

# STRENGTHEN SOCIAL SECURITY

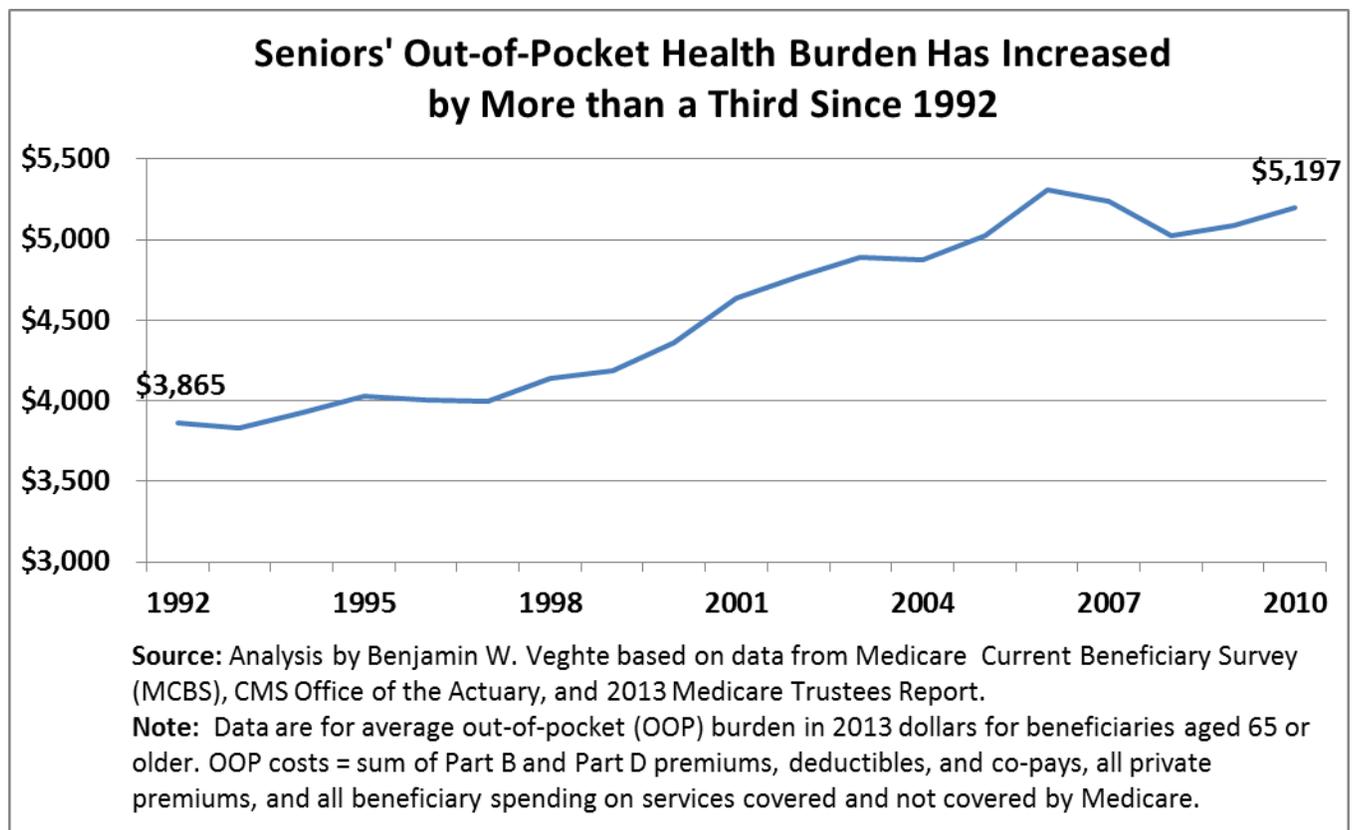
## ...don't cut it.

### Shifting More Medicare Costs to Seniors Is an Indirect Social Security Cut

The vast majority of Medicare beneficiaries – 42.1 million seniors, and 8.5 million people with disabilities<sup>1</sup> – receive Social Security benefits and live on modest, fixed incomes. Nevertheless, many in Washington are considering several proposals to increase out-of-pocket health care costs for seniors and people with disabilities. Congress should reject them all. Not only would they indirectly cut Social Security's modest benefits, they are poor policy for other reasons as well. There are better ways to reduce Medicare costs, without shifting costs to seniors and people with disabilities.

### Health-Care Costs Are Already Consuming More than a Third of Seniors' Social Security Checks

Growth in out-of-pocket health care costs has outpaced Social Security's cost-of-living adjustments by more than a third since 1992.<sup>2</sup> Beneficiary spending on Medicare premiums, deductibles, co-pays, all private premiums, and all other services covered and not covered by Medicare, has grown in real terms from \$3,865 per year in 1992 to \$5,197 per year in 2010, an increase of 34 percent.<sup>3</sup>



Social Security benefits were never intended to go largely toward out-of-pocket health expenses in retirement. Yet in 2010, even with Medicare (including prescription drug coverage which took effect in 2006), out-of-pocket health care costs consumed over a third (37%) of the average Social Security

check of seniors and their surviving spouses.<sup>4</sup> If the cost-shifting proposals on the agenda now – such as requiring ill seniors to have “more skin in the game,” or increasing Medicare premiums for middle-class beneficiaries – become law, this would cut net Social Security benefits even further.

### **“More Skin in the Game” Would Cut Net Social Security Benefits, Put the Health of Seniors and People with Disabilities at Risk**

Several measures now under consideration are designed to force seniors to have “more skin in the game,” a crude and offensive shorthand for them bearing a greater share of the costs of each doctor visit and other utilization of care. The most prominent such proposals are increasing the Part B deductible by 51 percent (from \$147 to \$222) by 2021,<sup>5</sup> requiring a co-payment of \$100 per home health episode for new beneficiaries,<sup>6</sup> and increasing Part B premiums by about 30 percent for new beneficiaries who buy private so-called Medigap policies with “first dollar” coverage.<sup>7</sup> All these provisions would achieve program savings by shifting costs to seniors and people with disabilities. Perhaps worse, they fall heaviest on those who are ill, discouraging them from seeking timely and, in some cases, life-saving care.

Such proposals stem from pure speculation that Medigap coverage and relatively lower deductibles and co-pays tempt seniors into having unnecessary doctor visits, medical tests and other wasteful medical treatments.<sup>8</sup> This economic theory defies common sense. People generally would prefer not to be subjected to time-consuming and often intrusive and painful medical procedures, irrespective of the cost. Consistent with this common-sense observation, studies show that “more skin in the game” fails to achieve substantial savings for Medicare overall.<sup>9</sup> By obliging many cash-strapped seniors to delay care because they cannot afford the cost, it also puts their health at risk.<sup>10</sup> Indeed, research shows that as out-of-pocket health costs increase, the risk for mortality also increases.<sup>11</sup>

### **Higher Premiums for Middle Class Beneficiaries Would Indirectly Cut Social Security Benefits**

One-quarter of Medicare Part B funding, which pays for physician and related services, comes from premium payments. Most Social Security beneficiaries have these premium payments deducted directly from their Social Security benefits. While everyone who has Part B coverage receives the same package of benefits, the five percent of those with incomes above \$85,000 (\$170,000 for couples) pay significantly higher premiums.<sup>12</sup> Those with income above these thresholds also pay a surcharge on their Medicare Part D prescription drug premiums as well.<sup>13</sup>

The Administration’s 2014 budget proposes freezing these thresholds so that, by roughly 2035, the share of beneficiaries subject to income-related premiums rises from 5 to 25 percent. By 2035, the nominal \$85,000/\$170,000 threshold will be equivalent to \$47,000/\$94,000 in today’s dollars.<sup>14</sup> In other words, this proposal would treat unmarried seniors living on the equivalent of \$47,000/year today as “wealthy” enough to warrant higher Part B and Part D premiums.

Given that in the January 2013 fiscal cliff deal, only the top **0.7 percent of earners** – those making **\$400,000** or above – were considered “upper income” and hence able to afford higher taxes,<sup>15</sup> it would be an absurd double-standard to now treat the top **25 percent of seniors** – living on **fixed incomes of as little as \$47,000** – as “upper-income” and hence able to afford higher premiums.

## **There are Better Ways than Indirectly Cutting Social Security Benefits to Reduce Medicare Costs**

Medicare's costs could, and should, be reduced by lowering health care costs generally. That would reduce private sector costs, as well – a boon to the entire economy. If policymakers want to ask upper-income Americans to contribute more to financing Medicare, they should do so through progressive income or payroll taxes on working-age Americans,<sup>16</sup> **not** higher premiums for seniors living on a fixed income.<sup>17</sup> And they should limit their proposals to the truly upper income, not those with incomes of \$47,000.

The United States spends more than twice what other countries spend on health care, often with worse health outcomes.<sup>18</sup> Growth in health care costs, private as well as public, needs to be better controlled. The Medicare system already does a better job of controlling costs than our private health care system does,<sup>19</sup> but much more can be done – for example, by:

- **Fully leveraging the delivery and payment system reforms in the Affordable Care Act (ACA).** It added a range of tools that are being pilot-tested now that have the potential of significantly slowing the growth of health care costs.<sup>20</sup> Providers, not seniors, make care decisions and receive Medicare expenditures; cost-control measures should focus there.
- **Allowing Medicare to negotiate with drug companies for lower prescription drug prices,** which is prohibited under current law. Medicaid and the Veterans Administration already do so, as do most other countries' health care systems. Allowing Medicare to also use its market power on behalf of beneficiaries would save the federal government between \$230 and \$541 billion – and beneficiaries another \$48 to \$112 billion – over 10 years.<sup>21</sup>
- **Restoring drug rebates for those eligible for both Medicare and Medicaid,** as Senator Rockefeller (D-WV) has proposed.<sup>22</sup> This would save \$141 billion over 10 years – enough, for example, to cover the cost of fully restoring physician payments in Medicare, the so-called “doc fix.”<sup>23</sup>

**Medicare needs more cost control, not more cost shifting.** Senior households live on 40 percent less than the \$57,000 on which the typical working-age household lives.<sup>24</sup> When you increase out-of-pocket health care costs for seniors, you are effectively lowering the income of Social Security beneficiaries. Given the insecure retirement awaiting today's workers, policymakers should be focused on enhancing their retirement security, not eroding it further by increasing their health-care expenses in retirement.<sup>25</sup>

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<sup>1</sup> Center for Medicare Services Office of the Actuary, “2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplemental Medical Insurance Trust Funds,” May 2013.

<http://downloads.cms.gov/files/TR2013.pdf>

<sup>2</sup> 1992 is the first year for which reliable data on out-of-pocket health-care costs are available. It is the first year of the Medicare Current Beneficiary Survey.

<sup>3</sup> Medicare Part D premiums are not specifically surveyed in the MCBS, though some may report Part D premiums when asked about private premiums. To account for this partial undercounting of Part D premiums in the MCBS, for the years 2006-10, one-third of Part D premiums paid have been included from CMS administrative records.

<sup>4</sup> Looked at in terms of total household income, in 2010 the average Medicare household spent 14.7 percent of its income on health care, vs. 4.9 percent for households not yet on Medicare. Kaiser Family Foundation (KFF) analysis of Bureau of

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Labor Statistics Consumer Expenditure Survey Interview and Expense Files, 2010. KFF, "Health Care on a Budget: The Financial Burden of Health Spending by Medicare Households," March 2012.

<http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8171-02.pdf>

<sup>5</sup> Office of Management and Budget (OMB), "Fiscal Year 2014 Budget of the U.S. Government," April 2013.

<http://www.whitehouse.gov/sites/default/files/omb/budget/fy2014/assets/budget.pdf>

<sup>6</sup> This Administration proposal would create a home health copayment of \$100 per home health episode for new beneficiaries, applicable for episodes with five or more visits not preceded by a hospital or other inpatient post-acute care stay. OBM, *ibid.*

<sup>7</sup> This surcharge, which the President's budget proposed to take effect in 2017, would be set at 15 percent of the average Medigap premium, which is about 30 percent of the standard Part B premium today. In 2012 about 66 percent of beneficiaries with Medigap were enrolled in plans that had "first-dollar coverage" — meaning that the plans covered all of the deductibles and coinsurance not covered by Medicare. America's Health Insurance Plans, Center for Policy and Research, "Trends in Medigap Coverage and Enrollment, 2012", May 2013. <https://www.ahip.org/Trends-Medigap-Coverage-Enroll2012/>

<sup>8</sup> The proposals are inspired by data showing a correlation between quality Medigap coverage and higher Part B (physician) utilization/costs. There is no evidence that the extra care is unnecessary, however. Congressional Budget Office, "Reducing the Deficit: Spending and Revenue Options," March 2011: 49-50.

<http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/120xx/doc12085/03-10-reducingthedeficit.pdf>

<sup>9</sup> A peer-reviewed study that took a closer look at this data found that the causal arrow here is likely reversed: it is disproportionately chronically ill and lower income seniors, who already have and expect to continue to have higher health care expenses, who choose to purchase quality Medigap coverage in order to better manage the costs of their higher care utilization. Jeff Lemieux et al., "Medigap Coverage and Medicare Spending: A Second Look," *Health Affairs* 27, no. 2 (2008): 469-77. <http://www.ncbi.nlm.nih.gov/pubmed/18332504> And a Harvard study found that approximately half of the savings from increasing cost-sharing for physician and drug expenses is offset by increased hospital utilization, especially among seniors with chronic or extensive health conditions. Amitabh Chandra et al., "Patient Cost-Sharing, Hospitalization Offsets, and the Design of Optimal Health Insurance for the Elderly," NBER Working Paper No. 12972, March 2007. <http://www.nber.org/papers/w12972>. A study by the Robert Wood Johnson Foundation as well as an analysis by the National Association of Insurance Commissioners' (NAIC) Senior Issues Task Force expressed similar concerns: "[D]ecreasing the use of some services among older populations can result in increased use of more intensive services that can offset the savings from reduction in the use of less costly services." NAIC Senior Issues Task Force, Medigap PPACA Subgroup, "Medicare Supplement Insurance First Dollar Coverage and Cost Shares," October 31, 2011. [http://www.naic.org/documents/committees\\_b\\_senior\\_issues\\_111101\\_medigap\\_first\\_dollar\\_coverage\\_discussion\\_paper.pdf](http://www.naic.org/documents/committees_b_senior_issues_111101_medigap_first_dollar_coverage_discussion_paper.pdf); Katherine Swarz, "Cost-sharing: Effects on Spending and Outcomes," Robert Wood Johnson Foundation, December 2010. <http://www.rwjf.org/en/research-publications/find-rwjf-research/2011/12/cost-sharing--effects-on-spending-and-outcomes.html>

<sup>10</sup> "Research does indicate the changes will most affect those with low or modest incomes, those who are sickest, those who live in rural areas of the country, and those with chronic conditions who need regular care. Additional cost sharing may lead such beneficiaries to avoid needed care because they are unable to afford it, exacerbating their health problems and increasing Medicare spending." NAIC Senior Issues Task Force, *ibid.*, pp. 14-15.

<sup>11</sup> Mark P. Doescher et al., "Supplemental Insurance and Mortality in Elderly Americans. Findings from a National Cohort," *Archives of Family Medicine*, 9, no. 3 (2000): 251-257. <http://www.ncbi.nlm.nih.gov/pubmed/10728112>

<sup>12</sup> The Administration's budget would also increase the share of per capita program costs covered by these income-related premiums from 35-80 to 40-90 percent starting in 2017. Centers for Medicare & Medicaid Services, "CMS Announces Major Savings for Medicare Beneficiaries," October 28, 2013.

<http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-10-28.html>

<sup>13</sup> The surcharge ranges from \$12.10 to \$69.30, depending on income. Medicare.gov, "Medicare 2013 & 2014 costs at a glance," accessed November 18, 2013. <http://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-a-glance.html#collapse-4811>

<sup>14</sup> Kaiser Family Foundation, "Income-Relating Medicare Part B and Part D Premiums under Current Law and Recent Proposals: What are the Implications for Beneficiaries?," February 2012.

<http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8276.pdf>

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<sup>15</sup> Tami Luhby, "Fiscal Cliff Deal Would Hit the Rich - but It Could Have Been Worse," January 2, 2013.

<http://money.cnn.com/2013/01/01/news/economy/fiscal-cliff-rich/>

<sup>16</sup> Medicare Part A is primarily funded through the 1.45% payroll tax paid by employees and their employers on all wage income. The Affordable Care Act levied an additional 0.9% payroll tax on earnings above \$200,000 for singles (\$250,000 for couples); unlike traditional payroll taxes, this tax is levied on employees only, and on household, not individual, income. Internal Revenue Service, "Questions and Answers for the Additional Medicare Tax," accessed November 18, 2013. <http://www.irs.gov/Businesses/Small-Businesses-%26-Self-Employed/Questions-and-Answers-for-the-Additional-Medicare-Tax>

<sup>17</sup> Currently, Medicare Part A, hospital insurance, is already financed on the front end through payroll taxes on workers. Parts B and D are financed about one-quarter by beneficiary premiums and about three-quarters by federal revenues.

<sup>18</sup> Organization for Economic Cooperation and Development, "OECD Health Data 2013," June 27, 2013.

<http://www.oecd.org/health/health-systems/oecdhealthdata.htm>

<sup>19</sup> Diane Archer, "Medicare Is More Efficient Than Private Insurance," *Health Affairs* Blog September 20, 2011.

<http://healthaffairs.org/blog/2011/09/20/medicare-is-more-efficient-than-private-insurance/>

<sup>20</sup> Medicare Rights Center, "Build on What Works: Medicare Cost Savers," June 2013.

<http://www.medicarerights.org/pdf/Medicare-Cost-Savers.pdf>

<sup>21</sup> The projected savings are based on the federal government paying the same amount for prescription drugs as other countries. The lower estimates are if it paid Canadian prices; the higher estimates are Danish prices. Dean Baker, "Reducing Waste with an Efficient Medicare Prescription Drug Benefit," February 2013.

<http://www.cepr.net/index.php/publications/reports/reducing-waste-with-an-efficient-medicare-prescription-drug-benefit>

<sup>22</sup> "Rockefeller and King Urge Hospital, Physician Support for Medicare Drug Savings Act," November 18, 2013.

<http://www.rockefeller.senate.gov/public/index.cfm/press-releases?ID=f24b5747-69d7-4516-b6be-42a8daf177e2>

<sup>23</sup> Before the Medicare Part D prescription drug benefit took effect in 2006, the government received a rebate from pharmaceutical companies for drugs provided to "dual eligible" individuals, i.e. those enrolled in both Medicare and Medicaid. When Part D was implemented, these rebates were discontinued. Medicare Rights Center, "Senators Rockefeller and King Push for Support of Medicare Drug Savings Act," *Medicare Watch*, November 2013. <http://www.medicarerights.org/resources/newsletters/medicare-watch/archive/11-21-13/>

<sup>24</sup> Median household income for seniors is \$34,000, and for Social Security Disability Insurance (SSDI) beneficiaries just under \$30,000. U.S. Census Bureau, Current Population Survey, 2013 Annual Social and Economic Supplement.

[http://www.census.gov/hhes/www/cpstables/032013/hhinc/hinc02\\_000.htm](http://www.census.gov/hhes/www/cpstables/032013/hhinc/hinc02_000.htm); Matthew W. Brault, "Americans with Disabilities: 2010," *Current Population Reports Household Economic Studies*, July 2012, Table A-2.

<http://www.census.gov/prod/2012pubs/p70-131.pdf>; adjusted for inflation for 2012 using Bureau of Labor Statistics Inflation Calculator: [http://www.bls.gov/data/inflation\\_calculator.htm](http://www.bls.gov/data/inflation_calculator.htm)

<sup>25</sup> Retirement income security is expected to worsen in the future due to decades of wage stagnation, disappearing pensions, and a private account system that has failed to contribute meaningfully to the retirement security of most Americans. While the typical retiree household aged 68-77 today is able to replace 99 percent of its pre-retirement income, Early Boomers (aged 58-67) will only be able to replace 82 percent, Late Boomers (aged 48-57) 59 percent, and Gen-Xers (aged 38-42) 50 percent of their pre-retirement earnings. Pew Charitable Trusts, "Retirement Security across Generations. Are Americans Prepared for Their Golden Years?," May 2013.

[http://www.pewstates.org/uploadedFiles/PCS\\_Assets/2013/EMP\\_Retirement-v4-051013\\_finalFORWEB.pdf](http://www.pewstates.org/uploadedFiles/PCS_Assets/2013/EMP_Retirement-v4-051013_finalFORWEB.pdf)