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CENTERS for MEDICARE & MEDICAID SERVICES

**Office of the Actuary**

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**SUBJECT:** Additional Information Regarding Comparisons of Beneficiary Income and Out-of-Pocket Costs for Medicare Supplementary Medical Insurance

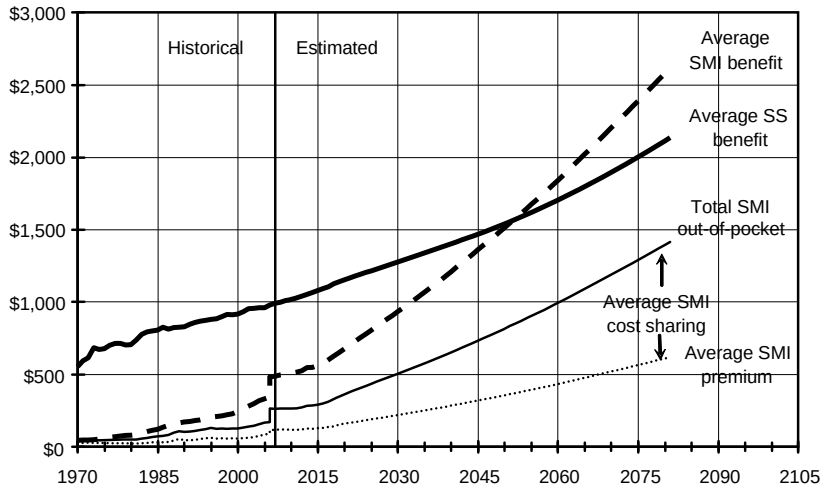
Over the past 8 years, the annual report of the Medicare Board of Trustees to Congress has included a comparison of growth trends for (i) beneficiary income, and (ii) beneficiary "out-of-pocket" costs for premiums and cost-sharing liabilities under the Supplementary Medical Insurance (SMI) component of Medicare. This comparison provides an important and informative illustration of the adverse consequences for Medicare beneficiaries if SMI costs continue to increase at a significantly faster rate than beneficiaries' incomes for a sustained period.[1]

Because of the complicated nature of the material presented, and the simplifying assumptions made for purposes of illustration, the comparison can be misinterpreted. The discussion on pages 81-83 of the Medicare Trustees Report explains the purpose of this comparison and describes its key limitations. This memorandum provides additional information on this subject.

Figure III.C1, which appears on page 83 of the 2008 Medicare Trustees Report, illustrates the comparison of beneficiary income and SMI out-of-pocket costs and is reproduced below. For this illustration, average cost sharing and premiums for SMI Part B and Part D are compared with an average Social Security benefit.[2] The chart and accompanying text raise the concern that the SMI premiums and cost sharing would typically increase as a proportion of a beneficiary's total income, if no changes are made to the Medicare program, and could reach very substantial levels in the long range.

[1] The Medicare Trustees Report also presents a corresponding illustration for the Federal Budget.
[2] The average cost-sharing payments are based on beneficiaries in the traditional "fee-for-service" Medicare program. Medicare Advantage enrollees currently have lower cost-sharing requirements on average, but detailed data on such amounts is not available.

**Figure III.C1.—Comparison of Average Monthly SMI Benefits, Premiums, and Cost-Sharing to the Average Monthly Social Security Benefit**
[Amounts in constant 2007 dollars]




*Introduction of Medicare Part D prescription drug coverage*

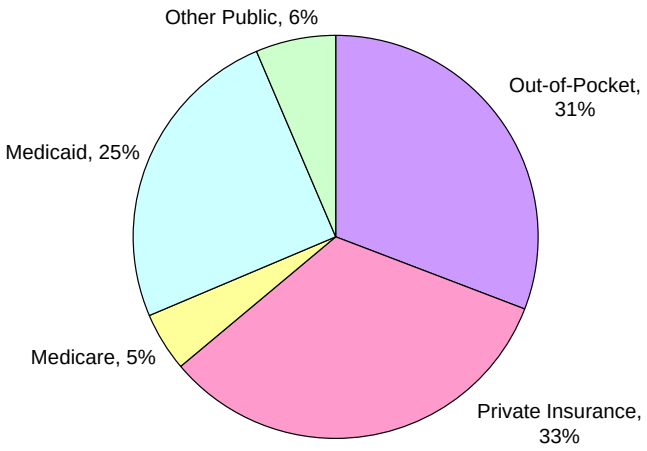
Figure III.C1 shows the out-of-pocket spending for SMI covered services but excludes out-of-pocket spending by Medicare enrollees for other services. As a result, the new access to prescription drug coverage under Medicare Part D, starting in 2006, is clearly evident in an increase in the premiums and cost sharing associated with Medicare-covered services. However, Medicare beneficiaries enrolling in Part D will generally see a significantly greater decrease in their total out-of-pocket healthcare spending.

To help illustrate this point, the following chart shows a rough approximation of the distribution of prescription drug spending, by source of payment, by or on behalf of the elderly (age 65 and older). Results are shown with and without the impact of Part D.[3] Under the new law, direct beneficiary spending for prescription drugs is estimated to be roughly 10 percent of total prescription drug spending for the elderly, rather than roughly 31 percent in the absence of Part D access to coverage. Thus, while the introduction of Part D increases Medicare cost-sharing requirements, beneficiaries' overall payments for drug cost sharing, and/or direct purchase of prescription drugs, are reduced substantially.

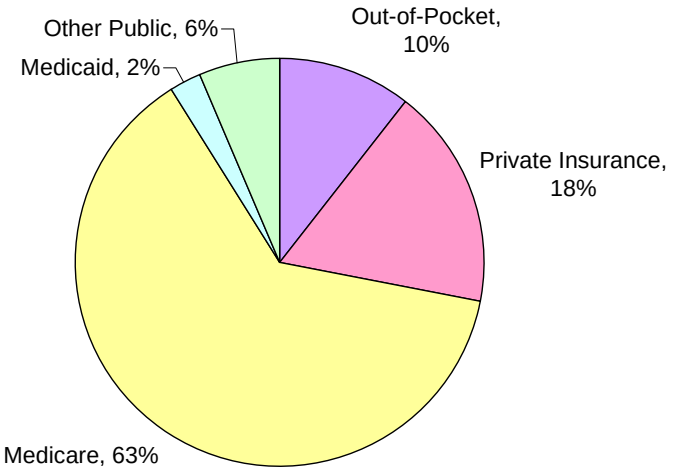
[3] For this purpose, out-of-pocket costs include any prescription drug costs not covered by private or government insurance. For beneficiaries without drug insurance coverage, all drug expenses are included. For those with such coverage, cost-sharing liabilities for deductibles, coinsurance or copayments, etc. are included. Insurance premiums are excluded, since the distribution shows how prescription drug expenses are paid rather than how drug insurance is financed.

**Estimated 2006 Aged Prescription Drug Spending Distribution, with and without the Impact of Part D, by Source of Funds**

Without Part D:




With Part D:




Source: OACT approximation, based on National Health Expenditure projections for 2005-2015.

Again, the purpose of Figure III.C1 is not to assess the impact of new benefit coverages under Medicare. Rather, its purpose is to illustrate that sustained rapid increases in SMI premiums and cost-sharing liabilities will cause most beneficiaries to spend an increasing share of their incomes

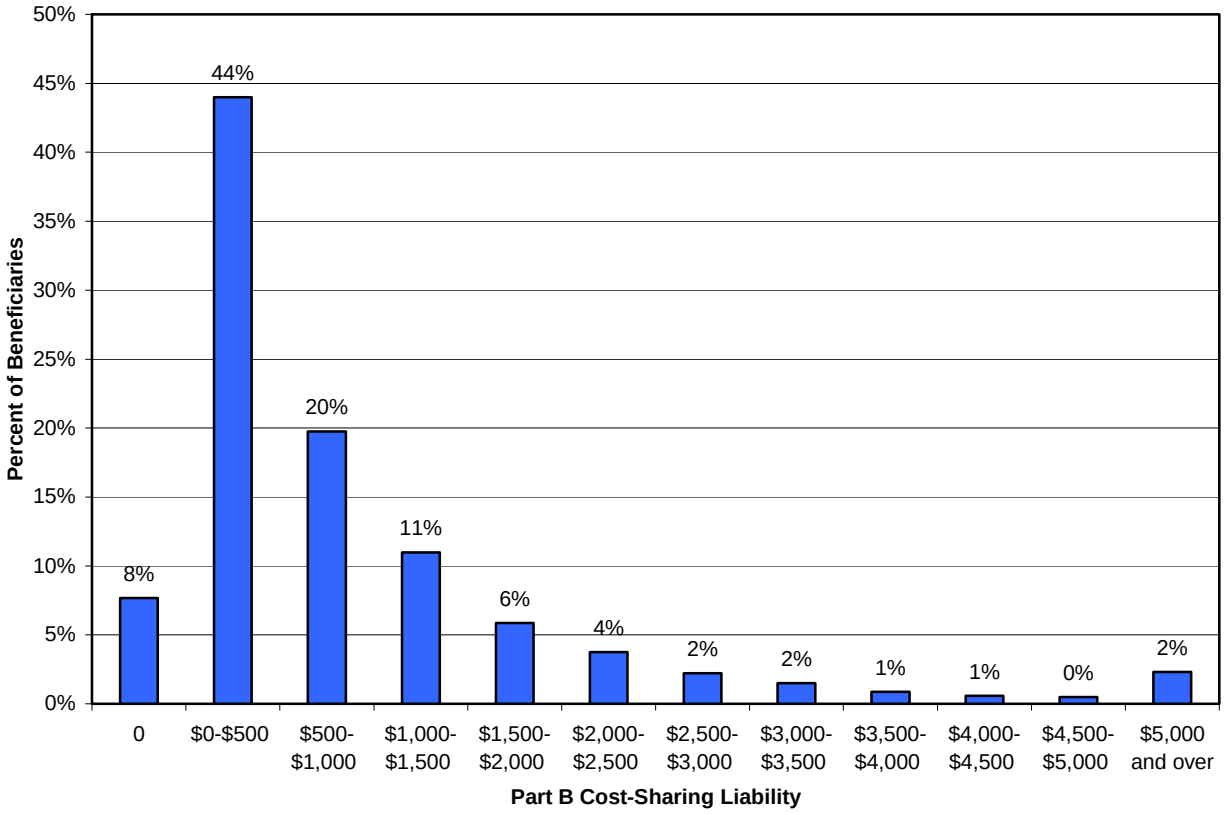
on such costs. This pattern is quite evident both before the introduction of Part D in 2006 and afterward.

*Variation in SMI beneficiary cost-sharing liabilities*

Figure III.C1 is based on the average SMI Part B and Part D premiums, the average beneficiary cost-sharing amounts, and the average Social Security benefit for a Medicare enrollee. While it is reasonable to compare long-range growth trends on the basis of such averages, this approach does not capture the wide range of results for individual Medicare enrollees. Some Medicare enrollees are in very good health and do not require medical services during a year. At most, these individuals would pay only the Part B and Part D premiums. Others are in very poor health and receive medical services far above the average level, often leading to cost sharing well above average.

The following chart shows the distribution of SMI Part B cost-sharing liabilities for beneficiaries in 2004.

**Distribution of SMI Part B cost-sharing liabilities in 2004, by amount**




Note: In 2004, the 50th percentile, or median, cost-sharing liability was in the $0-$500 range. About 48 percent of beneficiaries had a cost-sharing liability of at least $500. The Part B deductible was $100 in 2004.

Source: 2004 Medicare Current Beneficiary Survey.

As indicated, about 8 percent of Part B enrollees had no liability in that year, while 2 percent had a total liability for the Part B deductible and coinsurance requirements in excess of $5,000. In practice, many beneficiaries have supplementary health insurance coverage through Medicaid, employer-sponsored retiree health plans, or "Medigap" and other private health insurance policies. Such coverages help pay for a substantial portion of the Part B cost-sharing liabilities incurred by beneficiaries. The purpose of this chart is to demonstrate the very broad range of individual results relative to the average liability for all beneficiaries.

*Variation in SMI beneficiary premiums*

Beneficiary premiums for Part B and Part D can also vary significantly from "average" levels, although the range of variation is much less pronounced than in the case of cost-sharing liabilities. For Part B, most beneficiaries pay the standard premium amount, which is $96.40 per month in 2008. (As noted below, Medicaid pays these premiums on behalf of qualifying low-income beneficiaries.) Starting in 2007, however, beneficiaries with relatively high incomes must pay a greater premium for enrollment in Part B. The following table displays these higher Part B premiums by income level. The Part B premiums underlying Figure III.C1 are based on the standard premium amount paid by most beneficiaries and do not reflect the higher amounts paid by high-income individuals in 2007 and later.[4]

**Medicare Part B Income-Related Premium Thresholds and Premiums**

| Income thresholds (for 2008) | Less than $82,000 | $82,000 - $102,000 | $102,000 - $153,000 | $153,000 - $205,000 | $205,000 and over |
|---|---|---|---|---|---|
| Income-related Part B premium (for 2008) | $96.40 | $122.20 | $160.90 | $199.70 | $238.40 |
| Income-related Part B premium (2009 and later) | Standard Premium | 1.4 × Standard Premium | 2.0 × Standard Premium | 2.6 × Standard Premium | 3.2 × Standard Premium |

Note: This provision was effective in 2007. The amount of the Part B premium above the standard premium will be phased in at 33, 67, and 100 percent for 2007 to 2009 and later. The income thresholds are indexed to the CPI. The income thresholds shown are for beneficiaries filing tax returns as individuals; the threshold for couples filing jointly are twice these amounts.

In the case of Part D, the beneficiary premiums vary by individual insurance plan. Under the statutory premium formula, plans with below-average costs have premiums that are lower, dollar-for-dollar, by the full difference between the specific plan's cost and the average for all plans. Similarly, the beneficiary premium must cover the full difference between a higher-cost plan's bid and the average cost for all plans.

In 2006, the first year of operation for the Part D prescription drug plans, premiums for stand-alone plans ranged from as little as $1.87 to as much as $105 per month. For Medicare

[4] Individuals who enroll in Part B after their first opportunity to do so generally pay a late-enrollment penalty equal to 10 percent per year of delayed enrollment. These higher amounts are not reflected in Figure III.C1, which is based on the standard premium.

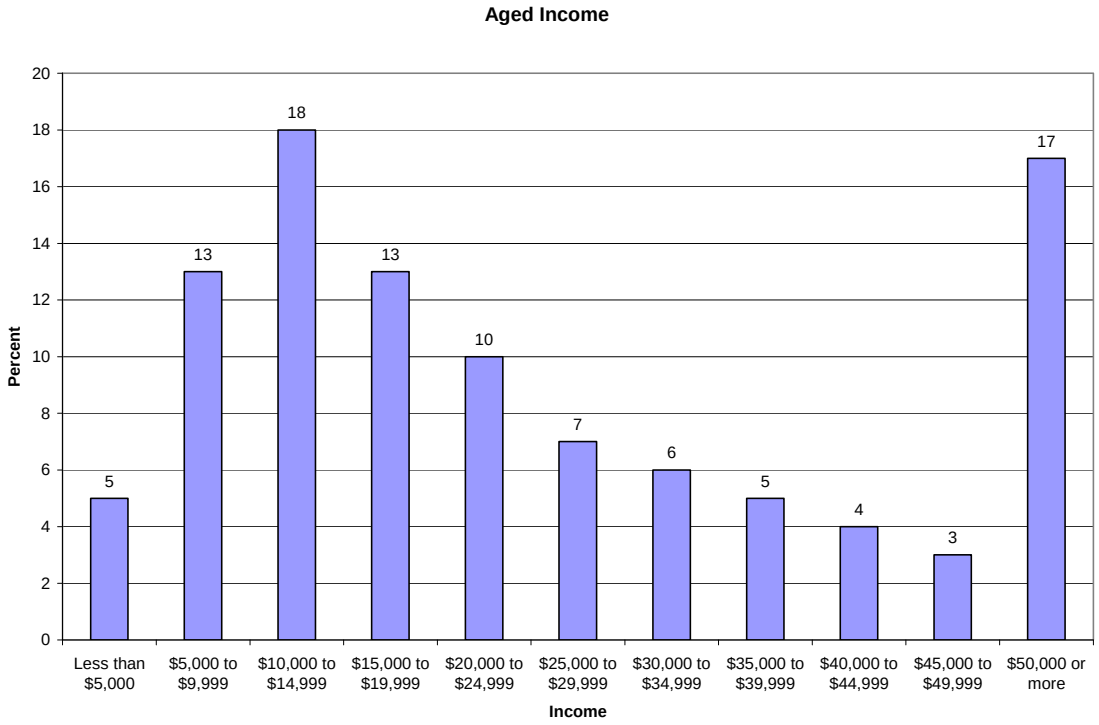
Advantage drug coverage, the range was from $0 to $147.[5] The Part D premium amounts underlying Figure III.C1 are based on the estimated average beneficiary premium in each year.

*Variation in, and other sources of, beneficiary income*

Similarly, the range of incomes for aged individuals also varies greatly around the overall average. Moreover, the majority of beneficiaries have other sources of income besides Social Security benefits, which are used in the illustration as a convenient proxy for income growth trends.

Periodically, the Social Security Administration produces the *Income of the Aged Chartbook* and the *Income of the Population 55 or Older*, which analyze the incomes for older persons. The following chart shows the distribution of incomes for the population aged 65 and over in 2004. As with other age groups, there is a broad range of income levels around the average.

**Distribution of Income for Persons Age 65 and Over in 2004**




Notes: (1) In 2004, the 50th percentile, or median, income for persons age 65 and over was $20,481.
(2) Income is the sum of all income received before any deductions such as those for taxes, union dues, or Medicare premiums, and does not reflect nonmoney transfers such as food stamps, health benefits, and subsidized housing. The sources of income include Social Security benefits, employments earnings, asset income, pensions, public assistance, and veterans' benefits.

Source: *2004 Income of the Aged Chartbook*, Social Security Administration, SSA Publication No. 13-11727, released September 2006.

[5] MA-PD plans can reduce their drug premium by allocating a portion of any Medicare Part A/Part B "rebate" amounts for this purpose. Roughly 30 percent of such plans had zero premiums in 2006.

In addition, while Figure III.C1 assumes both an average level of SMI out-of-pocket costs and an average Social Security benefit, a given individual could fall anywhere within either distribution. That is, a person could have both a low income and a high cost-sharing liability, a high income and a low cost-sharing liability, or any other combination.[6]

About 90 percent of the aged receive Social Security benefits. Most older persons receive income not solely from Social Security but from a variety of sources. For individuals 65 and over in 2004, the median total income was $20,481. The median income in 2004 for aged persons, by source of income—for those who receive that type of income—was $12,799 from Social Security, $20,000 from earnings, $7,200 from private pensions, $16,800 from government pensions, $9,600 from employer pensions, and $1,200 from asset income.

For 20 percent of the aged (households), Social Security is their only source of income. Social Security represented the only source for 50 percent of those elderly persons who were in the lowest 20 percent of total incomes in 2004. Conversely, in the highest two income quintiles together, only 2 percent of the elderly were solely dependent on Social Security. Thus, while using the average Social Security benefit provides a convenient proxy for comparing average income growth trends to average Medicare trends over the long range, the averages do not capture the wide range of income levels and sources of income for individual Medicare enrollees.

*Premium and cost-sharing assistance for low-income beneficiaries*

Individual results are further complicated because many low-income Medicare enrollees will receive subsidized coverage of Medicare cost sharing and premiums. The following two tables describe the benefits and eligibility requirements for Medicare low-income subsidies under Part D and Medicaid, respectively. Low-income Medicare enrollees qualifying for these subsidies often have little or no cost sharing or premium payment exposure. Therefore, the average cost sharing and premium burden for the subsidized low-income enrollees would be much lower than the amounts illustrated for an average beneficiary in Figure III.C1.

In this regard, it is important to note that many Medicare beneficiaries whose only incomes are from Social Security would qualify for both the Part D low-income subsidy and Medicaid, either as full dual beneficiaries, Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), or Qualifying Individuals (QIs).

[6] As noted below, for beneficiaries with relatively low income and assets, these liabilities are payable by Medicaid and the Part D low-income subsidy.

## 2008 Part D Low-Income Eligibility and Subsidy

| Income test | Medicaid Dual < 100% FPL | < 135% FPL | < 135% FPL | 135-150% FPL |
|---|---|---|---|---|
| Asset test | < 2× SSI | < 3× SSI | > 3× SSI & < $10,490 single $20,970 couple | < $10,490 single $20,970 couple |
| Deductible | $0 | $0 | $56 | $56 |
| Copay for generic drugs, to catastrophic threshold | $1.05 | $2.25 | — | — |
| Copay for brand-name drugs, to cat. threshold | $3.10 | $5.60 | — | — |
| Coinsurance, to catastrophic threshold | — | — | 15% | 15% |
| Coinsurance, above catastrophic threshold | 0% | 0% | 0% | 0% |
| Copay for generic drugs, above cat. threshold | $0 | $0 | $2.25 | $2.25 |
| Copay for brand-name drugs, above cat. threshold | $0 | $0 | $5.60 | $5.60 |
| Premium subsidy | 100% | 100% | 100% | Sliding scale |
| Estimated 2008 enrollees (in millions) | 6.1 | 3.2 | 0.1 | 0.3 |

NOTES: FPL = Federal Poverty Level
SSI = Supplemental Security Income

## Medicaid Eligibility and Subsidies for Medicare Beneficiaries

| | Medicaid Dual | QMB Only | SLMB Only | QI | QDWI |
|---|---|---|---|---|---|
| Income test | Varies by state | < 100% FPL | 100-120% FPL | 120-135% FPL | < 200% FPL |
| Asset test | Varies by state | < 2× SSI | < 2× SSI | < 2× SSI | < 2× SSI |
| Part A premium | Covered (if any) | Covered (if any) | — | — | Covered |
| Part B premium | Covered | Covered | Covered | Covered (through June 2008) | — |
| Part A cost sharing | Covered | Covered | — | — | — |
| Part B deductibles and coinsurance | Covered | Covered | — | — | — |

NOTES: QMB = Qualified Medicare Beneficiary
SLMB = Specified Low-Income Medicare Beneficiary
QI = Qualified Individual
QDWI = Qualified Disabled and Working Individual
FPL = Federal Poverty Level
SSI = Supplemental Security Income

*Conclusion*

As suggested by the preceding discussion, the portion of a beneficiary's income that is spent on SMI premiums and cost-sharing amounts can vary substantially. Moreover, simple illustrations cannot incorporate all of the complex factors that can affect out-of-pocket costs for SMI benefits or all of the sources of income that may be available to beneficiaries.

Nonetheless, the comparison shown in Figure III.C1 remains relevant and important. Specifically, for typical enrollees in Medicare Supplementary Medical Insurance, continued rapid growth in SMI costs will lead to an increasing share of their total incomes being required to cover SMI premiums and cost sharing. Under reasonable assumptions as to future growth rates in SMI expenditures and beneficiary incomes, the average out-of-pocket SMI costs would eventually represent an unaffordable share of income for many or most beneficiaries who do not have subsidized coverage of such costs through Medicaid and/or the Part D low-income subsidy.

As the Medicare Board of Trustees notes, "this outlook reinforces the Trustees' recommendation for development and enactment of reforms to reduce the rate of growth in SMI expenditures."