to achieve a significantly lower growth path of spending in these categories. As a result, budget control will ultimately require higher taxes.

The health care sector is also a microcosm of a broader fairness

problem. In health care we continue to dish out open-ended tax subsidies flowing largely to middle- and upper-income households at the same time that a significant number of our citizens fall into the cracks between public health care programs and the private health insurance market. The working poor are particularly victimized by cutbacks in government assistance to low-income households while the unemployed and those out of the labor force who are categorically ineligible for Medicaid are also vulnerable.

In recent years budget cuts have been disproportionately concentrated in programs targeted to low-income households. Government programs paying benefits to all economic groups have remained largely intact while tax subsidies have also been left untouched.

Broadening the federal revenue base and trimming benefits for those who can afford it would yield significant savings that could be used to help those who can least afford the sacrifice required by continued belt-tightening.

References

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Address correspondence to: Jack A. Meyer, Director, Center for Health Policy Research, American Enterprise Institute for Public Policy Research, 1150 Seventeenth Street, N.W., Washington, DC 20036.