A Closer Look

Health Hazard: How the House Republican Budget Resolution Would Dramatically Change Medicare

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Since its creation in 1965, Medicare has provided a guarantee of health security to America's seniors. This guarantee was extended to people with disabilities in 1972. Today, 46 million seniors and people with disabilities rely on Medicare for their health coverage. The program provides a core set of health benefits to everyone who qualifies. Eligibility is based on a person's (or a spouse's) work history, and all workers who pay sufficient Medicare payroll taxes during their working years are eligible. There are no exclusions for pre-existing conditions, and the basic premiums are the same for everyone who qualifies, regardless of age or health status.

The Republican budget proposal for 2012, passed by the House of Representatives on April 15, 2011, would radically transform Medicare. Within a decade, it would end the program as it exists today and replace it with a voucher to be used to purchase insurance from private insurance companies. The security that Medicare provides to its beneficiaries would be eliminated. Instead, seniors and people with disabilities would see massive increases in their out-of-pocket health care costs. In particular, those with limited incomes would incur such high costs that they would likely have to go without care. And the problem would worsen over time as health care costs continued to climb much faster than the value of the voucher.

In addition to this threat, the budget proposal would roll back coverage for today's beneficiaries by re-opening the coverage gap, or "doughnut hole," in the Part D prescription benefit. This change would increase prescription drug costs for nearly 4 million seniors and people with disabilities who already fall into the doughnut hole, and it would impose even higher costs on a growing number of beneficiaries in the future.

Finally, the budget proposal would further undermine health security for older Americans by increasing the eligibility age for Medicare to 67, while at the same time repealing the new coverage options that were created by the health care law, the Affordable Care Act. These changes will increase the number of older uninsured Americans.

To sum up, key threats to beneficiaries include the following:

- Turning Medicare into a voucher program will:
  - cost more than providing the same care through Medicare,
  - shift costs to individuals,
  - put seniors and people with disabilities at the mercy of private insurance companies,
  - provide inadequate financial protection for low-income seniors and people with disabilities, and
  - fail to bring health care costs under control.
- Re-opening the doughnut hole will increase prescription drug costs for current beneficiaries.
- Raising the eligibility age for Medicare will increase the number of uninsured.

This report takes a closer look at the impact that the House Republican budget proposal would have on seniors and people with disabilities, examining in detail the impact of the voucher plan.

What Is the Voucher Plan?

The House Republican budget proposal would turn Medicare into a voucher program. Under the current Medicare program, every senior and person with disabilities with Medicare is guaranteed a set of comprehensive health care benefits. Under the Republican proposal, starting in 2022, seniors and people with disabilities who were born after 1956 would no longer be able to join the traditional Medicare program. Instead, they would receive a voucher to purchase health insurance from private insurance companies.

Initially, the voucher would be set at $8,000 for an average 65-year old in 2022. The value of each individual's initial voucher would be adjusted to reflect that person's health status, so sicker people would receive a somewhat larger-than-average voucher, and healthier people would receive a smaller-than-average voucher. The value of these vouchers would increase each year in line with the consumer price index (CPI), which rises more slowly than health care costs.

Although the voucher is supposedly calculated to be roughly equal to the cash value of traditional Medicare coverage in 2022, it will, in fact, purchase much less coverage. This is because providing coverage using private insurance companies is more expensive than providing coverage through Medicare. According to the Congressional Budget Office, an average 65-year-old would incur a total of about $20,500 in health care costs in 2022 if she had to purchase private insurance coverage. By comparison, providing that same care through Medicare would cost a total of only $14,750–a difference of $5,750 (see table on page 3). Of course, seniors and people with disabilities would be expected to make up the difference with money from their own pockets.

Health Care Spending for a Typical 65-Year-Old in 2022

	Current Medicare Program	Proposed Voucher	Percent of Total Health Care Spending Under Proposed Voucher
Paid by Medicare or Voucher	$8,600	$8,000	39%
Paid by Individual	$6,150	$12,500	61%
Total Spending	$14,750	$20,500	100%

Source: Families USA calculations based on Congressional Budget Office, *Long-Term Analysis of a Budget Proposal by Chairman Ryan*, April 5, 2011, Figure 1.

Note: Projections for the current Medicare program are based on Alternative Fiscal Scenario.

Problems with the Voucher Plan

- ### It Costs More to Cover Seniors and People with Disabilities Using Private Insurers

  Private insurance companies typically have much higher administrative costs than the Medicare program does. Medicare's administrative costs are around 2 percent, while private plans that serve Medicare beneficiaries average about 11 percent in administrative costs and profits.[1] In addition, private insurers incur many costs that Medicare does not have, such as costs for marketing and executive salaries. Finally, because private insurers are not as large as Medicare, they must pay higher rates to doctors and other providers to get them to take their insurance.

- ### It Shifts Health Care Costs To Individuals

  It is unlikely that the value of the voucher alone would be adequate to purchase high-quality insurance. Insurance companies who accept the voucher would be required to issue policies to everyone, regardless of pre-existing conditions. Insurers would also be required to charge the same premiums to everyone of the same age. However, insurers would be able to charge higher premiums to people as they get older. Therefore, even if the value of the voucher was adjusted to reflect an individual's health status, as enrollees aged, they would see their premiums increase faster than the value of their vouchers. This is a marked difference from the current Medicare system, under which premiums are the same for everyone, regardless of age or health status.

  Seniors and people with disabilities would still be able to use their own money to purchase additional coverage, just as they do today. But because the voucher would cover less than 40 percent of their health care costs (see table above), they would need to spend much more out of pocket to obtain even the same level of coverage that Medicare provides them today. As noted above, financing health care exclusively through private insurance companies is significantly more costly than providing it through the traditional Medicare program. Thus, as shown in table above, even though the federal government would be paying roughly the same amount per person (in 2022, $8,000 under the voucher, $8,600 under the traditional program), individuals would have to pay more than twice as much out of their pockets.

Shifting costs to individuals makes a voucher program a particularly bad fit for the people Medicare serves. By definition, few people with Medicare are employed. Most have fixed and limited incomes. Nearly half of all people with Medicare (48 percent) have incomes below two times the federal poverty level ($21,780 for an individual, $29,420 for a couple in 2011).[2] Doubling these people's out-of-pocket health care costs would have devastating effects on their family budgets, and it could force them into situations where they'd have to choose between health care and other basic necessities like food and shelter.

In the years after 2022, the purchasing power of the voucher would shrink because the value of the voucher would increase more slowly than health care costs (see "The Incredible Shrinking Voucher" on page 5). By 2030, the voucher would cover only 32 percent of a 65-year-old's health care spending, compared with an already-meager 39 percent in 2022. Individuals would be responsible for the remaining 68 percent. This is more than twice what a typical 65-year-old would expect to pay under existing Medicare. And because people inevitably incur higher health care costs as they age, out-of-pocket expenses are sure to be even higher for older and sicker Americans.

- ### It Puts Seniors and People with Disabilities at the Mercy of Insurance Companies

  The voucher plan envisions seniors and people with disabilities shopping for private insurance plans in a new marketplace. There are at least two problems with this plan. First, private insurers have never wanted to cover the older and sicker Americans who rely on Medicare at anything close to a reasonable cost. This is not surprising: Seniors and people with disabilities have substantial health care needs and are therefore costly to cover. Prior to the creation of Medicare in 1965, more than half of seniors had no insurance at all because they could not find an insurer who was willing to sell them a policy, or they could not afford any policy that was offered. Those who could purchase insurance on their own often could afford only limited and inadequate policies.[3] Medicare was created to address this problem—to make sure that older Americans and Americans with disabilities had access to comprehensive, affordable coverage, regardless of their age or health status.

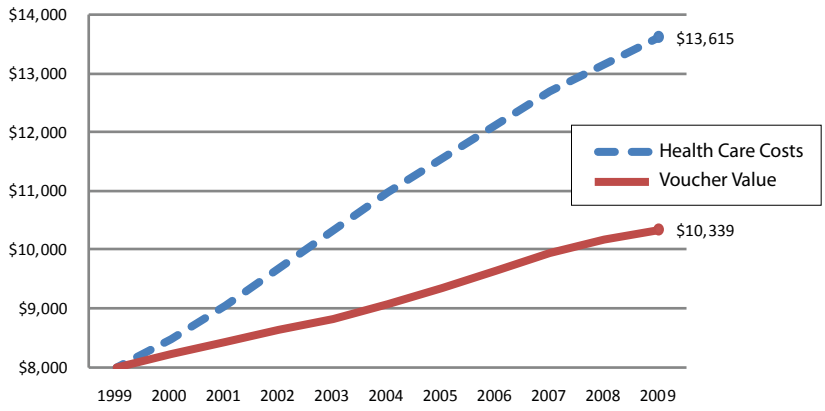
  Because the vouchers in the House budget proposal would not come close to covering the true cost of care, people who rely on them would be able to purchase only very limited insurance policies. Although insurance companies would have to offer a standard set of minimum benefits, they would likely be very limited in what they covered, would charge very high deductibles, would impose substantial cost-sharing, or would create bureaucratic obstacles to care (such as extensive prior authorization rules and benefit caps).

The Incredible Shrinking Voucher

Under the House Republican budget proposal, the value of the voucher that seniors and people with disabilities would receive to purchase health insurance would increase each year at the rate of consumer inflation as measured by the consumer price index (CPI). The problem with this formula is that health care costs have consistently risen faster than consumer inflation. As a result, the value of the voucher (which is inadequate to purchase quality insurance to begin with) would shrink over time relative to what it takes to buy insurance.

The chart below illustrates the difference between health care costs and general inflation had the House plan for Medicare taken effect in 1999. Imagine a voucher worth $8,000 in 1999 that increased each year at the rate of consumer inflation. By 2009, that voucher would have been worth $10,339. Over that same period, however, health care costs increased much more rapidly. By 2009, it would have cost $13,615 to purchase the same amount of health care that cost $8,000 in 1999. The difference, $3,276, represents consumers' additional out-of-pocket costs. And because the House plan makes no serious efforts to control health care costs in the future, seniors and people with disabilities would expect to experience similar erosion in the value of their vouchers in the future.

A Hypothetical Voucher vs. Health Care Costs, 1999-2009



Sources: Health care costs are based on a three-year moving average of per-capita National Health Care Expenditures as published by the Centers for Medicare and Medicaid Services. Voucher value is based on three-year moving average of CPI-U.

Second, seniors' recent experiences with shopping for private coverage have not been positive. The Part D prescription drug program is sometimes offered as a model for the voucher proposal. But beneficiaries have overwhelmingly found choosing a Part D plan to be confusing, and research shows that many beneficiaries have not chosen plans that best suit their needs.[4] Forcing all Medicare beneficiaries into private plans for all of their health care needs would increase this confusion exponentially.

- **It Does Not Adequately Protect Low-Income Seniors**

  About one-fifth of current Medicare beneficiaries also have coverage through their state's Medicaid program. These beneficiaries typically have very low incomes and/or have medical expenses that consume most of their income. For these people, Medicaid provides supplemental coverage that pays for Medicare's premiums and cost-sharing. Medicaid also provides vital additional benefits, such as long-term services and supports.

  The House budget proposal would cut Medicaid by $1.4 trillion.[5] It would also eliminate Medicaid's role as a provider of supplemental coverage for Medicare. Instead, low-income people who received a Medicare voucher would also receive an additional grant in the form of a medical savings account to pay for their health care expenses. This grant would be set at $7,800 in 2022 and would increase in future years in line with the consumer price index.

  It is questionable whether low-income seniors and people with disabilities, many of whom have multiple chronic conditions and cognitive impairments, are well-suited to managing a medical savings account. But putting that concern aside, the medical savings account scheme would be wholly inadequate to protect low-income seniors and people with disabilities from unaffordable out-of-pocket costs. As noted above, in 2022, the average 65-year-old would incur health care costs of $20,500. The Medicare voucher would cover $8,000 of these costs. The medical savings account grant would cover an additional $7,800 of these costs. This would still leave *$4,700* in out-of-pocket costs. By one estimate, this would mean that an average 65-year-old with income at the poverty level in 2022 (an estimated $13,620) would have less than $750 a month ($9,000 a year) for all other expenses, including food and shelter, after paying for her health care costs.[6] Those with health conditions that result in significant health care costs would be squeezed even more.

- **It Does Not Control Health Care Costs**

  Proponents of the voucher plan may believe that sending Medicare beneficiaries to private insurance companies will somehow result in lower health care costs. However, experience shows the contrary. Private plans have participated in Medicare for many years. But, on average, they have consistently cost more, not less, than traditional

Medicare to provide the same care.[7] This problem is reflected in the projections in the table on page 3, which show that the cost of care would be $5,750 higher per person under a voucher program than it would be under traditional Medicare.

Medicare faces fiscal challenges in the future not because its benefits are too generous or because it is inefficient. In fact, Medicare's benefits are rather modest compared to many job-based plans. And, as noted above, Medicare is highly efficient, spending only about 2 percent on administrative costs, compared to 11 percent for private insurance. Rather, Medicare faces rising costs because health care costs are rising across the economy, both for private insurers and for public programs like Medicare.

The voucher plan does nothing to fix the issues in the health care system that are driving up costs. It just makes seniors and people with disabilities pay more. Forcing people to pay more out of pocket may initially reduce the amount of health care they use, but this does not make people healthier. Instead, it results in higher costs down the road as chronic conditions that could have been treated affordably if managed early are left to worsen until they require costly interventions like hospitalizations.

Reducing health care costs can be achieved only by changing how the health care system operates. Many innovations that were included in the health care law lay the groundwork for improving care while reducing costs. Initiatives such as better coordination among health care providers, providing incentives for keeping patients healthy, and increasing prevention all hold the promise of reducing costs through a more efficient health care system. Unfortunately, the House budget resolution also would repeal the health care law, which would end these initiatives before they have a chance to bring costs down.

Other Hazards of the Budget Proposal's Medicare Plan

■ It Increases Prescription Drug Costs for Current Beneficiaries

Under the health reform law, the coverage gap in the Part D prescription drug program, often referred to as the "doughnut hole," is gradually being closed. In 2010, beneficiaries who fell into the doughnut hole received a $250 rebate check. In 2011, they are receiving a 50 percent discount on name-brand drugs while in the doughnut hole and other discounts on generic drugs. These discounts are scheduled to increase over the next decade until the doughnut hole is completely closed by 2020.

The House budget proposal would re-open the doughnut hole for current beneficiaries by repealing the health care law. Beneficiaries with substantial drug costs would immediately see the price of their name-brand drugs double while in the coverage gap. This year, the gap is more than $3,600. If it were re-opened, it would grow to more than $6,000 in uncovered prescription drug costs by the end of the decade.

- **It Eliminates Coverage for People under Age 67**
  The House Republican budget resolution also would gradually increase the eligibility age for Medicare from 65 to 67 by 2033. At the same time, it would repeal the provisions of the health care law that expand the availability of health insurance for those who do not qualify for Medicare and that protect people with pre-existing conditions. As a result, anyone who loses access to health insurance from an employer before reaching age 67 (for example, through losing a job or retiring) would have few, if any, options for obtaining affordable insurance. By their mid-60s, most people typically have one or more pre-existing conditions, which makes health insurance in the individual private market unaffordable--or even unavailable at any price. The budget proposal offers no help to this group, many of whom would likely end up uninsured.

Conclusion: A Massive Transfer of Costs and Risk to Seniors and People with Disabilities

This is not the first time conservatives have tried to dismantle Medicare. In 1995, then-Speaker of the House Newt Gingrich explained that his agenda was to see the traditional Medicare system "wither on the vine" by providing beneficiaries with incentives to move to private plans. He conceded that ending traditional Medicare all at once was not "politically smart," but that that was still his ultimate goal.[8]

The House budget proposal is, in fact, more radical than anything proposed during the Gingrich era. It abolishes traditional Medicare outright and replaces it with a voucher program that is inadequate to purchase even basic health insurance. The budget proposal does not explain how seniors and people with disabilities are expected to pay for the care they need. Wealthier people could presumably pay for additional care using their own resources. For the roughly half of people with Medicare who have limited incomes, however, the implication is that they would have to spend less on other necessities like food and shelter—or else go without health care.

Moreover, despite its massive cuts to Medicare and Medicaid, the House budget proposal does not even significantly reduce the deficit.[9] It is instead an example of upside-down priorities, increasing the costs for and endangering the health of America's senior citizens and many people with disabilities in order to finance massive tax cuts for Americans who can afford to pay more. If enacted into law, it would fundamentally violate the promise that Medicare has made to current and future generations of seniors and people with disabilities, which is to ensure access to comprehensive care at a time in their lives when they are most vulnerable.

Endnotes

[1] Congressional Budget Office, *Designing a Premium Support System for Medicare* (Washington: Congressional Budget Office, December 2006), p. 12.

[2] Kaiser Family Foundation, statehealthfacts.org, *Distribution of Medicare Enrollees by Federal Poverty Level, States (2008-2009), U.S. (2009)*, available online at http://www.statehealthfacts.kff.org/comparebar.jsp?ind=295&cat=6, accessed on April 27, 2011.

[3] Karen Davis and Sara Collins, "Medicare at Forty," *Health Care Financing Review* 27, no. 2 (Winter 2005-2006): 53-62.

[4] Jonathan Gruber, *Choosing a Medicare Part D Plan: Are Medicare Beneficiaries Choosing Low-Cost Plans?* (Menlo Park, CA: Kaiser Family Foundation, March 2009).

[5] *House Republicans Propose to Slash Funding for Medicaid, Medicare, and Other Health Coverage Programs* (Washington, Families USA, April 2011).

[6] January Angeles, *Out-of-Pocket Medical Costs Would Skyrocket for Low-Income Seniors and People with Disabilities under the Ryan Budget Plan* (Washington: Center on Budget and Policy Priorities, April 15, 2011).

[7] Kim Bailey, *Whose Advantage? Billions in Windfall Payments Go to Private Medicare Plans* (Washington: Families USA, June 2007).

[8] "Politics: Gingrich on Medicare," *New York Times*, July 20, 1996.

[9] James R. Horney, *Ryan Budget Plan Produces Far Less Real Deficit Cutting Than Reported* (Washington, Center on Budget and Policy Priorities, April 8, 2011).

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