

# Medicare Financing Reform: A New Medicare Premium

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FOR ALMOST TWENTY YEARS THE MEDICARE PROGRAM has operated with relatively little controversy—steadily paying the hospital and physician bills of millions of elderly and disabled Americans. Nearly 30 million elderly and disabled people, representing over 12 percent of the population, rely on Medicare to help finance their health expenses. Medicare has won widespread support by relieving some of the financial burden of health care bills for the elderly and disabled and their families and by ensuring financial access to hospital and physician services for many of the nation's most vulnerable and critically ill citizens.

Yet, despite its past success, the program is likely to come under intense scrutiny in the years ahead. The program spent \$47 billion in 1982, up 17 percent over the previous year (Office of Management and Budget 1983). It is a major item in the federal budget, accounting for one out of every fifteen dollars spent by the federal government and two-thirds of all federal health outlays. Medicare outlays are expected to continue their upward spiral—reaching \$112 billion by 1988 (Congressional Budget Office 1983a).

The substantial increases in Medicare outlays projected for the future will severely strain the revenue sources that currently finance Medicare spending. The problem is most immediate and critical for the Hospital

Insurance (HI) component of Medicare which is financed by a payroll tax and administered through a separate trust fund. The HI trust fund is projected to be depleted by the end of the decade and to incur a cumulative deficit of \$93 billion by 1995, even if tight limits are retained on hospital prospective payment levels after 1985 (Ginsburg and Moon 1984).

In response to the impending financing crisis in the HI trust fund, this paper explores an option to raise additional revenue to expand the financing base for Medicare. Instead of reducing the scope of services covered by Medicare or increasing the cost-sharing requirements for the elderly and disabled Medicare beneficiaries who use services, this approach calls for replacing the current Medicare Supplementary Medical Insurance (SMI) premium with a new income-related premium tax to raise additional revenues while preserving the integrity of program benefits. Under this approach, the HI and SMI parts of Medicare would be merged into a single program with integrated financing through a single Medicare trust fund. Three sources of revenue would be used to finance the program: the existing payroll tax, general revenues, and the new premium tax administered through the income tax system.

The use of an income-related premium tax is only a piece of the solution and should not stand alone. It should be introduced as part of a broader reform of Medicare coverage that assures greater financial protection to the elderly and disabled for both acute health and long-term care needs. It should complement efforts to reduce outlays through tighter controls on hospital and physician payment. This approach is offered to contribute toward reducing projected deficits in the HI trust fund, to provide flexibility to finance additional services and improved coverage under Medicare for the elderly and disabled, and to assure adequate and stable funding. It preserves the strength of Medicare, including universal entitlement to Medicare for the elderly and certain groups of disabled, and ensures the financial soundness of this essential program.

## Problems of Medicare

The Medicare program is facing both a pending financing crisis and an increasing inability to protect the elderly and disabled beneficiaries

against rising health care costs. Projections of Medicare outlays and revenues indicate very large future deficits in the Hospital Insurance (HI) trust fund and rapidly rising requirements for the Supplementary Medical Insurance (SMI) trust fund. At the same time, financial protection for the elderly and disabled beneficiaries of Medicare is eroding as out-of-pocket expenditures for cost-sharing and uncovered services continue to grow.

Medicare is also coming under increased scrutiny because of its impact on federal spending and the overall federal budget deficit. In 1982 Medicare accounted for 7 percent of all federal outlays. Spending under Medicare is projected to reach \$112 billion by 1988 (Congressional Budget Office 1983a). As cuts are made in other components of domestic spending, Medicare increasingly becomes a source for budget savings because of the size of its spending and magnitude of its annual increases.

### *Hospital Insurance Trust Fund Deficit*

Projections for outlays and income for the HI trust fund show the balances in the fund will be depleted by 1988, and the fund will accumulate a deficit of \$93 billion by 1995 (Ginsburg and Moon 1984). These predictions assume that the restrictions on the rate of growth in hospital payments under Medicare enacted as part of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 will be continued beyond their scheduled expiration in 1986, at a rate of increase equal to the hospital market basket plus 1 percentage point.

The basic reason for the financial crisis in the Medicare HI trust fund is clearly rising hospital costs which drain the trust fund reserves. Hospital expenditures account for nearly 90 percent of all HI Medicare spending. Hospital costs have been steadily increasing at rates exceeding inflation in the general economy. Cost escalation plus the growing number of elderly and disabled resulted in 18 to 20 percent annual increases in Medicare hospital expenditures prior to enactment of the TEFRA limits in 1982.

Future trends suggest that the financial problems in Medicare are chronic. The outlays of the HI trust fund are governed by hospital costs, but the trust fund's income is dependent upon the earnings to which the HI payroll tax is applied. Hospital costs have been increasing and are expected to continue to increase at a much faster rate than

the wage base for the payroll tax. Hospital costs for Medicare beneficiaries are expected to increase at an annual rate of 13.2 percent from 1982 to 1995, while covered earnings are only projected to grow 6.8 percent annually (Congressional Budget Office 1983b). The imbalances between the revenues derived from payroll tax contributions by employers and workers and Medicare hospital expenditures cause the HI trust fund deficit. A weak recovery or a worsening economy will exacerbate the HI financing problems by diminishing the earnings pool that is tapped to generate income to the trust fund. However, even a vibrant economy would not generate sufficient payroll tax income to match rising hospital expenditures.

The HI trust fund trustees estimate that the payroll tax rate would have to be increased to 4.3 percent to keep the fund solvent over the next 25 years (Davis 1983). The rate is currently scheduled to increase to 2.9 percent in 1986. Thus, the choices to keep the HI trust fund solvent for the next 25 years are to increase the HI payroll tax by 50 percent, reduce HI expenditures by 33 percent by further contracting payment rates to hospitals and physicians or by limiting benefits, or find additional revenue sources. Reductions in program expenditures can be accomplished by paying providers less for covered services, increasing beneficiary cost-sharing for services, reducing the scope and utilization of covered services, or, at the extreme end of the spectrum, reducing eligibility for the program by increasing the age for receipt of benefits or making eligibility on some basis other than universal entitlement. Additional revenue sources to support HI could be derived from use of general revenues to support the HI deficit or through the imposition of a new tax or premium.

### *Rising Costs for the SMI Program*

The Supplementary Medical Insurance (SMI) trust fund does not face the same solvency problems as the HI trust fund because it has a more flexible financing structure. The SMI trust fund obtains funds from the premiums paid by beneficiaries and appropriations from federal general revenues. The law requires that general revenues be appropriated to finance all benefit and administrative costs not covered by the income from premiums.

Although the SMI program faces no immediate funding crisis, its increasing outlays and growing reliance on general revenue financing

are of concern because the general revenue spending under Medicare contributes to the federal deficit and is viewed as "uncontrollable entitlement spending" in the context of the federal budget. SMI outlays account for one-third of total Medicare expenditures and are expected to increase by 16 percent per year through 1988 (Rivlin 1983). Since the 1972 amendments to the Social Security act limited SMI premium increases to the percentage increase in cash Social Security benefits, the share of SMI costs covered by premiums has steadily declined. In 1982 premium payments accounted for only 22 percent of SMI expenditures and general revenues paid 78 percent or \$13.4 billion of the \$17.2 billion in SMI spending (Davis 1983). As a result of recent legislative budget cuts, the premium will be set at a level that covers 25 percent of the incurred costs for 1983 through 1985. Unless the legislation is extended, the premium increases will again be tied to Social Security cost-of-living increases after 1985, renewing the trend toward greater reliance on general revenues to finance SMI.

The general revenue requirements of the SMI program contribute to the federal deficit and limit the availability of federal funds for other purposes. The size of the current federal deficit and the limits on federal revenues resulting from the recently enacted tax cuts have created a "cut-spending and reduce the federal budget" environment at the federal level. As discretionary domestic programs for public health, education, and social services are sharply reduced, unbridled increases in Medicare SMI spending and the resultant drain on limited general revenues politically become increasingly unacceptable.

### *Financial Burden for Medicare Beneficiaries*

Rising health care costs not only strain the fiscal resources of the Medicare program, but also undermine the level of protection against medical expenses provided by Medicare to the elderly and disabled. Many elderly and disabled beneficiaries already face serious financial burdens in meeting their health care expenses. In 1981 Medicare met only 45 percent of all health and long-term care expenditures of the elderly (Health Care Financing Administration unpublished statistics, 1982).

Medicare beneficiaries incur large out-of-pocket expenditures for services not covered by Medicare, such as prescription drugs, dental care, and nursing home care. In addition, Medicare's deductibles,

cost-sharing, and SMI monthly premiums are not inconsequential. The aged spent an average of \$1,154 per person privately on health care in 1981. If nursing home services are excluded, the elderly spent \$834 or nearly 10 percent of their mean income on out-of-pocket health expenditures (Callender 1983).

Out-of-pocket spending by the elderly is expected to continue to grow. The Congressional Budget Office estimates that out-of-pocket costs for Medicare cost-sharing will be \$505 per enrollee in 1984. The SMI premium, cost-sharing, and deductible will account for 80 percent of the cost. The SMI premium alone is now \$162 per year. In addition, it is estimated that the average beneficiary will pay an additional \$550 in 1984 for noninstitutional care not covered by Medicare, most notably prescription drugs and dental care. If nursing home care were included, it would add another \$650 per person, for a total out-of-pocket cost to the elderly of \$1,705 (Congressional Budget Office 1983a).

The incidence of acute illness and the prevalence of chronic, disabling illness and the financial burden of paying cost-sharing and other out-of-pocket costs for needed care is not related to ability to pay. Out-of-pocket health care expenditures, excluding nursing home care, represent 2 percent of total income in families with incomes in excess of \$30,000, and 21 percent of income in families with incomes less than \$5,000 (Congressional Budget Office 1983a). Cost-sharing requirements by their very design mean that those who are ill and use services bear the burden. The chronically ill and other high utilizers of care are most likely to incur large individual liability for Medicare cost-sharing and uncovered services and charges. The low-income elderly face the greatest financial burden because they are less likely to have medigap supplementary insurance to finance the cost-sharing requirements of Medicare (Wilensky and Berk 1983).

The distribution of out-of-pocket Medicare-program-related costs raises serious equity issues for Medicare. Should the sick elderly and disabled who rely on Medicare-financed services be asked to assume an even greater financial burden through increased cost-sharing to ease the HI deficit? The poor and especially the near-poor elderly already pay a greater share of their income for cost-sharing and flat-rate taxes such as the SMI premium. Should the less advantaged be further disadvantaged by increased cost-sharing and higher premiums?

## Policy Proposal

Reform of Medicare financing is long overdue. The current artificial distinction between the HI part of Medicare and the SMI part of Medicare does not contribute to sound fiscal or health policy. Awareness of the soaring increases in SMI expenditures is blocked by concern over projected deficits in the HI part of Medicare. Rapidly rising expenditures in both parts of Medicare affect the federal budget and should be of simultaneous concern. Further, there is no real reason why hospital benefits should automatically be made available to the elderly and disabled, but coverage of physicians' services should be optional. Both are essential to assuring access to needed health care services for the elderly and disabled. Preferred coverage of hospital care could lead to distortions in the health system, causing some types of care to be rendered in a costly, inpatient setting that could be provided on a lower cost, ambulatory basis.

Reform of Medicare should retain its basic objectives. Medicare provides much needed financial protection and access to health care for some of our nation's most vulnerable citizens. Given that Medicare even now covers only 45 percent of the expenditures of the elderly, there would appear to be little room for increasing the share of health expenditures paid directly by Medicare beneficiaries. Certainly, Medicare should continue to pursue improvements in cost controls or incentives to health care providers to improve efficiency and eliminate unnecessary or ineffective care. But assuring that Medicare can continue to provide financial protection to the elderly and disabled in the face of ever-rising health care costs and a growing elderly population will require reforming current methods of financing Medicare to assure stable and adequate revenues to support the program.

Sources of revenues which might be tapped to provide additional income to Medicare include:

- Increases in the HI payroll tax on employers and employees;
- Interfund borrowing from the Old Age, Survivors, and Disability Insurance (OASDI) trust funds;
- General tax revenues, largely from the personal income tax and the corporate income tax;
- Specific taxes, such as alcohol and cigarette taxes or value-added taxes;
- Premiums paid by Medicare beneficiaries.

Each of these alternatives has advantages and disadvantages, and could be tapped to eliminate HI deficits or to support a combined HI-SMI trust fund. The payroll tax is the current method of financing; past deficits have been met by raising the payroll tax rate. It is administratively straightforward and requires no major change in the program. However, the payroll tax is regressive (i.e., it represents a higher fraction of total income for lower income individuals than higher income individuals), both because there is a limit on taxable earnings and because interest, dividend, and rent income are not subject to the payroll tax. The share of the federal budget financed by the payroll tax has risen markedly in recent years, and is widely considered to place an excessive financial burden on workers.

Interfund borrowing would use payroll taxes raised to support Social Security pensions to relieve pressure on the Medicare HI trust fund. Under the 1983 Social Security financing plan, surpluses will be generated during the late 1980s and early 1990s. These funds could be borrowed to meet Medicare deficits. However, this is a short-term strategy. Surpluses under other trust funds will be required to meet pension payments in future years.

The Medicare law could be modified to permit supplementation of HI payroll tax contributions with general tax revenues, or to merge HI and SMI into a single trust fund with general tax revenues meeting a greater share of combined expenditures than is now projected. Since general tax revenues come from moderately progressive personal income and corporate income taxes, this source of financing would be more equitable than increases in the payroll tax. With annual federal budget deficits of \$100 to \$200 billion projected for the immediate future, channeling general tax revenues into Medicare would increase the pressure to reduce other governmental expenditures and would not contribute to lessening the overall budgetary deficit. However, some increase in funding from general revenues, especially in the longer term, is an option for consideration.

The alternative of generating revenues from new taxes such as alcohol and cigarette taxes is discussed elsewhere (Long and Smeeding 1984).

### *Proposal*

Reform of Medicare financing should guarantee the future solvency of Medicare, provide greater flexibility to adapt to changes in the health care system and in the federal budget, and promote sound



health policy through a comprehensive, predictable set of benefits. To achieve these objectives, it is recommended that the HI and SMI be merged into a single Medicare trust fund. Currently scheduled payroll tax contributions toward the HI trust fund would continue to flow to the new Medicare trust fund. General revenues currently projected to pay for SMI expenditures would be added to the Medicare trust fund. The current premium paid by the elderly for the SMI program, however, would be replaced by a premium for the entire Medicare program.

It is recommended that universal entitlement to Medicare benefits be guaranteed for all of the elderly and those disabled covered under current law. SMI coverage would no longer be optional. All Medicare benefits would automatically be provided to Medicare beneficiaries currently covered under HI. Benefits would not depend upon ability to pay or income of the elderly. Rather a uniform benefit package would be available to all beneficiaries. This recognizes that much of the past success of Medicare derives from its universal coverage, which fosters program excellence and social solidarity. Further, it guarantees that Medicare program administration will not be encumbered with the administrative complexity of income determination, or the potential for an adversarial role toward its beneficiaries.

The new Medicare premium, unlike the current SMI premium, would be related to income of Medicare beneficiaries and administered through the personal income tax system. The premium would be set at a level sufficient to guarantee the financial solvency of Medicare, in combination with other measures such as stringent provider cost controls. It is assumed that every effort would be made to achieve economies in Medicare through reasonable cost controls and incentives for health care providers to improve efficiency and eliminate unnecessary and ineffective care. It seems likely that even with such measures the overall premium for the program would need to increase beyond that of the current SMI premium. However, the income-related feature would avoid undue financial hardship on the most vulnerable of the elderly and disabled. Replacing the current SMI premium with an income-related premium would provide much needed financial relief to those elderly with incomes just above the Medicaid eligibility level who find the current SMI premium burdensome.

Several questions should be raised about any proposal to reform the Medicare program.

- What is the likely impact of the proposal on the financial soundness of Medicare?
- What is the likely impact of the proposal on Medicare beneficiaries, including the distributional impact by income and on vulnerable groups such as the chronically ill?
- Can the proposal be easily administered?

### *Impact on the Financial Soundness of Medicare*

The proposed reform of Medicare financing would provide a more flexible approach to guaranteeing the financial soundness of Medicare. The combination of revenues from the payroll tax, general revenues, and premiums should provide a stabler source of support. Further, if future projections prove inaccurate—for example, if the impact of provider cost controls and incentives have a greater or lesser impact on expenditures than predicted—premiums or the contribution from general revenues could be adjusted easily.

Necessary funds to eliminate the deficit could be generated by establishing the premium at the appropriate rate. Table 1 provides preliminary estimates of the impact on the projected deficit of a premium set to yield additional revenues of \$5 billion in 1985 (over and above the proceeds from the current SMI premium). This would require an additional average annual premium of \$165 for Medicare's 30 million beneficiaries. The proposal, however, would vary the premium with income. On average this would require a premium equal to approximately 2 percent of the income of Medicare beneficiaries. It is assumed that the proceeds of this fixed income-related premium would increase at an annual rate of 7 percent after 1985. This takes into account the 2 percent annual increase in the number of elderly as well as conservative estimates of growth in income per Medicare beneficiary. In 1995 the premium set again at an average of 2 percent of income of Medicare beneficiaries would yield \$10 billion. This premium would reduce the cumulative Medicare deficit from \$250 billion in 1995 to approximately \$134 billion.

If Medicare premiums are part of a Medicare reform package that includes greater cost controls or incentives to health care providers, the deficit would be eliminated. Table 2 records a combined strategy of holding prospective payment of hospitals to an annual rate of

TABLE 1  
 Projections of Hospital Insurance Trust Fund Outlays, Income, and  
 Balances (in billions of dollars)

Calendar year	Outlays	Premium income	Other HI income	Annual surplus	Year-end balance
1985	\$ 51.2	\$ 5.0	\$ 53.7	\$ 7.5	\$ 18.6
1986	57.3	5.4	67.3	15.4	34.0
1987	64.5	5.8	68.4	9.7	43.7
1988	72.5	6.2	68.4	2.1	45.8
1989	81.5	6.6	73.0	-1.9	43.9
1990	91.7	7.1	77.4	-7.2	36.7
1991	103.1	7.6	81.5	-14.0	22.7
1992	115.8	8.1	85.6	-22.1	0.6
1993	130.1	8.7	89.4	-32.0	-31.4
1994	146.2	9.3	93.0	-43.9	-75.3
1995	164.5	10.0	95.8	-58.7	-134.0

*Source:* CBO estimates of outlays and other HI income based on February 1983 assumptions, but updated to reflect the Social Security amendments of 1983. Authors' estimates of premium income assumes 7 percent annual increase.

*Note:* Minus signs denote deficits.

increase of hospital market basket inflation plus 1.0 percentage point (this would require extending the stringency in current legislation out to 1995) and assessing a premium on average set at 2 percent of Medicare beneficiary income (over and above the average percent of income currently contributed to the SMI premium). This combined strategy would be sufficient to eliminate the Medicare deficit through 1995.

Other cost-containment measures might further reduce the need for premium income to the trust fund. For example, if savings were achieved through prospective payment of physicians, the savings in general revenues could be allocated to meeting rising hospital expenditures.

The premium need not be set at a constant rate over time. It could be set at a lower rate initially and gradually increased over time as necessary to assure the ongoing financial solvency of the program.

What should be understood, however, is that the projected Medicare deficit is manageable. Simply extending current cost-controls on hospitals to 1995 reduces the cumulative deficit to \$93 billion (Ginsburg and Moon 1984). Part of the deficit comes from interest expenses on the

TABLE 2  
 Projections of Hospital Insurance Trust Fund Outlays, Income, and  
 Balances Assuming Tighter Prospective Payment Limits after 1985  
 (in billions of dollars)

Calendar year	Outlays	Premium income	Other HI income	Annual surplus	Year-end balance
1985	\$ 51.2	\$ 5.0	\$ 53.7	\$ 7.5	\$18.6
1986	57.3	5.4	67.3	15.4	34.0
1987	62.1	5.8	68.6	12.3	46.3
1988	68.3	6.2	68.7	6.6	52.9
1989	75.1	6.6	73.8	5.3	58.2
1990	82.6	7.1	78.8	3.3	61.5
1991	90.9	7.6	83.7	0.4	61.9
1992	99.9	8.1	89.1	-2.7	59.2
1993	109.8	8.7	94.6	-6.5	52.7
1994	120.8	9.3	100.3	-11.2	41.5
1995	133.0	10.0	106.1	-16.9	24.6

Source: CBO estimates of outlays and other HI income based on February 1983 assumptions, but updated to reflect the Social Security amendments of 1983. These estimates assume that diagnosis-related group (DRG) hospital rates after 1985 are increased one percentage point per year faster than the increase in the hospital market basket. Authors' estimates of premium income assume 7 percent annual increase.

Note: Minus signs denote deficits.

cumulative deficit. Injection of additional revenues at an earlier stage or more effective cost-containment measures can eliminate those interest expenses. Further, the \$93 billion is accumulated over a 10-year period. It should also be noted that future projections are not adjusted for inflation. Growth in incomes and the economy will also take place over this time period, making any given expenditure easier to meet.

### *Impact on Beneficiaries*

The impact of an income-related premium on different groups of elderly hinges on the specific manner in which the premium varies with income. Table 3 illustrates the distributional impact of four alternative income-related premiums. The table records premium payments as a percent of adjusted gross income.

Option 1 is a fixed premium for all Medicare beneficiaries with family incomes above \$10,000. No premium would be assessed for those with incomes under \$5,000. Premiums for beneficiaries with

TABLE 3  
 Distributional Impact of Alternative Income-related Premiums,<sup>1</sup> 1985

Adjusted gross income class	Option 1	Option 2	Option 3	Option 4
	Fixed dollar premium reduced for poor	Premium set at constant percentage of adjusted gross income	Premium set at constant percentage of taxable income	Premium set at constant percentage of tax liability
	Increased Revenue as a Percent of Adjusted Gross Income			
<u>Total</u>	<u>2.0%</u>	<u>2.0%</u>	<u>2.0%</u>	<u>2.0%</u>
\$0-4,999	0.0	2.0	0.1	0.0
\$5,000-9,999	3.7	2.0	1.2	0.4
\$10,000-14,999	4.6	2.0	2.0	0.9
\$15,000-19,999	3.3	2.0	2.0	1.2
\$20,000-24,999	2.5	2.0	2.1	1.4
\$25,000 and over	1.0	2.0	2.1	2.6

<sup>1</sup> Each option yields \$5 billion revenues in 1985.

Source: Calculated from Brookings Institution 1980 personal income tax file projected to 1985. Includes effects of 1981 tax act (ERTA) and 1982 tax act (TEFRA), but not the 1983 Social Security financing plan. Estimates for disabled based on income of taxpaying units with members aged 65 and over.

incomes between \$5,000 and \$10,000 would be on a sliding scale. Option 2 is a premium set at a constant percent of adjusted gross income. Option 3 is a premium set at a constant percent of taxable income. Option 4 is a premium set at a constant percent of tax liability, that is, a tax surcharge.

The fixed premium would be regressive at incomes above \$10,000. That is, it would represent a higher fraction of income for those elderly, say, with incomes between \$10,000 and \$15,000 than for those with incomes over \$25,000. The premium set at a fixed percentage of adjusted gross income is by definition a proportional tax. All elderly would pay the same fraction of income to finance Medicare. The tax on taxable income is moderately progressive. Virtually no premium would be charged the elderly with incomes below \$5,000; but elderly with incomes above \$10,000 would all pay approximately the same proportion of income toward the program. The tax surcharge is the most progressive method of financing. Under the tax surcharge, elderly

with incomes below \$5,000 would pay virtually no premium. Those with incomes between \$5,000 and \$10,000 would pay about 0.4 percent of income; those with incomes between \$10,000 and \$15,000 would pay 0.9 percent of income. By contrast those elderly with incomes above \$25,000 would pay almost 2.6 percent of income.

All of the options for varying the premium with income are more equitably distributed than raising similar revenues from hospital co-insurance charges. Under the premium approach, all elderly (except low-income elderly) would share in the financial burden. Under the hospital coinsurance approach, only those 20 percent of the elderly who are hospitalized would contribute toward reduction of the deficit. Those chronically ill elderly could be faced with quite burdensome contributions under hospital coinsurance. Approximately one-fifth of the elderly at all income levels are hospitalized during a year; average days of care are somewhat higher for lower income elderly. As shown in table 4, raising a comparable level of revenue from hospital coinsurance would place enormous financial burdens on those low-income elderly who were hospitalized. Even if Medicaid were to assume these amounts for the 3.5 million elderly covered under Medicaid, serious financial burdens would be felt by those elderly with incomes just above Medicaid eligibility. For example, the elderly with incomes between the poverty level and twice the poverty level would pay 16 percent of income for those hospitalized. In addition, such individuals would likely incur substantial nonhospital out-of-pocket expenditures. Clearly, as a tax

TABLE 4  
Distributional Impact of Hospital Coinsurance<sup>1</sup>, 1977

Income class	Hospital coinsurance payments as a percent of income of hospitalized elderly
<u>Total</u>	<u>6.4%</u>
Income below poverty level	27.1
Poverty to two times poverty level	16.2
2 to 4 times poverty level	6.2
Over 4 times poverty level	2.2

<sup>1</sup> Coinsurance set to yield \$5 billion revenues.

Source: Calculated from 1977 National Survey of Medical Care Expenditures, National Center for Health Services Research, U.S. Department of Health and Human Services.

matter coinsurance is the most inequitable form of taxation that could be assessed on Medicare beneficiaries.

Premiums, which represent a fixed contribution to Medicare, could not be expected to encourage or discourage use of health care services. Thus, they would not pose a barrier to access to needed health care services. Hospital coinsurance, on the other hand, could be expected to reduce utilization particularly for those elderly with modest incomes who do not purchase supplementary private insurance. Very little is known about what types of hospital stays would be eliminated. There is a very real danger that burdensome hospital coinsurance charges would deter necessary care for many vulnerable elderly and quite obviously would place serious financial burdens on a chronically ill group of elderly.

### *Administrative Feasibility*

Administering an income-related premium would represent a major departure from current administrative practice. Any systematic relationship of premiums to income would require administration through the personal income tax system. Even with this approach, however, certain administrative issues are raised. Low-income elderly who do not now file income tax statements would be required to do so under some variations. Decisions would be required about the definition of income subject to tax—Social Security pensions, tax-exempt bond interest income, etc. The disabled receiving Medicare would need to be identified. Rules governing tax households with both Medicare and non-Medicare beneficiaries would need to be designed. All of these issues require resolution, but do not represent insurmountable obstacles. Administration through the income tax system would assure fair and effective compliance without the demeaning administrative procedures that means-tested benefits administered directly by Medicare would entail (Hsaio and Kelly 1984). It would also not engender the complexity and confusion that varying the benefit package with income would create.

### Summary

Medicare is an extremely important program assuring many vulnerable Americans necessary protection from the financial hardship that major

illness can bring. It is unthinkable that necessary measures will not be taken to assure the financial soundness of the program. Some relief may be possible by adoption of more effective cost-controls or incentives for health care providers than have been instituted to date. Even with such measures, however, Medicare expenditures are likely to continue to outstrip currently scheduled sources of revenues.

Relying on patient charges for health care services, such as hospital coinsurance, would concentrate payments on the chronically ill, many of whom have extremely modest incomes. Increases in payroll taxes or diversion of funds from general revenues are not promising for the next few years, given major increases in payroll taxes that have already occurred and unprecedented deficits in the federal budget. However, these sources may be more attractive in the 1990s, and could be part of an overall package of financing reform.

To assure the financial soundness of the program, it seems imperative that a fundamental reform of Medicare's financing be undertaken. This reform should merge the HI and SMI portions of Medicare with a combined Medicare trust fund financed by currently scheduled HI payroll taxes, general revenues currently projected to meet SMI expenditures, and a new Medicare premium related to income of beneficiary. The flexibility of altering premiums or general revenue support depending upon requirements of the program, the effectiveness of cost-containment measures, and budgetary considerations would be greatly enhanced by a merger of the two parts of Medicare.

Reliance upon a premium which varies with income would assure that any financial contribution by Medicare beneficiaries is equitably borne and does not place a financial burden on any Medicare beneficiary. Unlike hospital coinsurance, it would not provide a barrier to the receipt of care and would not place heavy financial burdens on the chronically ill. With an assured, stable funding base, Medicare benefits could be expanded to meet many current gaps in acute and long-term care benefits. If coupled with cost-controls on providers, such as extension of current limits on hospital payments and physician fee schedules with mandatory assignment, this financing reform could restore the original promise of Medicare to ensure adequate health care without the threat of financial ruin for all our nation's senior citizens.



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