Painting a Grim Picture:

Deficit-Reduction Proposals that Hurt People with Medicare

As the Joint Select Committee on Deficit Reduction, also known as the "supercommittee," moves forward to its November 23rd deadline, determining what deficit-reduction proposals mean for people with Medicare is only possible if we understand the financial pressures already faced by Medicare consumers and the vital role that Medicare and Medicaid play in meeting their many health care needs. While some proposals may seem promising in name, with terms like "reform" and "flexibility" used to describe them, the underlying reality is that they dramatically cut Medicare and Medicaid. These proposals do not save money by making the health care system more efficient, but by shifting extra costs to people with Medicare—those who are least able to afford those costs—and by limiting their access to medical care when they need it.

We provide some statistics below that illustrate the modest financial resources of most people with Medicare. We then summarize some of the proposed deficit-reduction proposals that target Medicare and indicate the impact they would have. In short, Medicare consumers are not in a financial position to carry the burden of any extra costs, though their need for care is great. Further, these proposed changes to Medicare and Medicaid do not address the root cause of the programs' increasing costs, which is rising costs in the health care sector overall. To get at this problem, the Affordable Care Act (ACA), enacted last year, is beginning to implement delivery system reforms, which could be built upon to create savings while increasing the quality of care. Finally, in order to prevent the need for deep cuts to Medicare and Medicaid, the supercommittee and Congress as a whole must raise revenues by eliminating tax cuts and loopholes for the wealthiest Americans and corporations.

Sketching the Scene: Who are people with Medicare? Why are Medicare costs growing?

Medicare and Medicaid Growth

Growing costs in Medicare and Medicaid are a symptom of growing costs in the health care sector overall.

- While Medicare and Medicaid spending is growing—because the number of people the programs cover is increasing due to an aging population and the

economic downturn—the programs themselves are more efficient than their private counterparts.

- From 2002 to 2009, Medicare spending grew by 4.6 percent per enrollee compared to private health insurance, which grew by 6.7 percent for similar benefits.[1]
- Per enrollee, Medicaid spending grew by 6.1 percent compared to comparable coverage under private health insurance, which grew by 10.6 percent.[2]

Income and Assets

People with Medicare live on a more limited income than the non-Medicare population.

- Half of all Medicare beneficiaries have annual incomes of $22,000 or less (about 200 percent of the federal poverty level) and the poorest 25 percent earned less than $12,760.[3]
- Half of Medicare beneficiaries have less than $2,100 in a retirement account (e.g. IRA or 401k).[4]
- For 80 percent of the Medicare population over 65, Social Security accounts for half or more of their annual income.[5]
- Median incomes and assets are lower for black and Hispanic populations and for non-married individuals, and decline as people get older.[6]

Health Care Needs and Trends

People with Medicare use care because they need it.

- Nearly half of all Medicare consumers have three or more chronic conditions, almost one-third have a cognitive or mental impairment, and over one-fourth report being in fair or poor health or having a limitation in activities of daily living (ADLs), such as eating, dressing or bathing.[7]
- Medicare does not cover long-term care services and supports, but roughly 7 out of 10 people turning age 65 will need these services during their lifetimes.[8] However, only 12.4 percent of people with Medicare have long-term care insurance. Many rely on Medicaid, which is the largest source of long-term care coverage in the country, paying for about 62 percent of all long-term care.[9]
- According to the latest data, 21 percent of people with Medicare are dual eligible, meaning they rely on both Medicare and Medicaid for health coverage. About

---

[1] CMS Office of the Actuary. *National Health Expenditure – Historical Data*, August 2011. Available at http://www.cms.gov/NationalHealthExpendData/downloads/tables.pdf.
[2] Kaiser Family Foundation, *Ten Myths and Facts about Medicaid*. Available at http://www.kff.org/medicaid/upload/7306%20Ten%20Myths%20about%20Medicaid_Final-3.pdf.
[3] Kaiser Family Foundation, *Projecting Income and Assets* , June 2011. Available at http://www.kff.org/medicare/upload/8172.pdf.
[4] *Id.*
[5] Kaiser Family Foundation, *Medicare Chartbook, 2010*, November 2010. Available at http://www.kff.org/medicare/upload/8103.pdf.
[6] Kaiser Family Foundation, *Projecting Income and Assets* , June 2011. Available at http://www.kff.org/medicare/upload/8172.pdf.
[7] Kaiser Family Foundation, *Medicare Chartbook, 2010*, November 2010. Available at http://www.kff.org/medicare/upload/8103.pdf.
[8] Richard W. Johnson and Janice S. Park, Urban Institute, *Who Purchases Long Term Care Insurance?*, March 2011. Available at http://www.urban.org/UploadedPDF/412324-Long-Term-Care-Insurance.pdf.
[9] NHPF, *The Basics: National Spending for Long-Term Services and Supports (LTSS)*, March 2011. Available at http://www.nhpf.org/library/the-basics/Basics_LongTermServicesSupports_03-15-11.pdf.

one-third of Medicaid dollars are spent on people with Medicare, due in part to the population's complex health issues and the need for long-term care services and supports.[10]

Out-of-Pocket Costs

People with Medicare have low incomes but spend more of that limited income on health care than the non-Medicare population.

- Even though the majority of people with Medicare have some form of supplemental insurance, out-of-pocket spending is increasing. Median out-of-pocket spending as a share of income for the Medicare population grew from 11.9 percent in 1997 to 16.2 percent in 2006 and is expected to exceed 25 percent within the next 10 years. This means that a typical individual with an income of $20,000 per year would spend about $3,240 on health costs.
- On average, Medicare households spend 15 percent of their total incomes on health care, three times as much as non-Medicare households.[11]
- People with Medicare with serious chronic conditions will spend even more of their income on health than the average beneficiary. For example, a Medicare beneficiary with cancer will spend 23 percent (median) of total income out of pocket on health care, one with Alzheimer's disease will spend 26 percent, and someone with congestive heart failure 25 percent.[12]
- Unless individuals have long-term care or qualify for Medicaid by exhausting their income and assets, they or their families will have to pay these costs out of pocket. Per year on average, nursing homes cost $72,000 and assisted living facilities cost $38,000. On average, home health services cost $21 per hour, so 15 hours of home health care per week will cost $16,380 per year.[13]

Painting the Picture: The landscape of deficit-reduction proposals

Although people with Medicare have disproportionately limited incomes and complex health needs that require access to care in order to prevent serious illness, many deficit-reduction proposals increase their out-of-pocket spending and would likely reduce their access to care or Medicare benefits.

Increasing the Eligibility Age for Medicare

Some proposals would increase the Medicare eligibility age from 65 to 67, and others would raise the eligibility age as high as 70.[14]

Issues: Raising the eligibility age would require the vast majority of individuals who are between 65 and 67 to pay more for care or coverage out of pocket;

---

[10] Kaiser Family Foundation, *The Role of Medicare for the People Dually Eligible for Medicare and Medicaid*, January 2011. Available at http://kff.org/medicare/upload/8138.pdf.
[11] Kaiser Family Foundation, *Health Care on a Budget*, June 2011. Available at http://www.kff.org/medicare/upload/8171.pdf.
[12] AARP, *Medicare Beneficiaries' Out-of-Pocket Spending for Health Care*, 2011. Available at http://assets.aarp.org/rgcenter/ppi/health-care/i48-oop.pdf.
[13] Kaiser Family Foundation, *Medicaid and Long Term Care Services and Supports*, March 2011. Available at http://www.kff.org/medicaid/upload/2186-08.pdf.
[14] Lieberman Coburn Proposal, June 2011; House Concurrent Budget Resolution (H. Con Res. 34), April 2011; National Commission on Fiscal Responsibility and Reform, *The Moment of Truth,* December 2010; Alice Rivlin and Paul Ryan, *A Long-Term Plan for Medicare and Medicaid*, November 2010.

some analyses estimate more than $2,000 extra on average in 2014 if the age were to be increased that year.[15] While the increase in Social Security age allows individuals to take retirement benefits early at age 62, and in fact half of people do so though even though full retirement age is higher, there would be no such option for those aging into Medicare.

Further Means-Testing Medicare

Some proposals discussed would require those with higher incomes to pay even more for Medicare.

Issues: Medicare is already requiring those with higher incomes to pay more (this is called "means testing"). People with Medicare who earn over $85,000 per year pay higher Part B and Part D premiums. Given the median income of the Medicare population, the only way to generate significant savings would be charge these higher premiums to those with lower incomes, shifting costs to those who are unable to afford them. Allowing tax cuts for the wealthiest Americans to expire would generate more significant savings and would not put the burden solely on people with Medicare.

Restructuring, Modernizing and Simplifying the Medicare Benefit

Some proposals would replace the current deductibles and coinsurance people with Medicare must pay when they see the doctor or are admitted to a hospital with a common deductible and coinsurance for all services under Medicare, regardless of whether they are billed as hospital care (Part A) or doctor care (Part B). These proposals are often coupled with an annual out-of-pocket limit, which is a cap on what someone with Medicare must spend in a year on medical care, though the out-of-pocket limit is typically higher than what an average consumer spends each year.[16]

Issues: This proposal would save the government money by shifting increased costs to people with Medicare, many of whom would seek no care at all because they could not afford the deductibles or coinsurance. While simplification seems and sounds appealing, proposals would raise out-of-pocket costs for many Medicare consumers, who under some proposals would need to spend about $500 before they would be able to receive any type of health coverage at all. These proposals would also create cost-sharing where none previously existed, such as for home health care. In addition, while many would see an increase in out-of-pocket costs, these individuals may never reach an out-of-pocket limit set as high as those included in the existing proposals.

Eliminating First-Dollar Coverage in Medigap

This proposal would create deductibles for Medigap plans, eliminating first-dollar coverage for services received under Medicare. Supporters believe that additional cost-

[15] Tricia Neuman, Juliette Cubanski, et al. Kaiser Family Foundation, *Raising the Age of Medicare Eligibility: A Fresh Look Following the Implementation of Health Reform*, July 2011. Available at http://www.kff.org/medicare/8169.cfm.
[16] Lieberman Coburn Proposal, June 2011; National Commission on Fiscal Responsibility and Reform, *The Moment of Truth,* December 2010; Alice Rivlin and Paul Ryan, *A Long-Term Plan for Medicare and Medicaid*, November 2010; The Debt Reduction Task Force, *Restoring America's Future*, November 2010.

sharing will drive down use of services because people with Medicare will choose to pay only for care that is necessary.[17]

Issues: The supporters are partially right. This proposal would create a new coverage gap with no coverage for care, and studies show that individuals without insurance coverage are more likely to delay even needed care.[18] The Part D coverage gap—commonly known as the doughnut hole—also demonstrates that if people are unable to afford care, they will not get it, regardless of need. People with low and moderate incomes, who are in poorer health compared to their wealthier counterparts, would be the hardest hit and most likely to not seek care.[19] This proposal wrongly assumes that consumers without medical backgrounds are able to second-guess their doctors and distinguish between necessary and unnecessary care. Some studies even demonstrate that because people delay care, long-term costs increase because of the need for more expensive medical treatments at a later point in time.[20]

Require People with Medicare to Pay Coinsurance for Home Health Care and for the First 20 Days of SNF Stays

These proposals would shift costs to consumers by imposing cost-sharing for home health and the first 20 days of a stay in a Skilled Nursing Facility (SNF), services which currently have no coinsurance under Original Medicare. Supporters also believe that this would save the government money because people will be less likely to use care if they must pay for care out of pocket.[21]

Issues: The result for people with Medicare is higher costs with less access, especially for those with lower incomes who may be most in need of care. For example, a significant number of people with Medicare who use home health services report being in poor to fair health and having incomes below $30,000 per year.[22] In addition, long-term costs to Medicare could increase if individuals choose not to receive home care due to cost but as a result require more expensive care, such as hospitalization, later.[23]

Increasing Premiums for Medicare

This proposal would increase the Medicare Part B premium by reducing the share of the premium paid for by the government.[24]

Issues: This proposal would shift costs to consumers, who already pay significant premiums.[25] Two-thirds of all health care spending for people with

---

[17] Lieberman Coburn Proposal, June 2011; National Commission on Fiscal Responsibility and Reform, *The Moment of Truth,* December 2010; Alice Rivlin and Paul Ryan, *A Long-Term Plan for Medicare and Medicaid*, November 2010.
[18] Kaiser Family Foundation, *The Uninsured: A Primer,* December 2010. Available at http://www.kff.org/uninsured/upload/7451-06.pdf.
[19] Bruce Vladeck, Kaiser Health News, *Proposals to Forbid First-Dollar Coverage for Medicare Beneficiaries*, August 2011. Available at http://www.kaiserhealthnews.org/Columns/2011/August/different-takes-080111-vladeck.aspx.
[20] Katherine Swartz, Robert Wood Johnson Foundation, *Cost-sharing: Effects on Spending and Outcomes*, December 2010. Available at http://www.rwjf.org/pr/product.jsp?id=71583.
[21] Kaiser Family Foundation, *Medicare Chartbook, 2010*, November 2010. Available at http://www.kff.org/medicare/upload/8103.pdf.
[22] *Id.*
[23] Home Care Association, *Home Health Care Co-Payment Would Affect Poorer, Sicker Beneficiaries, Many of Whom Would Have to Pay the Full Co-Payment Out of Pocket*, June 2011. Available at http://www.kshomecare.org/GenRefer/Avalere_CopaymentWhitePaper_2_.pdf.
[24] Lieberman Coburn Proposal, June 2011; The Debt Reduction Task Force, *Restoring America's Future*, November 2010.
[25] Congressional Budget Office, *Reducing the Deficit: Spending and Revenue Options*, March 2011. Available at http://www.cbo.gov/ftpdocs/120xx/doc12085/03-10-ReducingTheDeficit.pdf.

Medicare goes toward premiums, which equates to, on average, 10 percent of their total household incomes.[26] In addition to raising costs for consumers, such proposals would also increase costs to states that pay Part B premiums for their citizens with very low incomes.

Voucher Programs

The scheme proposed here would replace the current Medicare program and provide a capped annual voucher that individuals enrolled in Medicare could use to buy health insurance.[27]

Issues: This proposal would shift costs to people with Medicare, increasing their out-of-pocket spending. Voucher amounts under these proposals would not be enough to buy coverage as good as Medicare. Some experts question whether, as time goes on, voucher amounts would be sufficient to buy comprehensive coverage at all.[28] In addition, proposed voucher plans do not contain adequate consumer protections, such as preventing insurers from charging higher premiums based on age.

Blended Rate for Federal Medicaid Contributions (Blended FMAP)

This proposal would replace the current federal matching rates for Medicaid, which vary by population, with a single matching rate across all populations covered by Medicaid.

Issues: This proposal would save the federal government money by shifting costs to states, which are in precarious budget situations. As a result, states would be forced to cut Medicaid by restricting eligibility, reducing coverage, and reducing Medicaid provider payments, and research demonstrates that those with Medicaid already have difficulty finding doctors.[29]

Medicaid Block Grants

This proposal would cap the amount of money given to states to administer the Medicaid program. However, the amount of the grant would not be enough to sustain the cost of coverage Medicaid currently provides, leading states to potentially cut benefits or whole groups of recipients, such as certain people with Medicare, from the Medicaid program.

Issues: One-third of Medicaid dollars are spent on people with Medicare, who rely on Medicaid for long-term care because Medicare does not cover it. Cutting Medicaid will harm Medicare beneficiaries' financial stability, forcing individuals and their families who currently rely on Medicaid for long-term care to pay for a substantial portion, or even all of this expensive care, out of pocket.

---

[26] Kaiser Family Foundation, *Health Care on a Budget*, June 2011. Available at http://www.kff.org/medicare/upload/8171.pdf.

[27] House Concurrent Budget Resolution (H. Con Res. 34), April 2011; National Commission on Fiscal Responsibility and Reform, *The Moment of Truth,* December 2010; Alice Rivlin and Paul Ryan, *A Long-Term Plan for Medicare and Medicaid*, November 2010; The Debt Reduction Task Force, *Restoring America's Future*, November 2010.

[28] Congressional Budget Office (CBO), *Letter to Representative Paul Ryan*, April 2011. Available at http://www.cbo.gov/ftpdocs/121xx/doc12128/04-05-Ryan_Letter.pdf; Congressional Budget Office (CBO), *Preliminary Analysis of the Rivlin-Ryan Health Care Proposal*, November 2010. Available at http://www.cbo.gov/ftpdocs/119xx/doc11966/11-17-Rivlin-Ryan_Preliminary_Analysis.pdf.

[29] Edwin Park and Judith Solomon, Center on Budget and Policy Priorities, *Proposal to Establish Federal Medicaid "Blended Rate" Would Shift Significant Costs to States*, June 2011. Available at http://www.cbpp.org/cms/?fa=view&id=3521.

Spending Caps and Targets

This proposal would set a cap on overall federal spending, federal spending on all health programs as a bundle (Medicare, Medicaid and other programs), or federal spending on individual programs. Targets would require that overall spending, federal health spending or spending on individual health programs be reduced by a certain amount.[30]

Issues: The caps or targets under these proposals would not be set to increase at a rate that matches increases in costs across the entire health sector. This would likely result in cuts to Medicare and Medicaid across the board or trigger more specific proposals (such as those listed below), which would result in reductions in coverage under Medicare and Medicaid, reductions in benefits, or more restrictive eligibility requirements. Many people with Medicare rely on Medicaid for long-term care because such care is not covered by Medicare, so cuts to Medicaid may reduce access to long-term care.

Painting a Path Forward

In finding a path forward, there are ways to ensure that deficit reduction can occur without burdening people with Medicare with added costs or curtailed coverage:

- Increased revenues would prevent the need for cuts to programs that support Medicare and Medicaid beneficiaries, their families and caregivers.
- The way to strengthen Medicare and Medicaid's financial outlook is to address the underlying driver of programmatic spending, which is growing health care costs overall.
    - Policymakers should build on the progress made by the Affordable Care Act (ACA), including by investing in delivery system reforms that will curb health care spending without sacrificing the quality of care people receive and by further reducing fraud, waste, and abuse.
    - Other potential savings include reforming the Medicare drug benefit to ensure that the Medicare program is paying a fair price for drugs. Such reforms may include allowing Medicare to negotiate drug prices, requiring Medicaid-level rebates on Part D drugs for Medicare low-income populations, and making cheaper and effective generic drugs available to consumers more quickly.

[30] Gang of Six Proposal, July 2011; House Concurrent Budget Resolution (H. Con Res. 34), April 2011; National Commission on Fiscal Responsibility and Reform, *The Moment of Truth,* December 2010; Alice Rivlin and Paul Ryan, *A Long-Term Plan for Medicare and Medicaid*, November 2010; The Debt Reduction Task Force, *Restoring America's Future*, November 2010.