Center for American Progress

Latest House Republican Budget Threatens Medicare and Shreds the Safety Net

Instead of Reducing Health Care Costs, Blueprint Shifts Costs to Seniors, Providers, Businesses, and States

Topher Spiro March 2012

Introduction

The Republican majority in the U.S. House of Representatives released its proposed budget for fiscal year 2013 today, taking particular aim at our nation's health care programs. This latest House Republican budget would fundamentally alter these programs, setting us on an uncharted path that would have adverse consequences for tens of millions of Americans.

Major consequences of the House Republican budget

- Many seniors would be forced to pay sharply higher premiums to stay in traditional Medicare and keep their current choice of doctors.
- New Medicare beneficiaries could pay more than $1,200 more by 2030 and more than $5,900 more by 2050.
- More and more seniors would gradually shift to private health insurance plans over time, increasing the privatization of Medicare.
- Hundreds of thousands of seniors would become uninsured.
- Premiums would increase for most Medicare beneficiaries.
- More than 47 million Americans would lose health insurance coverage in 10 years.
- Tens of millions of Americans would lose consumer protections that are essential for health and economic security.
- States would be forced to slash Medicaid eligibility, benefits, and payments to health care providers.

The House budget would provide vouchers to Medicare beneficiaries to purchase either a private health insurance plan or the traditional Medicare plan. This plan would shift costs to seniors, making many seniors pay sharply higher premiums to stay in traditional Medicare and keep their current choice of doctors. For these seniors the choice of traditional Medicare would be a false one in reality.

This premium support plan would also limit growth in Medicare spending to growth in the economy plus 0.5 percentage points. But since it's unclear how this cap would be enforced, it's likely that the cap would limit the amount of the vouchers provided to beneficiaries. Since the proposed growth rate is much slower than the projected growth in health care costs, the nonpartisan Congressional Budget Office estimates that new beneficiaries could pay more than $1,200 more by 2030 and more than $5,900 more by 2050.[1]

What's more, private plans could "cherry pick" healthier seniors, driving up premiums for those who remain in traditional Medicare. And private plans would be able to undercut traditional Medicare in other ways, such as by offering free gym memberships or other perks. As a result more and more seniors would gradually shift to private plans over time. This gradual privatization of Medicare does not make sense because traditional Medicare costs less than comparable private coverage. But with fewer beneficiaries Medicare would have less leverage to contain the growth in health care costs.

The House budget would also shift costs to seniors by raising Medicare's age of eligibility to 67. Some seniors who would no longer be eligible for Medicare would pick up employer coverage—but they would pay more in premiums and cost sharing. And since the budget would scale back or eliminate other coverage options, hundreds of thousands of seniors would become uninsured.

But the House budget's cost-shifting approach would not stop with Medicare. The budget would also shred the safety net for the middle class and the most vulnerable people in our society—jeopardizing the health and economic security of tens of millions more Americans. All told, more than 47 million Americans would lose health insurance coverage in 10 years.

The House budget would repeal affordable health insurance coverage for 33 million Americans under the Affordable Care Act.[2] And the budget would eliminate the new law's consumer protections, which have already benefited tens of millions of Americans.

The House budget would also transform Medicaid, replacing guaranteed federal funding with block grants to states. This would shift costs to states, which are already under enormous strain. According to the Congressional Budget Office, states would be forced to reduce eligibility, benefits, or payments to health care providers. More than 14 million Americans would lose coverage in 10 years.[3]

All told, the House budget would cut Medicaid by more than $1.4 trillion over 10 years.[4] But these cuts would not go toward deficit reduction. Rather, they would largely pay for expensive tax cuts. In essence the House budget seeks a massive transfer from the middle class and the most vulnerable in our society to high-income individuals. (For an overview of the budget, click here.)

Premium support plan threatens Medicare

Beginning in 2023 for new beneficiaries, the House budget would convert Medicare spending into "premium support," providing vouchers to beneficiaries to purchase either a private health insurance plan or the traditional Medicare plan.

Plans would submit bids for how much they would charge to provide coverage. The voucher would be tied to the premium of the private plan with the second-lowest cost, or the premium for traditional Medicare—whichever is lower. If beneficiaries choose a plan that costs more than the voucher, they would have to pay the difference.

This premium support plan would:

- Increase premiums for seniors
- Threaten traditional Medicare

Let's review both of these consequences in turn.

Increases premiums for seniors

In some geographic areas traditional Medicare might make the lowest bid; in others, some private plans might make lower bids. In areas where private plans make bids that are lower than the cost of traditional Medicare, the voucher would be tied to the premium of a private plan. As a result many beneficiaries would be forced to pay sharply higher premiums to stay in traditional Medicare.

For this reason the nonpartisan Congressional Budget Office concluded that premium support would achieve much of its savings from "increases in the premiums paid by beneficiaries, not from increases in the efficiency of health care delivery."[5]

The House budget would also limit growth in Medicare spending to growth in the economy plus 0.5 percentage points. But it's unclear how this cap would be enforced. As a result, it's likely that the cap would be enforced by limiting the amount of the vouchers provided to beneficiaries.

Since the proposed growth rate is much slower than the projected growth in health care costs, the voucher would leave beneficiaries to pay substantially more over time. CBO estimates that new beneficiaries could pay more than $1,200 more (in 2011 dollars) by 2030 and more than $5,900 more by 2050 under the House budget.[6]

What's more, the Affordable Care Act already established an Independent Payment Advisory Board that will control the growth in Medicare spending. While the target growth rate for the independent panel is growth in the economy plus 1 percentage point, the president has proposed reducing that growth rate to growth in the economy plus 0.5 percentage points—the same growth rate as the cap under the House budget. The proposed budget cap, therefore, would produce little or no savings compared to the president's alternative approach.

But the cap under the House budget plan would have serious consequences for Medicare beneficiaries. While the Independent Payment Advisory Board is specifically prohibited by law from increasing premiums or cost sharing, the budget cap would likely shift these costs to beneficiaries substantially.

Threatens traditional Medicare

Many studies show that private plans attract healthier, less costly beneficiaries—a phenomenon known as "adverse selection."[7] If less healthy, more costly beneficiaries are left behind in traditional Medicare, then premiums for traditional Medicare would rise. In turn, more beneficiaries would leave traditional Medicare, causing premiums to rise further, and so on—creating a so-called "death spiral."

The House budget would adjust the voucher for health status—redistributing payments from plans with healthier enrollees to plans with less healthy enrollees. This "risk adjustment" mechanism would certainly help, but current risk-adjustment methods are still far from perfect.[8] Current methods tend to overpay plans with healthier enrollees and underpay plans with less healthy enrollees.

As a result premiums for traditional Medicare would likely rise and enrollment would likely decline over time.[9] This outcome is even more likely because the House budget would not require private plans to provide a standard set of benefits—allowing them to design benefits that attract healthier beneficiaries.

Premium support would stack the deck against traditional Medicare in another way. Currently, traditional Medicare cannot provide an integrated benefit package that includes prescription drug coverage, modify benefit designs, or offer provider network options. And significantly, traditional Medicare must provide financing that private plans do not provide, such as financing for graduate medical education, rural hospitals,

and hospitals that disproportionately serve low-income people. Traditional Medicare, therefore, would not be competing on a level playing field.

If private plans use these artificial advantages and risk selection to underprice traditional Medicare, then more and more beneficiaries would gradually shift to private plans over time. With fewer beneficiaries, traditional Medicare would lose its leverage with health care providers, driving up health care costs even more.

Increasing the privatization of Medicare does not make sense because traditional Medicare costs less than comparable private coverage. Private plans pay higher rates to health care providers and have significantly higher administrative costs.[10] To be as efficient as Medicare, private plans must offset these higher costs through aggressive management to reduce the use of services.

Plan restricts eligibility for Medicare

The House budget would raise Medicare's age of eligibility from 65 to 67 by 2034.[11]

CBO estimates that such proposals would reduce Medicare spending by about $150 billion over 10 years.[12] But raising the eligibility age would shift health care costs to seniors who are age 65 or 66. CBO estimates that roughly 5.4 million seniors would be affected in 10 years.[13]

Of this group, about 2.7 million seniors would pick up health insurance offered by employers.[14] But since employer coverage is less generous than Medicare coverage, these seniors would pay more in premiums and cost sharing. And the costs to employers would increase since they would have to pay more in premium contributions.

Some of the remaining seniors would obtain coverage through Medicaid, qualify for Medicare because they are disabled, or purchase private health insurance in the direct-purchase market. But since the House budget would also cut Medicaid and repeal reforms in the Affordable Care Act that would make the direct-purchase market accessible and affordable,[15] hundreds of thousands of seniors would become uninsured.[16]

What's more, raising the eligibility age would remove the youngest and healthiest—and least costly—beneficiaries from the Medicare program. As a result average costs among the remaining beneficiaries would be higher. Since premiums for physician services are linked to average costs, premiums would increase for most beneficiaries.

Plan repeals key elements of the Affordable Care Act

The House budget would repeal the following key elements of the Affordable Care Act:

- State-based health insurance exchanges—online marketplaces where individuals and small businesses can easily shop for and enroll in private health insurance plans.

- The ban on discrimination based on health status, which will guarantee access to health insurance at an affordable premium. This protection prohibits health insurance companies from denying coverage to those who are sick or have a pre-existing condition—or from charging them higher premiums.

- Other consumer protections that have already benefited tens of millions of Americans. Because young adults can stay on their parents' plans, 2.5 million young adults have already gained health insurance coverage.[17] Fifty-four million Americans have already gained access to free preventive care, such as screenings for colon cancer, mammograms, and flu shots.[18] And 105 million Americans no longer face arbitrary lifetime caps on their coverage.[19]

- Premium tax credits for individuals—which will guarantee that premiums never exceed a certain percentage of income—as well as tax credits for small businesses for up to 50 percent of their health insurance costs.

- The expansion of Medicaid coverage to all individuals with income below 138 percent of the federal poverty level, or about $31,000 for a family of four. Repealing this coverage would reduce enrollment by 17 million people in 10 years.[20]

- The Independent Payment Advisory Board, which will recommend proposals to slow the growth in Medicare spending while improving the quality of care. Repealing the independent panel would increase the federal budget deficit by $3.1 billion over 10 years—and increase long-term deficits and the debt.[21]

All told, CBO estimates that 33 million Americans would lose health insurance coverage in 10 years.[22] And millions more would lose consumer protections that are essential for health and economic security.

Plan shreds the Medicaid safety net

Medicaid provides essential health care and long-term care to millions of low-income children, pregnant women, seniors, and people with disabilities—the most vulnerable people in our society. But Medicaid is also a safety net for middle-class families. Many beneficiaries were once in the middle class until the high costs of long-term care burned through their savings and assets. In fact, the costs of long-term care for seniors account for more than one-fifth of total Medicaid spending.[23]

As noted above, repeal of the Affordable Care Act would dramatically reduce Medicaid coverage. But the House Republican budget would go even further by fundamentally transforming the program.

Currently, Medicaid is a partnership between states and the federal government, which together finance the costs of the program. On average, the federal government covers about 60 percent of total costs, and states contribute the rest. States are entitled to federal funding that matches their costs, no matter how many individuals become eligible for the program.

The House budget would replace this guaranteed funding with block grants to states—lump sums of money set in advance, regardless of actual costs. Since federal funding would be capped, states would have to bear all of the costs of any contingencies—such as a recession, epidemic, or natural disaster.

The block grants would grow each year with population growth and inflation. Since this growth rate is much slower than the projected growth in health care costs, federal spending on Medicaid would decline substantially. The block grants would reduce federal Medicaid spending by $810 billion over 10 years. CBO estimates that the block grants would reduce federal Medicaid spending by more than 35 percent in 10 years.[24]

Combining the block grants with the repeal of the Affordable Care Act, the House Republican budget would reduce federal Medicaid spending by more than $1.4 trillion over 10 years—by more than one-third.[25] In 10 years the House Republican budget would reduce federal Medicaid spending by more than 44 percent each year.[26]

But the House Republican budget would produce these savings only by shifting costs from the federal government to states, which are already under enormous strain. The states that would be hit most hard would be those that have a higher rate of uninsured and lower enrollment in Medicaid. These states include Florida, Colorado, Nevada, North Carolina, and Virginia.[27]

While states might be able to achieve some cost efficiencies, CBO concludes that states would need to make substantial cutbacks that involve "reduced eligibility for Medicaid and [the Children's Health Insurance Program], coverage for fewer services, lower payments to providers, or increased cost-sharing by beneficiaries—all of which would reduce access to care."[28]

Here is a review of the likely consequences:

- In 10 years the block grants alone would reduce enrollment by more than 14 million people, or almost 20 percent—even if states were able to slow the growth in health care costs substantially.[29] The vast majority of these people would become uninsured. States would be able to reduce enrollment by establishing enrollment caps or waiting lists.

- States would likely cut benefits that are not typically covered by private health insurance. Benefits that are critical for people with severe disabilities—such as case management and mental health care—would be at risk. Also at risk would be com-

prehensive preventive care, screening, and follow-up treatment for children, known as Early Periodic Screening, Diagnostic, and Treatment, or EPSDT.

- Medicaid generally charges little or no premiums or cost-sharing to ensure coverage is affordable for low-income people. But states would likely increase premiums and cost-sharing substantially—limiting access to needed care for the most vulnerable people in our society.

- Since payment rates under Medicaid are already low and inadequate in many cases, health care providers may not be willing to accept even lower payment rates. Providers could turn away beneficiaries, jeopardizing their access to needed care.

- In 10 years the House Republican budget could reduce payments to hospitals by more than $84 billion each year, or 38 percent.[30] Hospitals would receive much less revenue as a result of reductions in payments, benefits, or eligibility. At the same time, the loss of coverage and benefits would increase the cost of uncompensated care substantially, placing an enormous burden on hospitals.

The evidence is clear: Turning Medicaid into a block-grant program would shred our nation's safety net.

Conclusion

Instead of reducing health care costs, the House Republican budget would shift costs to seniors, health care providers, businesses, and states. But real solutions would slow the growth in health care costs across the system—for seniors, families, businesses, states, and the federal government—rather than shift costs from one party to another.

In particular, the House budget assumes that major structural changes to Medicare are needed. That premise is false. Over the next 10 years, Medicare's growth in costs per beneficiary is projected to average only 2.8 percent per year—compared to growth in our economy of 3.9 percent per capita and growth in total health care costs of 5.1 percent per capita.[31] In fact, the Affordable Care Act contributes significantly to this projected slowdown: Without the new law, Medicare would grow more than 1 percentage point faster.[32]

This means that real solutions—including many already underway under the Affordable Care Act—would focus more broadly on policies that contain national health spending—which would also contain spending on federal health care programs. But the House Republican budget would not address the problem—with dangerous consequences for tens of millions of Americans.

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Endnotes

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2 Congressional Budget Office, "Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act" (2012).

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4 Ibid., p. 5.

5 Congressional Budget Office, "Budget Options Volume I: Health Care" (2008), p. 121.

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7 Thomas Rice and Katherine Desmond, "The Distributional Consequences of a Medicare Premium Support Proposal," *Journal of Health Politics, Policy and Law* 29 (6) (2004): 1196; Medicare Payment Advisory Commission, "Report to the Congress: Promoting Greater Efficiency in Medicare" (2007), p. 63.

8 Congressional Budget Office, "Designing a Premium Support System for Medicare" (2006), p. 27; Brian K. Frogner and others, "Incorporating New Research Into Medicare Risk Adjustment," *Medical Care* 49 (3) (2011): 295–300. According to some studies, risk adjustment accounts for less than half of the variation in predictable health care spending. Congressional Budget Office, "Key Issues in Analyzing Major Health Insurance Proposals" (2008), p. 89.

9 In a simulation of one premium support proposal—which assumed that risk adjustment would remove 75 percent of variation in costs—participation in traditional Medicare declined by 24 percentage points over a 20-year period. Thomas Rice and Katherine Desmond, "The Distributional Consequences of a Medicare Premium Support Proposal," *Journal of Health Politics, Policy and Law* 29 (6) (2004): 1202.

10 Topher Spiro, "The Inherent Flaws in Medicare Premium Support" (Washington: Center for American Progress, 2011), pp. 3–4.

11 Congressional Budget Office, "The Long-Term Budgetary Impact of Paths for Federal Revenues and Spending Specified by Chairman Ryan," p. 4.

12 Congressional Budget Office, "Raising the Ages of Eligibility for Medicare and Social Security" (2012), p. 6.

13 Ibid.

14 Ibid.

15 The Affordable Care Act provides premium tax credits for lower-income individuals, bans discrimination based on health, and restricts premium charges based on age.

16 Congressional Budget Office, "Raising the Ages of Eligibility for Medicare and Social Security", p. 6.

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20 Congressional Budget Office, "Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act."

21 Congressional Budget Office Cost Estimate, H.R. 452 Medicare Decisions Accountability Act of 2011, March 7, 2012.

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23 Kaiser Commission on Medicaid and the Uninsured, "Medicaid's Long-Term Care Users: Spending Patterns Across Institutional and Community-Based Settings" (2011).

24 Congressional Budget Office, "Long-Term Analysis of a Budget Proposal by Chairman Ryan", p. 26.

25 Holahan and others, "House Republican Budget Plan," p. 5.

26 Ibid., p. 7.

27 Ibid., p. 6.

28 Congressional Budget Office, "The Long-Term Budgetary Impact of Paths for Federal Revenues and Spending Specified by Chairman Ryan," p. 9.

29 Holahan and others, "House Republican Budget Plan," p. 9.

30 Ibid., p. 8.

31 Centers for Medicare and Medicaid Services, Office of the Actuary, "National Health Expenditures 2010-2020," available at https://www.cms.gov/NationalHealthExpendData/downloads/proj2010.pdf.

32 See, for example: Andrea M. Sisko and others, "National Health Spending Projections: The Estimated Impact of Reform Through 2019," *Health Affairs* 29 (10) (2010): 1933–1941: "The Medicare provisions in the Affordable Care Act … are anticipated to result, on net, in much slower Medicare spending growth over the projection period."