

## Medicare Means Testing: Test the Deductible, Not the Premium

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- Outside the Administration, few politicians are serious about addressing the impending bankruptcy of Medicare, and some are even hastening it along.
- While the President has been unable to execute fundamental reforms to Medicare, he has taken marginal, but substantive, steps to improve the incentives and “bend the curve” of rising costs.
- One promising reform is an income-based means test for Part B and Part D benefits; but the premium is likely not the right place to apply the test, whereas applying the means test to the deductible would have a positive impact on both patients’ and suppliers’ behavior.

The looming insolvency of Medicare is disappointingly absent from the list of policy issues on the *carte du jour* for the November general election. Fortunately, the current Administration recognizes the clear and present danger of Medicare insolvency. “Time is running out. Medicare is drifting toward disaster,”<sup>1</sup> said U.S. Secretary of Health and Human Services Michael O. Leavitt earlier this month.

Two months ago, I addressed the looming fiscal crisis in Medicare, and questioned why the President had not really succeeded in injecting a healthy dose of consumer-direction into the program, as he has in private health insurance and (to some degree) Medicaid. Indeed, Medicare, the single-payer program for seniors, has been a black hole for consumer-driven reform. It is *illegal* for Medicare beneficiaries to fund Health Savings Accounts (HSAs), although they can maintain and spend from accounts that they opened prior to enrolling in Medicare. It took until January 2007 for the government finally to allow consumer-driven Medicare Medical Savings Account (MSA) plans – three years *after* HSAs started in the private market. MSA plans look very similar to the high-deductible health plans that qualify working-age Americans to open HSAs. Unfortunately, slightly more than 3,000 of 44 million Medicare beneficiaries were in Medicare MSA plans in February 2008 – not even a rounding error.<sup>2</sup>

Unfortunately, Congress is blocking the Administration’s intention of saving money and improving quality in Medicare in many ways – and even threatening to roll back some of the innovations launched by the Medicare Modernization Act of 2003 (MMA), which have yet to take hold. For example, the MMA took a significant step away from government price-fixing for durable medical equipment, such as oxygen tanks or mail-order diabetic supplies for Medicare beneficiaries, by mandating competitive bidding for a number of those items. Last November, a *New York Times* investigative report revealed how spending on bottled oxygen had spiraled out of control. Over the past 20 years, suppliers have figured out how to game the fixed prices, and oversupply unnecessary services, for which taxpayers pay the tab.<sup>3</sup>

The Administration finally got competitive bidding off the ground and last month announced the results of phase one: for 10 product categories in the initial group of urban areas, competitive bidding resulted in payments *26 percent lower* than under fixed prices.<sup>4</sup> Incredibly, a number of legislators, led by U.S. Senator George Voinovich of Ohio, continue to lobby against this step to protect American taxpayers.<sup>5</sup> Neither is the congressional majority making any attempt whatsoever to rescue Americans from their forthcoming immolation on the bonfire of exploding Medicare benefits.

The congressional budget resolution, which the Senate and House of Representatives approved on June 5, committed to spending \$420 billion in 2009 and \$2.4 trillion over five years to 2013.<sup>6</sup> The President, on the other hand, proposed spending only \$2.2 trillion over five years! Remarkably, this tiny difference has become a battlefield between the President and Congress. A small part of the presidential savings comes from means testing premiums: \$2.6 billion for Part B, which pays for physicians’ services; and \$3.2 billion for the Part D Prescription Drug Plan.<sup>7</sup>

Despite (or perhaps because of) the minor impact of means testing, this is an area where the President is

pressing his agenda. Earlier this month, the President promised to veto S.3101, the Medicare Improvements for Patients and Providers Act. This bill would have the primary effect of “fixing” Medicare Part B physician payments, which are otherwise scheduled to be cut by more than 10 percent in the second half of 2008. However, the bill includes no offsetting reductions to finance this “fix.” In fact, Congress passed a law years ago to cut physician reimbursement, but has “fixed” it for five out of the past six years to give doctors an actual increase. As a result the “cliff” gets higher every year, and Medicare spending projections get less and less realistic.<sup>8</sup>

In his veto threat, the President emphasized his support for H.R. 5480 and S. 2662, the Medicare Funding Warning Act, which includes the means testing that he proposed in his budget.<sup>9</sup> While Medicare has imposed means testing on premiums for Part B (physicians’ services) for the last couple of years, the President’s proposal tightens up means testing along two fronts. First, he proposes to impose the same means test on Part D Prescription Drug Plans, as well. Second, he proposes to fix the income cut-offs at current levels, and not raise them with inflation as they have been since 2007. Thus, the means test will catch more people every year.

Table 1 shows the estimated monthly premiums for Medicare Part B and Part D, if the President’s proposal comes into force. Clearly, there is a fairly stiff marginal effect on higher earners. The highest earning households will pay slightly less than \$400 per month, per person, versus \$125 for the majority which has household incomes below the first cut-off.

Although this would certainly help patch up Medicare finances, if only a little, it is likely not the best place to impose a means test. This is because increasing the premium for higher earners is very close to a tax increase. Most free-market conservatives want to *flatten* income taxes, not *steepen* them. Secondly, imposing the means test on premiums does not inject consumer-driven incentives into Medicare in any way. If the Medicare beneficiary simply has more premium dollars deducted from her Social Security check because she earns a high income, this is unlikely to make her a better consumer of health goods and services.

However, there is another way to impose a means test, by which it looks a lot less like a tax and a lot more like consumer-driven health care. That is to lay it on the deductible. For 2009, the Medicare Part B annual deductible will be \$135, and the Part D deductible \$295.<sup>10</sup> These deductibles are well below what is needed to create incentives for consumer-driven health care, especially for high earners.

According to professor Thomas R. Saving, a public trustee of the Social Security and Medicare Trust Funds, who was appointed by President Clinton: “The reform perhaps most likely to reduce the level of expenditures projected by the trustees is the elimination of first-dollar coverage. It also has the greatest potential to reduce per-capita spending growth.”<sup>11</sup> Although they did not model Medicare Part D, Saving and his co-author, Professor Andrew J. Rettenmaier modeled a Medicare Part A (hospital insurance) and Part B combination plan with a deductible of \$5,000, and no co-pays above the deductible. Their model estimated an immediate “shock” of a reduction of 27 percent of hospital expenditure and 49 percent for all other expenditure. This would result in a much smaller transfer from federal non-entitlement taxes than the status quo: 4.1 percent from 11.2 percent – a gap that would grow as time progresses, and wipe out almost 40 percent of Medicare’s \$32 trillion liability, as estimated in 2007.<sup>12</sup>

Well, that sounds pretty good. Unfortunately, asking the majority of America’s seniors to pay more for their health care, through a higher deductible, is a sure way to cut short a promising political career. However, President Bush successfully increased Part B premiums a couple of years ago, and he is sticking to his guns. Table 1 also shows what would happen if Medicare imposed the same means test as President Bush is proposing, but applied it to the deductible, *instead of* premiums. In this case, the majority of Medicare beneficiaries would continue to enjoy a relatively nominal combined deductible of \$430 for both Parts B and D, but the highest earners would face a much higher combined deductible of \$3,706 in 2009.

People who don’t trust Americans to spend their own money on their health care will immediately retort that high deductibles will cause patients to stop seeing their doctors and taking their meds, leading to higher costs elsewhere. Certainly, there is good evidence that consumer-driven health care and value-driven health care meet on the field of prescription co-payments, and many payers are cutting Rx co-pays because of evidence that it improves adherence to Rx therapy and reduces overall cost.<sup>13</sup> Note, however, that this impact is greater for low-income people. High earners do not cut back when co-pays go up.<sup>14</sup> Further, the government does not deliver Part D directly. All beneficiaries enroll in private plans, which fully exploit the great flexibility they have to design benefits.<sup>15</sup>

The President’s plan to impose more means testing in Medicare is a good one. He just needs to apply it in the right place.

**Table 1: Estimated 2009 Medicare Part B & D Premiums by Income, Under the President's February 2008 Budget, and Alternative Means Tested Deductible**

Household Income		Monthly Premiums		Excess Premium Due to Means Test		Excess Premium Annualized		Alternative Means Tested Deductible		
Singles	Couples	Part B	Part D	Part B	Part D	Part B	Part D	Part B	Part D	Parts B & D
Up to \$82,000	Up to \$164,000	\$96.40	\$28.52	NIL	NIL	NIL	NIL	\$135	\$295	\$430
Up to \$102,000	Up to \$204,000	\$134.96	\$39.15	\$38.56	\$10.63	\$463	\$128	\$598	\$423	\$1,020
Up to \$153,000	Up to \$306,000	\$192.80	\$55.93	\$96.40	\$27.40	\$1,157	\$329	\$1,292	\$624	\$1,916
Up to \$205,000	Up to \$410,000	\$250.64	\$72.70	\$154.24	\$44.18	\$1,851	\$530	\$1,986	\$825	\$2,811
Over \$205,000	Over \$410,000	\$308.48	\$89.48	\$212.08	\$60.96	\$2,545	\$732	\$2,680	\$1,027	\$3,706

Source: Author's estimates

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## Endnotes

- <sup>1</sup> Michael O. Leavitt, *Medicare: Drifting Toward Disaster*, Heritage Lecture #1088 (Washington, DC: The Heritage Foundation) June 11, 2008.
- <sup>2</sup> John R. Graham, "Why Consumer-Driven Health Care is Crashing on the Shoals of Medicare," *Health Policy Prescriptions*, Vol. 6, No. 4 (April 2008), and references.
- <sup>3</sup> Charles Duhigg, "Oxygen Suppliers Fight to Keep a Medicare Boon," *New York Times*, November 30, 2007, p. 1.
- <sup>4</sup> "DMEPOS Competitive Bidding Program, *Contract Suppliers—Round 1*," press release, Baltimore, MD: Centers for Medicare & Medicaid Services, May 19, 2008. <http://www.dmecompetitivebid.com/Palmetto/Cbic.nsf/docsCat/Contract%20Suppliers%20-%20Round%201?opendocument>.
- <sup>5</sup> George Voinovich, et al., Letter to Senators Reid, McConnell, Baucus, and Grassley re. DMEPOS competitive bidding program, Washington DC: Office of U.S. Senator George Voinovich, June 10, 2008.
- <sup>6</sup> U.S. House of Representatives, *Concurrent Resolution on the Budget for Fiscal Year 2009*, report 110-659 to accompany S. Con. Res. 70 (Washington, DC: U.S. House of Representatives) May 20, 2008.
- <sup>7</sup> Office of Management and Budget, *Analytical Perspectives: Budget of the United States Government, Fiscal Year 2009* (Washington, DC: Office of Management and Budget) February 4, 2008.
- <sup>8</sup> Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *The 2008 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Fund* (Washington, DC: Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds,) March 25, 2008, pp. 2, 10, 21-22.
- <sup>9</sup> Office of Management and Budget, *Statement of Administration Policy: S. 3101 – Medicare Improvements for Patients and Providers Act of 2008* (Washington, DC: Office of Management and Budget) June 12, 2008.
- <sup>10</sup> Abby L. Block, *Announcement of Calendar Year (CY) 2009 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies*, note to prescription drug plan sponsors, Medicare Advantage organizations, and other interested parties (Baltimore, MD: Centers for Medicare & Medicaid Services,) April 7, 2008, p. 33.
- <sup>11</sup> Andrew J. Rettenmaier and Thomas R. Saving, *The Diagnosis & Treatment of Medicare*, (Washington, DC: The AEI Press) 2007, p. 84.
- <sup>12</sup> *Ibid*, pp. 79-86.
- <sup>13</sup> Vanessa Fuhrmans, "New Tack on Copays: Cutting Them," *Wall Street Journal*, May 8, 2007, p. D1.
- <sup>14</sup> John R. Graham, *The Fantasy of Reference Pricing and the Promise of Choice in BC's Pharmacare*, Public Policy Sources No. 66 (Vancouver, BC: The Fraser Institute) November 2002, pp. 28-32 discusses this fully in an analysis of the means testing of pharmaceutical benefits in the Canadian province of Quebec.
- <sup>15</sup> Jack Hoadley, et al., *Medicare Prescription Drug Plans in 2008 and Key Changes Since 2006: Summary of Findings*, Publication No. 7762 (Menlo Park, CA: Henry J. Kaiser Family Foundation) April 2008.