This Isn't Such a Bitter Pill

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As they struggle to craft a compromise Medicare bill, members of Congress are facing an unusually contentious and politically explosive issue: Whether the time has come to charge higher-income elderly Americans more than they charge the less affluent for the benefits they receive under Medicare.

On the surface, that may not sound so controversial. Many federal programs - welfare being the prime example - already distinguish between high-income and low-income people, and many government health-care programs have "means tests" in place to determine eligibility. But Medicare was created in 1966 as a social insurance program, not a welfare program. For almost 40 years, its benefits have been available to all who paid payroll taxes during their working lives and the required premium in retirement.

This week, as a House-Senate conference committee continues to wrestle with the proposal, the argument is reaching fever pitch.

Proponents claim that charging high-income people more will significantly improve Medicare's bleak fiscal outlook. Opponents on the left see it as a dastardly breach of the social contract, the first step down a slippery slope that will transform Medicare from a universal insurance program into a welfare program. Opponents on the right consider it yet another proposal to hike taxes.

But the fact is, if you strip out the hyperbole and demagoguery, making affluent beneficiaries pay more than those with fewer resources is eminently sensible. It is not the long-term solution - it will provide only a drop in the bucket toward Medicare's long-run solvency - but it will help.

Currently, participants pay no premium for Medicare Part A insurance, which covers in-patient hospital, nursing home, hospice and some home health care.

The reason for this is that Medicare beneficiaries or their spouses, together with their former employers, have already paid a combined payroll tax of 2.9% of their earnings into the Hospital Insurance trust fund, which pays for these benefits.

Medicare beneficiaries do pay a uniform premium for Medicare Part B insurance, which covers physician and other professional bills, lab tests, outpatient hospitalization and other services. This premium - $58.70 a month in 2003 - is set at a level that covers one-quarter of the Part B program costs, while the general taxpayers pick up the balance.

The proposal now throwing off sparks in Washington would require Medicare beneficiaries with incomes above certain relatively high thresholds to pay gradually increasing Part B premiums. While policymakers are still debating what those thresholds should be, discussion has hovered around $75,000 for individuals and $100,000 for couples. Individuals with incomes over $100,000 and couples with incomes over $200,000 would pay premiums that would cover the full cost of their Part B insurance.

Contrary to some claims, pegging premiums to incomes would not constitute a "means test" like those used in welfare programs that actually limit eligibility, nor would it break the social contract between Americans and the Medicare program. All those retirees currently eligible for Medicare would continue to be eligible for benefits no matter how high their incomes.

The proposed policy simply extends into the retirement years the principle that already underlies individuals' payroll tax payments for Part A insurance during their working years. After all, a worker with annual income of $150,000 already contributes five times as much payroll tax to the hospital insurance trust fund as the worker earning $30,000, while both receive the same benefits in retirement.

It is no different to ask retirees to contribute to Part B's costs according to their ability to pay.

But might not the well-off elderly, who tend to be healthier and less costly to the program, drop their elective Part B insurance and sign up for private coverage if their premiums go up? Don't count on it, except for the very few who have access to an employer-sponsored retiree policy that does not require its participants to enroll in Medicare.

Even those who would have to pay premiums equal to the full cost of Part B will find that Medicare remains a good, reasonably priced buy compared with what they would find in the private marketplace. No private insurer could offer coverage for unmanaged fee-for-service care through such an extensive network of health-care providers at a similar price. Fewer still would be willing to guarantee a uniform premium no matter how old or sick the purchaser.

Contrary to charges from tax-a-phobics on the right, premiums that increase with income do not constitute a tax increase.

Taxes are compulsory, whereas the elderly can choose to opt out of Part B if they think they can find a better deal. To be sure, the simplest, most efficient and most confidential way to administer supplemental premiums would be to allow high-income Medicare participants to calculate and pay them in conjunction with their tax returns. But this would be just a convenience; it would not transform the premium into a tax.

The new policy, if approved, won't generate boatloads of money. Only about 6% of beneficiaries will end up paying higher premiums if Congress sticks to the proposed income thresholds and Medicare's receipts rise at most only a couple of billion dollars a year. Over the longer haul, only 1% of Medicare's Part B expenditures would be offset by this proposal.

Is it worth taking this step for such relatively small sums? Yes, asking the very richest seniors to chip in a bit more for their insurance is preferable to other ways of strengthening the program's financial base.

Just consider the alternatives: scaling back the benefit package (which already lacks coverage for drugs, catastrophic expenses, long-term care and many preventive services), raising cost-sharing (which would disproportionately hit the sick and is already higher than what the working-age population pays), increasing premiums for everyone (which would most burden the 60% of beneficiaries living on less than $30,000 a year) or raising taxes on the working-age population (about 15% of whom have no health insurance of their own).

All of these less-palatable alternatives will probably have to play some role over the long run. But that day can be postponed if those beneficiaries who can afford to pay more for Medicare are asked to step up now.

Other Publications by the Authors

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