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POLICY FORUM
Medicare and Means-Based Fees
Richard G. Stefanacci, DO, MBA, MGH

Means-based fees have been a part of the practice of medicine since doctors began treating patients. Well before Medicare and Medicaid were introduced in 1965, physicians commonly charged a lower rate for patients with lower means and allowed patients to adjust their payments based on their ability to pay. When Medicare came along, it was financed through payroll taxes, tied, of course, to employees' incomes. Most, however, did not view this income-based payroll tax as means-based until many years later, when income adjustments were made directly to Medicare premiums, first for the Part B program and most recently the Part D program [1].

Several Forms of Means-Based Adjustment

Although adjustment to premiums—the amount paid for insurance coverage, regardless of use of services—is often considered the basic form of means-based pricing (premium adjustments are made based on one's income and assets), there are in fact two other ways in which means are taken into account in determining the price a particular person pays for health care: taxation and out-of-pocket costs.

The principal purpose of means-based pricing is to subsidize beneficiaries with lower incomes. This concept was introduced at the outset of Medicare in 1965. A major component of Medicare funding comes from individual income-based payroll taxes—a flat payroll tax (at a rate of 2.9 percent, shared equally between employers and employees) [2, 3], though some elements of the program are funded by general revenue and by premiums paid by enrollees [4].

Medicare parts B and D premium adjustments. Within the last decade, a premium adjustment was added to Medicare and has been expanded in recent years. This adjustment was first applied to the Medicare Part B premiums and was added to the Medicare Part D program in 2011 [1]. The premiums for Medicare Part B (which covers physician services, outpatient care, and medical equipment) and Part D (which covers prescription drugs) are higher for wealthier retirees [5]. Today, roughly 5 percent of retirees pay higher Part B premiums based on their incomes [1]; due to the Affordable Care Act (ACA), this share will rise to around 14 percent over the next decade because the law will end the practice of adjusting income thresholds for inflation [6]. Under the Part D prescription drug program, about 3 percent of beneficiaries currently pay income-adjusted premiums [7]; this number also will rise under the ACA to about 9 percent. This represents a threefold increase in the number of Medicare beneficiaries who will have higher premiums due to their income levels.

Health insurance marketplaces. With the introduction of the health insurance marketplaces (HIMs) in October 2013, means-based adjustments are occurring in both the premium subsidies and penalties. (The tax penalties go into effect in 2014; if a citizen or documented immigrant is uninsured for more than 3 months in 2014, he or she will incur the tax penalty, which will be applied to his or her 2014 income tax return, except in cases of financial hardship, membership in certain religious groups or Native American tribes, or incarceration [8, 9].) The amount of the penalty is based on the person's taxable income.

Drug Pricing for Dually Eligible Beneficiaries

As mentioned previously, means-based price adjustments are also applied to patient out-of-pocket expenses, specifically in the Medicare Part D prescription drug plan. The lowest-income people—those with Medicare who also are covered by Medicaid and, hence, called "dual eligibles"—pay only a few dollars for their prescription medications: $1.15 per generic prescription and $3.50 for brand-name products [10]. Dually eligible patients have no incentive to opt for cheaper generic drugs because the price difference is so small. Conversely, higher-income Medicare beneficiaries might be charged as much as several hundred dollars for the same brand-name medication, nudging them to make the less costly choice.

MedPAC has explained that Part D plans are limited in their ability to modify drug co-payments for low-income subsidy (LIS) enrollees, which is why brand-name drug co-pays for this group of enrollees do not differ significantly from generic drug co-pays [11, 12]. MedPAC has recommended that Congress modify the Part D low-income subsidy co-payments for Medicare beneficiaries with incomes at or below 135 percent of the federal poverty level to encourage the use of generic drugs when available in selected therapeutic classes.

Potential Problems in Means-Based Price Adjustments

The principle behind means-based price adjustments is collecting more funds from those with greater means to subsidize support for those with lower incomes. Chief among the challenges to this principle is disagreement about fairness or equity. Specifically, policymakers must grapple with determining the levels at which society will agree that one group deserves to receive support and another to contribute to the support of the first group. Consider for example, the rich tradition of social solidarity and workers' organizations in European countries. In my opinion, it is this heritage of solidarity, along with fairly homogenous national populations, that has led to health policies in those countries that reflect a collectivist spirit. In the United States, there are myriad social cleavages across cultural, economic, and political lines, so that consensus on equity and fairness of health policy is extremely difficult to reach. Suffice to say, this is a difficult political discussion and one that is outside the scope of this discussion and of the typical focus of most physicians. What is most pressing for physicians is pricing that ensures appropriate health care resource utilization, neither underuse nor overuse. This is the area where physicians should be most actively involved.

If the application of means testing sets the bar for assistance or subsidy too high, poor patients might underutilize needed medical services. The opposite is true as well. When means testing sets the level for assistance too low, overuse can contribute to waste, or worse, to unnecessary patient interventions that carry risk and can be harmful. By voicing their opinions to regulators and legislators, physicians can play a role in assuring the proper balance in means testing so that utilization levels are most efficient, effective and equitable.

Optimal Means-Based Adjustments

To apply means-based adjustments optimally, society must identify services that are considered essential—meaning that it is not acceptable for people to forgo or have less of them due to inability to pay—and why. In the United States, this group of services might be adapted from the services which the ACA requires a health plan to provide in order to participate in the health care exchange marketplace. Such services could include vaccinations, which are often cited as one of the most cost-reducing health care services to a society. At the other end of the spectrum, one might argue that medications to promote hair growth do not have sufficient value to society to justify public payment for them. Consider a tougher example: treating a younger patient with advanced cancer may be deemed to have higher societal value than the same treatment for an older person, in which case the decision might be made to subsidize more of the cost of treatment for the younger patient.

Although there may be some controversy even about the first example I cited, great debate is certain to surround all of the areas in the middle because citizens in a diverse society have varying priorities. The bottom line is that policymakers, with input from the medical profession about which services are most needed, must devote the necessary attention to determining the means-based pricing that will lead to optimal use of services, that which is neither harmful nor wasteful.

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Richard G. Stefanacci, DO, MBA, MGH, is an internist-geriatrician who practices in a PACE (Program for All-inclusive Care for the Elderly) and holds an academic appointment in health policy at the University of the Sciences in Philadelphia, Pennsylvania. Previously, he was a health policy scholar at the Centers for Medicare and Medicaid Services (CMS). Dr. Stefanacci is chief medical officer of the Access Group and president of the Go4theGoal Foundation, which is dedicated to serving children with pediatric cancer.

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