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MEDICARE

Do We Need a Grand Bargain?

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For those professing concern over long-run budget deficit projections, it makes some sense to focus on Medicare, as health care expenditures (public and private) have been increasing faster than GDP for several years. Net spending on Medicare is projected to grow from about 3 percent of GDP today to 5 percent by 2030, according to the Congressional Budget Office. Rather than looking at this as a problem with the overall U.S. health care system in containing costs, many in Congress view it simply as a federal government spending problem and do not realize (or care) that squeezing Medicare will shift the cost elsewhere.

But much like cuts to Social Security, simply cutting back the benefits offered by Medicare makes no sense substantively or politically. Substantively, Medicare actually does a better job than private insurers at containing health costs. So shifting costs onto households and off Medicare is simply inefficient. Politically, most Americans do not want Medicare spending reduced, with 82 percent supporting increased spending or no spending change. However, when faced with specific reforms to reduce spending on Medicare, 60 percent support reducing benefits for high-income seniors, but only 35 percent support raising the eligibility age.

Proposals for Medicare reform include means-testing, raising the eligibility age, and vouchers/premium support. Let's examine each of these in turn.

Means-testing: A perennial GOP proposal, and one cited with approval by President Obama, is to increase the means-testing of Medicare—asking higher-income recipients to pay higher premiums for the program. Currently, there is

already limited means-testing of Medicare beneficiaries. Increasing means-testing of Medicare generally means extending income adjustments of Part B and Part D premiums further down the income ladder.

Monthly premiums for Medicare Part B for 2013 vary from $104.90 (for singles with annual income less than $85,000 and couples with income less than $170,000) to $335.70 (for singles with annual income above $214,000 and couples with income above $428,000). About 5 percent of Medicare beneficiaries have income above the threshold ($85,000 for individuals or $170,000 for couples) that requires them to pay a premium greater than $104.90 per month. The threshold amounts are fixed in nominal terms until 2019, which increases the means-testing of premiums for the next six years; it is estimated that almost 10 percent of seniors will have income above the threshold by 2019.

The current means-testing seems genuinely targeted at affluent households. But because there are so few elderly households in these far upper reaches of the income distribution, this means-testing does not contribute significant amounts to Medicare's finances. To make a large dent in Medicare spending in coming decades, an increase in means-testing would have to start impacting households that are far from rich.

Further, increasing income-related premiums could help to undermine political support for Medicare. Social insurance programs, such as Medicare and Social Security, are successful, popular, and politically sustainable programs largely because all workers pay into the system and all workers eventually get something out. Means-tested public assistance programs tend to be less popular and are often a target for budget cuts (witness the current budget debate over food stamps).

More importantly, increasing premiums for higher-income beneficiaries could reduce the participation of higher-income elderly in Medicare Part B and Part D if alternative, less expensive private health insurance is available. The withdrawal of higher-income and presumably healthier elderly from the program could ultimately lead to higher costs and premiums for the remaining Part B and Part D beneficiaries.

Raising the eligibility age: Raising the eligibility age for Medicare is another oft-cited recommendation in "grand bargain" talks. It was on the menu of cuts demanded by the House GOP in exchange for raising the debt ceiling, and has been included in successive versions of budgets passed out of the House of Representatives (often referred to as versions of the "Ryan budget"). This policy saves money by denying nondisabled 65- and 66-year-old people access to Medicare. However, CBO projects that this policy would reduce aggregate deficits over the next 10 years by just $19.1 billion—0.3 percent of aggregate deficits between 2014 and 2023, and by far, far less than what has previously been estimated.

By shifting many elderly people into either employer-sponsored health insurance plans, plans through the health insurance exchanges, or Medicaid, this policy would actually *increase* total national health care spending, because of higher costs of private health insurance compared with Medicare.

Raising the age of eligibility for Medicare would likely have unintended consequences for others as well. Private health premiums would rise for all as older adults shifted from Medicare to employer plans or the exchanges. Older adults use

more health services than younger workers, so increased insurance payments for the older adults would be paid for by higher premiums for everyone covered by health insurance.

Additionally, the elimination of healthier 65- and 66-year-olds from Medicare would lead to an increase in the per-beneficiary costs of Medicare. It is likely that Medicare premiums would be increased for seniors 67 years old or older. Given the paltry cost savings from this policy, it seems clear that the main attraction for its advocates is that it will undermine political support for traditional Medicare.

Vouchers/premium support: The "voucherization" of Medicare seems unlikely in the near term, but it is clearly a longer-term goal for conservative deficit hawks.

For example, successive versions of the Ryan budget have proposed providing premium support to Medicare beneficiaries for private health insurance plans. The plan would only let newly eligible Medicare beneficiaries obtain health care coverage through private insurance plans, rather than through traditional Medicare or a Medicare Advantage plan. Under the premium support system, the federal government would provide a payment to help defray the premium and other health care costs (which is not much different than the insurance subsidy under Obamacare).

CBO projects that the total cost of insuring a typical 65-year-old could be considerably higher under the premium support plan than under traditional Medicare. Since government spending under the premium support plan would be lower, the typical elderly beneficiary would spend more out of pocket on health care under the premium support plan than under traditional Medicare. For example, using the CBO analysis, the Kaiser Family Foundation suggests that the typical beneficiary's out-of-pocket costs in 2022 would be $12,500 under the premium support plan, compared with $5,630 under traditional Medicare. This proposal may reduce federal spending, but it would exacerbate our health problem—health care spending is rising faster than GDP.