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Should Higher Income Beneficiaries Pay More For Medicare?

By Jill Bernstein

Summary

As Medicare costs increase, policymakers are searching for equitable ways to secure the program's financial base. Proposals that would require higher-income Medicare beneficiaries to pay a higher proportion of the program's costs are designed to increase beneficiaries' contribution without placing an unacceptable financial burden on those least able to afford it. Designing and implementing such a policy involves difficult tradeoffs in terms of revenue gains, burden on beneficiaries, and political support for Medicare over the long term.

The increasing costs of an expanding array of beneficial and expensive diagnostic and therapeutic options, compounded by the aging of American society, are threatening the solvency of the Medicare Hospital Insurance (HI) Trust Fund, and increasing the general fund contribution needed to support the Supplementary Medical Insurance (SMI) program. Even if the rate of increase in per capita Medicare outlays is slowed by reforms that reduce provider payments, increase efficiency in the delivery of services, and eliminate substantial amounts of fraud and abuse, rapid increases in the number of participants will make it difficult to maintain current benefits without some additional revenues. These can come from increased payroll taxes or general revenues, or from requiring program beneficiaries to pay more. This *Brief* focuses on the second set of broad financing options: contributions from Medicare beneficiaries themselves.

Sharing the Burden

When considering how much of the burden of Medicare costs should be borne by the beneficiary population, policymakers will need to address three basic questions:

1. Should beneficiaries, as a whole, take on a greater share of the increasing costs of Medicare?

The arguments for increasing the contribution made by beneficiaries relate to concepts of equity, and are based on demographic, economic, and health care considerations. Since Medicare was enacted, the number of beneficiaries has doubled. As the population ages, the ratio of workers to beneficiaries is projected to decline from 3.9 in the year 1998 to 2.3 by 2030.[1] In relative terms, there will be less revenue from workers, and more beneficiaries to pay premiums. Because Medicare became operational in 1966, those now receiving benefits paid payroll HI taxes for

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only a portion of their adult lives; the first beneficiaries who will have contributed from the age of 20 on will not turn 65 until 2010. Through 1986, workers paid lower payroll tax rates than current workers pay.[2]

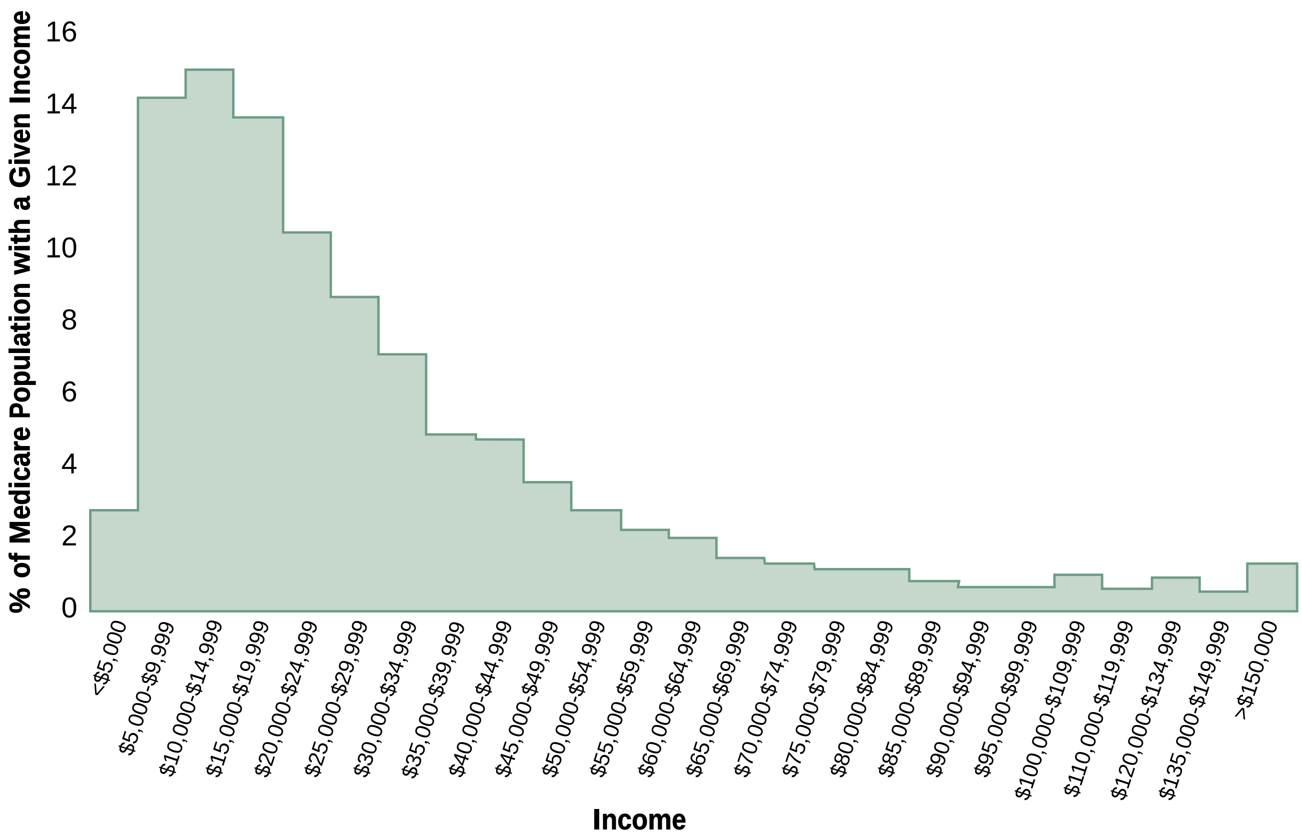
In the three decades since Medicare was created, the financial status of America's elderly has improved considerably. Real incomes of the elderly have risen, and poverty rates have declined. Although many of the elderly have very modest incomes, on the whole, their ability to contribute to the program's support is greater than was the ability of the beneficiaries in the late 1960s, 1970s or 1980s.[3]

Over the past generation, the scope and intensity of the diagnostic, acute care and surgical services covered by Medicare has expanded tremendously as medical science has made possible far more effective treatment for many of the serious health care conditions that can accompany old age. Medicare pays for surgical procedures, joint replacements, organ transplants, etc. that extend life and improve its quality in ways, and at prices, that could not have been anticipated when the program was created. As a beneficiary participating in an Academy-sponsored focus group on Medicare reform said, "I get more medical services than my predecessor, you know, did years ago, and I think I should pay more for the service I get."[4]

At the same time, a significant proportion of the elderly and disabled have limited retirement incomes (Figure 1). Therefore, the increasing costs of medical care, including costs not covered by Medicare, constitute a serious threat to the financial security of many elderly households. Over the

Figure 1

Projected Family Income Distribution of Medicare Beneficiaries, 1998



Source: An analysis of the 1997 Current Population Survey done by Marilyn Moon and colleagues at the Urban Institute, 1998.

three decades since Medicare was enacted, out-of pocket costs for health care have increased far more rapidly for the elderly than for the non-elderly. Elderly households are now paying about 19 percent of their household income, on average, for health care compared to about ten percent in the early 1970s. Overall, Medicare covers only about half of the personal health care expenditures for the elderly.[5] And, under current policy, the Part B premiums which beneficiaries pay monthly are projected to grow more rapidly than their incomes or overall Medicare spending.[6]

2. What form would additional payments by beneficiaries take?

When Medicare was first created, the Part B premium was designed to cover half of the Part B program costs. As these costs increased faster than inflation, Congress chose to limit the increases charged to beneficiaries to the rate of Social Security cost-of-living increases, so that the beneficiary contribution rate fell to below 25 percent over time. The Balanced Budget Act set the premium contribution permanently at 25 percent of Part B costs in 1997. Increasing Part B premiums to a somewhat higher level would therefore be consistent with the historical design of the program.

A premium increase would be spread broadly across Medicare beneficiaries. Greater contributions from beneficiaries could also be obtained through higher copayments and deductibles. However, increasing copayments and deductibles in the Medicare program, where out-of-pocket costs are already higher than in most employer-based insurance policies, could have disadvantages.[7] If copayments and deductibles were increased, the greatest burden would fall on those who used medical services the most, i.e. people who are the sickest. For the poorest beneficiaries, i.e. those eligible for Medicaid, increases in copayments or deductibles would be passed back to states and the federal government. For the rest, increasing copayments and deductibles could increase the demand for supplemental insurance to cover the increases in out-of-pocket payments. Faced with higher costs, some employers might drop retirees' supplemental coverage altogether. Others might raise premiums charged to their former employees. Those purchasing coverage in the individual (Medigap) insurance market would face increased premiums. Some beneficiaries might decide they could no longer afford supplemental coverage.

3. If beneficiaries should pay more, how should the additional burden be allocated among the beneficiary population?

Over the past several years, Congress and the Bipartisan Commission on the Future of Medicare have debated proposals to increase contributions from beneficiaries. The pivotal issue in these debates has been whether the increase should be applied uniformly, to all beneficiaries, to beneficiaries who have relatively high incomes, or some combination of both.

Across-the-board increases in Medicare premiums

- would be easy to administer,
- could generate significant revenues for the program, and
- would not impinge heavily on the low-income beneficiaries who have additional support from existing programs, such as Medicaid, which covers the cost of Medicare premiums, copayments, and deductibles for qualified beneficiaries.[8]

Increasing premiums for all beneficiaries, however, could pose problems for many lower and moderate income beneficiaries:

- Existing federal / state programs that subsidize Medicare premiums do not cover those with incomes over 175 percent of the poverty level; without changes in current policy, protection for the near poor would be limited;
- The higher costs would be in addition to increased beneficiary liability related to cutbacks in supplemental employer-sponsored retirees coverage[9] and rapid increases in Medigap premiums[10], and

- Even when financial protection is offered through federal or state programs, many eligible participants with lower incomes do not receive these benefits.[11]

Should High Income Beneficiaries Pay Higher Premiums?

A second way to increase the proportion of Medicare costs borne by beneficiaries is to institute a sliding scale, with higher-income beneficiaries paying more. As stated by an Academy focus group participant, “I just believe that when you have more, you should contribute more.” A poll conducted in late 1998 indicated that a majority of Americans support the notion of a sliding scale for premiums,[12] although previous polls, including one conducted by the Academy in 1997 (discussed below) have shown mixed results.

Are Higher-Income Beneficiaries Paying Their Fair Share?

Some beneficiaries are, financially speaking, quite comfortable, and could afford to pay more for Medicare. Even if they had to pay the program’s full actuarial cost, wealthy people would find Medicare a wise purchase. The program provides insurance at a very low price because it pools the costs of the entire beneficiary population, has very low overhead costs, and uses its dominant market position to ensure that providers accept steep discounts on their charges. Participants would be hard-pressed to find comparable renewable insurance at a better price in the private market.

Some have suggested that it is reasonable to ask upper-income beneficiaries to pay more because they tend to use more covered services and live longer.[13] Most have good supplemental insurance coverage provided by a former employer (Figure 2). These supplemental policies generally require small, and sometimes zero premium contributions from retirees, and the value of their benefits is not taxed. Faced with little or no out-of-pocket expense when they seek health care, these beneficiaries use more services.[14]

It is important to consider, however, that higher income beneficiaries are already paying more for Medicare, in three ways:

1. Because the payroll tax that funds most of the HI Trust Fund (Medicare Part A) is applied without limit, higher-income people contribute substantially more than low-wage workers during their working lives although they receive the same benefits.

2. Three-fourths the revenues for Medicare Part B come from general revenues (largely income taxes). Only a bit over half of elderly Medicare beneficiaries have incomes high enough to pay income taxes; tax liability is concentrated among the richest elderly. About 76 percent of all income taxes collected from elderly households are paid by those with incomes over $75,000.[15]

3. Higher-income beneficiaries are required to include a portion (up to 85 percent) of their Social Security benefits in their calculation of income for tax purposes. A portion of the revenues derived from the taxation of Social Security benefits is deposited in the HI Trust Fund.[16] In 1998, $5.1 billion, accounting for 4 percent of the HI Trust Fund revenues, came from the benefits tax.[17]

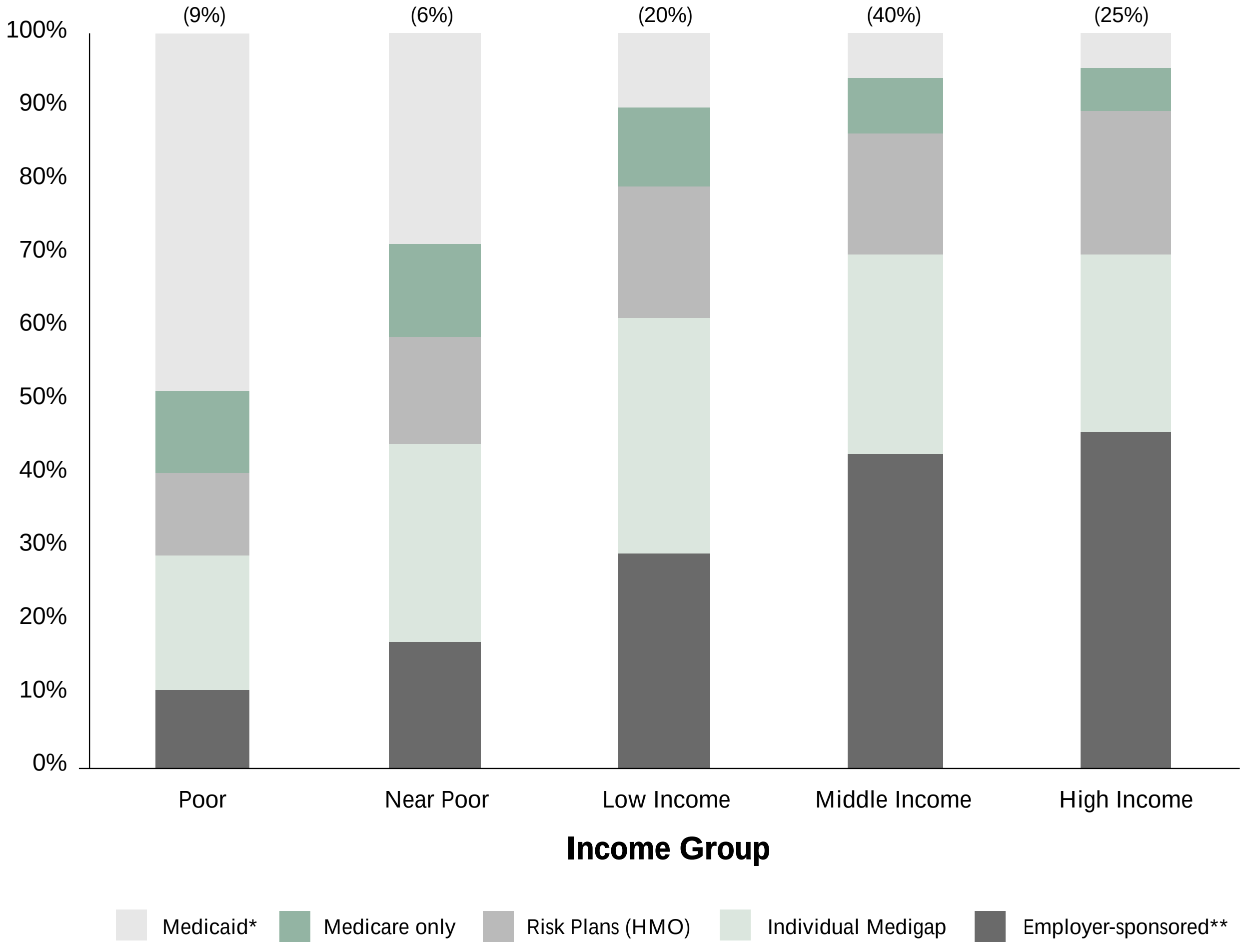
How would income relating beneficiary contributions be implemented?

Because the only accurate and reliable information on individuals’ incomes is collected by the Internal Revenue Service (IRS), the most efficient and practical method of charging higher-income beneficiaries more would be through the income tax process. Social Security income is sometimes used as a proxy for income, which would provide a means of assessing income-related payments through the existing administrative system. But because earnings, assets, and pensions, rather than Social Security, are the main predictors of high income among the elderly, Social Security payments would be poor proxies for this purpose.[18] Using IRS information to determine the monthly premium payments that would be subtracted from beneficiaries’ Social Security checks would require a new

Figure 2

Percent of Medicare Beneficiaries Age 65 and Older, by Supplemental Coverage and Beneficiary Income Status, 1999

(Income Status as a Percentage of Total Number of Medicare Beneficiaries)



Note: Excludes all-year institutionalized. Income measure is family income. For individuals age 65 and older the 1999 projected poverty levels are as follows:

Poor: less than 100% of poverty (less than $8,075 for individuals and less than $10,185 for couples)

Near Poor: 100%-125% of poverty ($8,075-$10,094 for individuals and $10,185-$12,731 for couples)

Low Income: 125.01%-200% of poverty ($10,094-$16,150 for individuals and $12,731-$20,370 for couples)

Middle Income: 200.01%-400% of poverty ($16,150-$32,300 for individuals and $20,370-$40,740 for couples)

High Income: more than 400% of poverty) more than $32,300 for individuals and more than $40,740 for couples)

*A small percentage of Medicare beneficiaries with Medicaid are reported in the AARP model to have incomes above 200 percent of poverty. This may reflect the fact that poverty level is based on reported household income, while Medicaid is based on individual income. Some beneficiaries living with family members may have personal incomes low enough to qualify for Medicaid, while others may incur sufficiently high medical costs to spend down their incomes and assets at some point in the year and qualify for Medicaid.

**Includes people with both employer-sponsored and individual Medigap policies.

Source: National Academy of Social Insurance, 1999. Data based on AARP/PPI analysis using the Medicare Benefits Simulation Model (1999 projections).

and complex administrative system. The approach used in levying the Social Security benefits tax involves involved adding a worksheet and line entries to income tax forms. This approach was also used in the Medicare Catastrophic Coverage Act of 1988 (P.L. 100-360). A similar method could be used to collect additional Medicare premiums, and the revenues could be automatically transferred to Medicare. This approach would make the additional payments look like a new tax, rather than an increased Medicare premium.

Who is going to pay more?

The Social Security benefits tax provisions now in place for collecting revenues allocated to the HI Trust Fund establish the threshold at $34,000 for single individuals and $44,000 for couples filing jointly. A proposal included in one version of the reform plan put before the National Bipartisan Commission on the Future of Medicare in early 1999 set the initial thresholds at 300 percent of poverty (estimated at $24,000 for individuals, $30,000 for couples) with increasing surcharge rates ranging from 1.5 percent up to a maximum of 15 percent of a health plan's premium for those with incomes over 500 percent of poverty ($40,000 for individuals and $50,000 for couples).[19] The upper bounds of the thresholds are consistent with the income levels that were most often mentioned as defining "wealthier" in both focus groups and in a national poll conducted by the Academy, although a significant number of people indicated that far higher incomes cutoffs ($75,000-$125,000) should be used to indicate those who should contribute more (Table 1).[20]

Close to 40 percent of beneficiary households had incomes above $30,000 in 1998.[21] A similar proportion of the population was included in the income-related contribution provisions of the Medicare Catastrophic Coverage Act of 1988, which included an income-related payment to finance a drug benefit and an out-of-pocket limit on expenditures. Rather than establishing income thresholds directly, that legislation put in place a surtax that was assessed for all beneficiaries liable for more than $150 in federal income tax.[22] About 40 percent of beneficiaries were liable for at least the minimum assessment ($22.50) in the first year of the program, and about 5 percent would have paid the maximum $800 (per individual) if the law had not been repealed in 1989.[23]

How much revenue will be raised for Medicare?

The amount raised by an income-related surcharge would depend on the premium contribution rates and the income thresholds that were used. If the income thresholds are set to require greater contributions from only the highest-income beneficiaries (e.g. those with household incomes over $75,000), only a very small proportion of the beneficiary population will be affected and the amount of total revenue that can be raised will be limited. Even if the income thresholds are set relatively low, however, the potential for raising revenues for Medicare is limited if the increased cost-sharing is limited to Part B premiums, which account for slightly less than ten percent of Medicare's total revenues.[24]

Revenues from an income-related premium depend critically on where the income threshold is imposed. Table 2, which provides estimates generated by an Urban Institute model, presents two examples using different income thresholds. Setting the threshold at a relatively high income level (beginning at $50,000 for individuals and $90,000 for couples) would generate only about one-third the revenues that would be obtained if the thresholds were set with lower bounds, closer to the median income of the elderly ($30,000 for individuals and $50,000 for couples).[25]

The income-related premium proposal introduced for consideration by the Bipartisan Commission on the Future of Medicare established income thresholds similar to the those in the second example in Table 2, but the contributions required of higher-income beneficiaries would have been somewhat higher, because they were based on an average beneficiary payment of 12 percent of the amount of total Medicare costs (combined Parts A and B), rather than a percentage of Part B only. Additional payments for affected beneficiaries would, according to Commission staff estimates, amount to about $4.00 per month for each percentage point

Table 1

Poll Results: Should Wealthier People Eligible for Medicare Pay More?

	Respondents' Family Income Per Year		
	Less Than $30,000	**$30,000-$60,000**	**More Than $60,000**
Total	*48%*	*31%*	*21%*
Question: Should Wealthier People Eligible for Medicare Pay More?			
They should pay the same for the same benefits as everyone else who paid into the program	49%	52%	58%
They should be required to pay more	44%	46%	39%
Don't Know/Refuse	4%	2%	2%
Total of those who said "Wealthier should pay more"	*49%*	*33%*	*18%*
Question: At What Income Level Should Wealthy Pay More?			
More Than $20,000	6%	6%	3%
More Than $30,000	14%	7%	7%
More Than $40,000	13%	17%	7%
More Than $50,000	26%	30%	28%
More Than $70,000	20%	23%	30%
More Than $125,000	13%	14%	25%
Don't Know	7%	2%	0%

Source: National Academy of Social Insurance, National Poll, May-June 1997. The poll included 1,000 adults age 18 or over from across the continental United States. This sample size yields results that are statistically accurate (for the full sample) within 3 to 4 percent at the 95 percent confidence level.

assessment in the first year, then increase somewhat over time.[26] If the policy were implemented in 2000, couples earning over $50,000 would pay an additional $60 per month (per beneficiary). Analysis by the Health Care Financing Administration projected that this proposal would increase Medicare revenues by about 2.7 percent over five years (equivalent to increasing monthly Part B premiums under the current system for all beneficiaries by about $13).

Political Considerations

Proposals to increase cost-sharing for wealthier beneficiaries are among the more controversial in the wider debate about how to secure Medicare's future. These proposals can be viewed very differently from different perspectives; how the public reacts to them may be a function of how they are described, and how they fit into a larger discussion of options for reforming Medicare.

Some social insurance experts believe that there is an important distinction between progressive levies assessed on the population as a whole as they pay into Medicare through payroll or other broad-based taxes (which is common among most forms of social insurance), and income-related charges required for those receiving benefits. From this perspective, relating the costs (premiums, copay-

Table 2

Examples of Revenues Gained by Increasing Beneficiary Premiums

Increasing Beneficiary Contributions

	Income Thresholds	Contribution rate*	Revenue Gained	Equivalent to
Example 1	$50,000 for beneficiaries filing individual returns; $90,000 for couples	Maximum contribution of 75% of Part B costs for those with incomes over $115,000	0.6% of projected Medicare outlays over 5 years	Increasing all beneficiary premiums from 25% to 27% of Part B outlays (adding about $3.00 to each beneficiary's monthly premium)
Example 2	$30,000 for beneficiaries filing individual returns; $50,000 for couples	Maximum contribution of 75% of Part B costs for those with incomes over $70,000	1.7% of projected Medicare outlays over five years	Increasing all beneficiary premiums from 25% to 30% of Part B outlays (adding about $8.00 to each beneficiary's monthly premium)

*Sliding scale from 25-75% starting at threshold.

Source: National Academy of Social Insurance, 1999. Based on Gage, B., Moon, M., Nichols, L., et al., *Medicare Savings: Options and Opportunities* (Washington, DC: Urban Institute, June 1997).

ments and deductibles) that beneficiaries must bear to their ability to pay could undermine the concept of Medicare as an earned "entitlement", or "social insurance". Under most definitions of social insurance, everyone who qualifies by paying into the program (no matter how progressive the rules may be) should receive the same insurance coverage, regardless of health care needs or ability to pay.

Others view the issue of income-relating beneficiary contributions as no different from other broad principles of progressive taxation, i.e. that those who can afford to pay more should do so.[27] The arguments are complicated, moreover, by the fact that Part B is technically distinct from Part A, and, unlike Part A, is financed through general revenues and premiums, rather than a separate trust fund that workers pay into in order to earn eligibility for program benefits. From some perspectives, Part B is not contributory social insurance, and concerns about providing benefits to all eligible participants regardless of health or economic status are moot.[28]

Increasing cost-sharing for higher-income Medicare beneficiaries may be acceptable to the public, if there is an awareness among the public that solving Medicare's financing problem will mean making some hard choices, and if the policy, including the definition of "higher-income" is seen as fair. In principle, the concept that those who can afford to pay more should be asked to do so is consistent with American values revealed in polls over the past two decades.[29] If, however, single beneficiaries and couples earning in the $25,000-$40,000 range perceive themselves as being solidly middle class (and in need of tax relief) rather than "wealthy", there is clearly a risk that increasing premiums for this group will be characterized as a burdensome tax increase, and rejected by the public, as was the Catastrophic Coverage Act of 1988. Introducing an income-related premium system also could focus attention an array of thorny tax and revenue issues, including the tax benefits associated with employer-provided supplemental insurance, age-related deductions, and the provisions of the Social Security benefits tax that in effect move money from the Social Security Trust Fund to the HI Trust Fund.

Finally, income-related Medicare premiums may raise some broader social as well as political questions about the role of the Medicare program in American society. Medicare is a remarkably popular program, one that people depend on and want to preserve. If a growing number of lower-income beneficiaries have to depend on supplemental programs administered by Medicaid to pay for part of their health insurance, confidence in Medicare could fade. If higher income people know that they will pay more throughout their working lives, but then have to pay more to enroll when they retire, their support for the program could erode.[30]

In assessing the costs and benefits of changing the way that beneficiaries help to pay for Medicare, policymakers will need to assess the financial, political, and social consequences of potential reforms. Policies that would have higher-income beneficiaries pay more for Medicare may present among the most difficult trade-offs they have to face.

Endnotes

1. The Board of Trustees, Federal Hospital Insurance Trust Fund, *1999 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund*, (Washington, DC: March 30, 1999).
2. From 1966 through 1985, the Medicare payroll tax rate for workers and for employers rose from .35 percent to 1.30 percent, while the maximum tax base rose from $6,000 to $39,600. The tax rate has been 1.45 percent since 1986, but the maximum base increased to $135,000 by 1993, and was lifted altogether in 1994. Therefore the payroll contributions of higher-paid employees have increased significantly since the program was created; those retiring over the past 5 years paid in substantially more than earlier retirees.
3. Clark, R. and Quinn, J.F., *Can Adverse Effects of Reductions in Medicare be Offset by Improvements in Other Retirement Programs?* Draft, January 1999. Prepared for the National Academy of Social Insurance Study Panel on Medicare Financing.
4. National Academy of Social Insurance, *Medicare and the American Social Contract — Final Report of the Study Panel on Medicare's Larger Social Role* (Washington, DC: National Academy of Social Insurance, February 1999).
5. AARP Public Policy Institute and the Lewin Group, *Out-of-Pocket Health Spending by Medicare Beneficiaries Age 65 and Older: 1997 Projections*, Publication # 9705 (Washington, DC: AARP Public Policy Institute, December 1997); U.S. Department of Health and Human Services, Health Care Financing Administration, *Profiles of Medicare* (Washington, DC: 1996). Also see *Medicare and the American Social Contract.*
6. Moon, M., *Growth in Medicare Spending: What Will Beneficiaries Pay?* (Washington, DC: Urban Institute, January 1999).
7. Copayments and deductibles are generally thought to create incentives for patients to use more judgment when deciding to seek out medical services. This can discourage the unnecessary or inappropriate use of health care, but there is also some evidence that patients do not necessarily have the information they need to make informed decisions about when to seek care, so that cost sharing may also discourage some from seeking appropriate care (see for example, Manning, W., et al., "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment," *The American Economic Review* 77(3): June 1987, and Lohr, K. N., et al., "Use of Medical Care in the Rand Health Insurance Experiment: Diagnosis and Service-specific Analyses in a Randomized Controlled Trial," *Medical Care* 24(9): supplement, September 1986.
8. The Qualified Medicare Beneficiary (QMB) program pays for Medicare premiums, copayments and deductibles for Medicare beneficiaries with incomes below the poverty line. Medicaid also provides some supplemental coverage to three other groups of low income individuals: Specified low income Medicare beneficiaries (SLMBs) are individuals with incomes under 120 percent of the poverty level; they are eligible to have Medicaid pay their Medicare premiums; qualifying individuals (called QI-1's) are individuals who have incomes of less than 135 percent of the poverty level. They may apply to Medicaid to have their Medicare premiums paid, and a second category of qualifying individuals (called QI-2's) includes individuals with incomes that are below 175 percent of the poverty line. These individuals can apply to Medicaid to pay for a portion of their Medicare premium that is the result of a shift in program costs for most home health services from Part A to Part B by the 1997 Balanced Budget Act. See U.S. Congress, Congressional Budget Office, *Long-Term Budgetary Pressures and Policy Options, Report to the Senate and House Committees on Budget* (Washington DC: U.S. Government Printing Office, May 1998).

9. U.S. Congress, General Accounting Office, *Private Health Insurance: Declining Employer Coverage May Affect Access for 55-to 64-Year-Olds*, GAO / HEHS-98-133 (Washington, DC: June 1998).

10. Alecxih, L., Vice President, The Lewin Group, “Statement,” *Supplemental Coverage for Medicare Beneficiaries*, presentation to the Reform Task Force of the National Bipartisan Commission on the Future of Medicare, Washington, DC, June 16, 1998.

11. Medicaid will cover all QMBs and SLMBs (see endnote 8) who apply for the benefit and meet the requirements. Recent estimates are that about 53 percent of beneficiaries eligible for the QMB or SLMB programs did not participate in these programs in 1996. See *A Profile of QMB-Eligible and SLMB-Eligible Beneficiaries*, prepared for the Health Care Financing Administration (Washington, DC: Barents Group, April 7, 1999). Annual funding for the QI’s is capped, so that only those who apply before the funds appropriated for the program are expended can receive the additional coverage.

12. The 1998 survey, conducted in August and September, 1998, included a sample of 1,909 people aged 18 or older. Overall, 64 percent favored a sliding scale (44 percent “strongly”, compared to 20 percent not strongly; 66 percent of all respondents under age 65 favored a sliding scale, compared to 56 percent of those 65 or older). Kaiser Family Foundation / Harvard School of Public Health, *National Survey on Medicare: The Next Big Health Policy Debate?* (Menlo Park, CA: Kaiser Family Foundation, October 20, 1998). The published survey summary does not indicate whether there was a relationship between favoring a sliding scale and respondents’ income levels (i.e. whether they would be likely to view themselves as liable for higher payments under a sliding scale). Poll results on this topic may be particularly sensitive to wording and to respondents’ perceptions about who is wealthier, what “paying more” might actually entail, and how Medicare financing works. See *Medicare and the American Social Contract*, *op. cit.*

13. McClellan, M., and Skinner, S., “Medicare Reform: Who Pays and Who Benefits?” *Health Affairs* 18 (1) (January / February, 1999: 48-62). Overall, higher income beneficiaries are, on average, a bit healthier than those with lower incomes, they tend to live longer, and they use more Medicare services (particularly Part B services).

14. The Congressional Budget Office has estimated that Medigap coverage increases enrollees’ use of services by about 24 percent. U.S. Congress, Congressional Budget Office, *Long-Term Budgetary Pressures and Policy Options*, *op. cit.*

15. U.S. Congress, Congressional Budget Office, *CBO Memorandum: Estimates of Federal Tax Liabilities for Individuals and Families by Income Category and Family Type for 1995 and 1999* (Washington DC: Congressional Budget Office, May 1998). Given the specific provisions of the tax code and types of deductions allowed, families headed by persons age 65 or more pay slightly less in income taxes than the average American family. In 1997, the average household paid $7,194 in taxes; household with heads age 65 or more paid $7,151 (National Bipartisan Commission on the Future of Medicare, photocopy background materials, December 2, 1998).

16. Determining how benefits are taxed is based on a two-part income threshold calculation. For single beneficiaries, the thresholds are $25,000 and $34,000; for couples filing a joint return, $32,000 and $44,000. An adjusted income figure based on earnings, pensions dividends and taxable interest plus 50% of Social Security benefits is compared to the thresholds. Fifty percent of any excess over the first threshold, plus 35 percent of any excess over the second threshold is included in adjusted gross income for tax purposes. This amount cannot exceed the smaller of (a) 85 percent of the benefits or (b) 50 percent of the benefits, plus 85 percent of any excess over the second threshold. The increment in tax revenues resulting from applying the higher threshold level is deposited in the Medicare HI Trust Fund. Treanor, J., Detlefs, D., and Myers, R., *1999, Guide to Social Security and Medicare* (Louisville, KY: William M. Mercer, Inc., November 1998).

17. The Board of Trustees, Federal Hospital Insurance Trust Fund, 1999, *op. cit.*

18. Clark, R. and Quinn, J.F., *op. cit.*

19. The provisions for income-relating premiums were developed as part of a proposal for a premium support system for Medicare, in which payments to plans would be established thorough a managed competition system. In such a system, the actual amount paid by individuals (above the payment made by Medicare) would vary according the price of plan. (National Bipartisan Commission on the Future of Medicare, staff memorandum, February 17, 1999. http / / thomas.loc.gov / medicare / jeff.html.)

20. See *Medicare and the American Social Contract*, *op. cit.*

21. See *Medicare and the American Social Contract, op. cit.,* Exhibit 4, based on data from the *1997 Current Population Survey* analyzed by M. Moon, Urban Institute, Washington, DC, 1998.

22. The Catastrophic Coverage legislation imposed an annual supplemental Medicare premium on individuals who were eligible for benefits under Part A of the Medicare program for more than six full months in a taxable year and whose tax liability equaled or exceeded $150. Additional increments were charged against each additional $150 of tax liability, with an annual cap, set at was $800 for individuals in 1989 (scheduled to increase to $1,050 by 1993). U.S. Congress, Congressional Budget Office, *Updated Estimates of Medicare's Catastrophic Drug Insurance Program,* (Washington, DC: October 1989).

23. The surtax rate was scheduled to increase significantly over the first five years of the program, to about twice the initial rate; see Moon, M., *Medicare Now and In the Future* (Washington, DC: Urban Institute Press, 1993).

24. National Bipartisan Commission on the Future of Medicare, *Medicare Financing Sources,* Washington, DC: March 17, 1999. http://thomas.loc.gov/medicare/anne.html.

25. Estimates based on projections of expenditures for 1998-2002 from both the intermediate estimates of program outlays in the 1998 Report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund, and CBO projections (Committee on Ways & Means Green Book, 1998); and estimates from Gage, B., Moon. M., Nichols, L., et al., *Medicare Savings: Options and Opportunities* (Washington, DC: Urban Institute, June 1997). Technical adjustments to the original model, to correct for changes in legislation and estimates of program costs over the past two years, would be needed to generate more precise estimates.

26. National Bipartisan Commission on the Future of Medicare, staff memorandum, *op. cit.*

27. It is interesting to note, in this regard, that proposals to introduce higher premiums for higher income beneficiaries are generally referred to in the press as "means-testing," which is a term normally used to describe welfare programs, where eligibility is limited to those who demonstrate financial need. This terminology is not used in this *Brief* because it is misleading. Requiring higher-income beneficiaries to pay more for Medicare would not affect their program entitlement or the nature of the insurance benefits provided. The term "means-testing" projects a notion that may be problematic from the perspective of traditional supporters of social insurance principles, if it implies a system in which those paying more for premiums would have a somewhat different status (paying their "full share") than those paying less (who qualify for a government "subsidy"); see *Medicare and the American Social Contract, op. cit.*

28. It should be noted, however, that while enrollment in Part B is voluntary, almost all individuals enrolled in Part A are also enrolled in Part B (96 percent), and only a small number of individuals who are not eligible for Part A enroll in Part B (about 1 percent of all individuals enrolled in Medicare are enrolled in Part B but not Part A); Social Security Administration, *Annual Statistical Supplement to the Social Security Bulletin,* November, 1998. Since in the great majority of cases it actually serves as an "automatic" supplement to Part A (individuals are enrolled in Part B when they become eligible for Part A unless they specifically request not to be), Part B is generally viewed as part of the social insurance package provided by Medicare.

29. *Medicare and the American Social Contract, op. cit.*

30. Illustrating this point, an Academy focus group participant argued that,

    "The guy who's worked his tail to the bone all his life, saved everything, is going to have to pay more?. . . I don't think that's fair. I think he's been taxed his 1.45 percent for his ten years plus in the labor force, he deserves everything else that anybody else gets. . . . He actually paid in more, because he had more taxable income. . . Let's say, if I felt that if I was going to be wealthy, I wouldn't want to contribute, all through my working career, I'd say 'Forget it. Don't take it out of my check, and I won't collect it.'"

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