

# No Social Security COLA causes Medicare flap

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Chestnut Hill, Mass.: Center for Retirement Research at Boston College, August 2015

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# NO SOCIAL SECURITY COLA CAUSES MEDICARE FLAP

BY ALICIA H. MUNNELL AND ANQI CHEN\*

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## Introduction

The 2015 *Social Security Trustees Report* assumes that – for just the third time since the automatic adjustments were adopted in 1975 – Social Security recipients will not receive a cost-of-living-adjustment (COLA) in 2016. The reason is that the Consumer Price Index is not expected to increase in the base period used to determine the COLA.

The anticipated lack of a Social Security COLA will cause a flap in the Medicare program because, by law, the cost of higher Medicare Part B premiums cannot be passed on to most beneficiaries when they do not get a raise in their Social Security benefits. This flap also highlights the complicated interaction between Medicare premiums, which are generally deducted automatically from Social Security benefits, and the *net* benefit – the money available for non-health care expenditures. Because, for a number of reasons, the COLA does not fully reflect the increase in health care costs faced by the elderly, the *net* Social Security benefit does not keep pace with inflation. This *brief* explores the interaction of inflation, Medicare premiums, and Social Security benefits.

The discussion proceeds as follows. The first section describes Social Security's COLA. The second section describes how Medicare premiums are calculated and explains next year's flap. The third reports

that Medicare Part B premiums have increased more than twice as fast as the COLA and discusses three reasons why this differential matters for non-medical care spending. The final section concludes that, while the inflation adjustment in Social Security is extremely valuable, the rise in Medicare premiums undermines the ability of beneficiaries to maintain their purchasing power for non-health-care items.

## Social Security's COLA

Workers' Social Security benefits are subject each year to a COLA.<sup>1</sup> Automatic indexing is generally viewed as a positive feature of social security systems, both in the United States and abroad. Without such automatic adjustments, the government would have to make frequent changes to benefits to prevent retirees' standard of living from eroding as they age.<sup>2</sup>

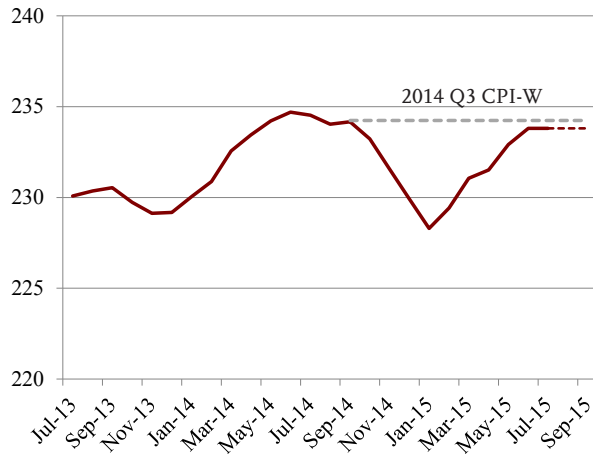
The Social Security COLA is based on the change in the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W) over the last year.<sup>3</sup> Since the COLA first affects benefits paid after January 1, Social Security needs to have figures available before the end of the year. As a result, the adjustment for January 1, 2016 is based on the increase in the CPI for the

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third quarter of 2015 over the third quarter of 2014. As shown in Figure 1, the CPI-W dipped substantially from the 2014 third-quarter average of 234.2 and, although it has turned around, is still below that benchmark.

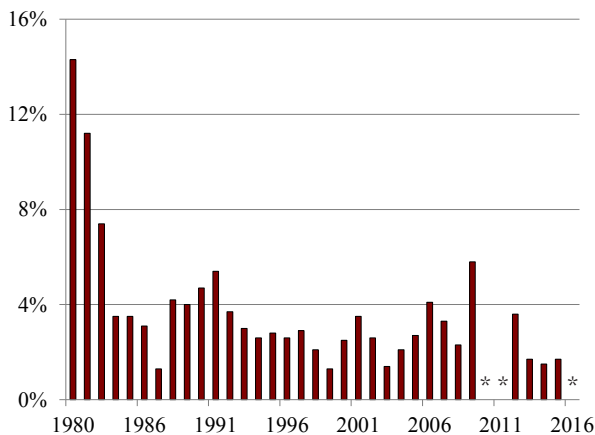
FIGURE 1. CONSUMER PRICE INDEX (CPI-W), JULY 2013-SEPTEMBER 2015



Note: The index benchmark of 100 equals price levels in 1983. Sources: U.S. Social Security Administration (2015a, b); and U.S. Bureau of Labor Statistics (2015a).

If, as anticipated, the CPI-W does not increase over the relevant period, the Social Security Administration cannot provide any automatic increase. This would only be the third time in the last 40 years that no COLA would be paid (see Figure 2).

FIGURE 2. SOCIAL SECURITY COST-OF-LIVING ADJUSTMENT, 1980-2016

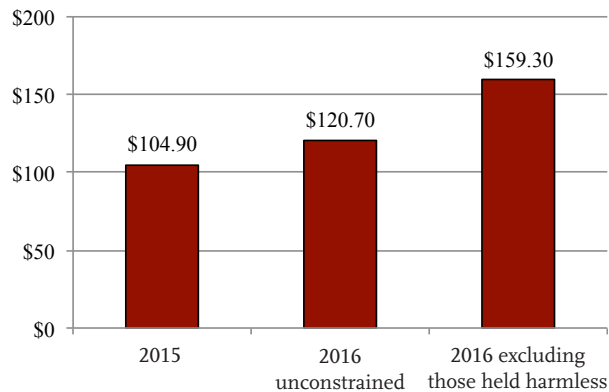


Note: Asterisk indicates no COLA was received in 2010 and 2011 and none is anticipated for 2016. Source: U.S. Social Security Administration (2015a, c).

## The Medicare Flap

Medicare is composed of two programs. Under Part A, the Hospital Insurance (HI) Trust Fund pays for inpatient hospital services, skilled nursing facilities, home health care, and hospice care. HI is financed by a 2.9 percent payroll tax, shared equally by employers and employees. The Supplementary Medical Insurance Trust Fund consists of two separate accounts: Part B, which covers physician and outpatient hospital services and Part D, which was enacted in 2003 and covers prescription drugs. About 75 percent of the costs of Parts B and D are paid from the government’s general revenues, which come from the personal income tax, corporate income tax, etc. The other 25 percent comes from monthly premiums paid by beneficiaries, which typically are deducted from Social Security benefits before they are sent to the recipient.<sup>4</sup>

FIGURE 3. MEDICARE PART B PREMIUMS 2015, 2016 UNCONSTRAINED, AND 2016 EXCLUDING THOSE HELD HARMLESS



Source: Centers for Medicare and Medicaid Services (2015a).

The flap centers on the premiums for Medicare Part B. Typically, the Medicare Part B premium is increased each year in line with Part B per capita expenditures.<sup>5</sup> In the absence of any complicating factors, the premium would increase from \$104.90 in 2015 to \$120.70 for 2016 (see Figure 3). The problem is that the law contains a hold-harmless provision that limits the dollar increase in the premium to the dollar increase in an individual’s Social Security benefit. This provision applies to roughly 70 percent of Part B enrollees. The 30 percent not eligible for the hold-harmless provision include new enrollees during the year; enrollees who do not receive a Social Security

benefit check; enrollees with high incomes, who are subject to the income-related premium adjustment; and dual Medicare-Medicaid beneficiaries, whose full premiums are paid by state Medicaid programs.

Because the COLA for Social Security benefits is expected to be zero for 2016, premiums would not increase for the 70 percent protected by the hold harmless provision. Under current law, Part B premiums for other beneficiaries must be raised enough to offset premiums foregone due to the hold-harmless provision. Under the intermediate economic assumptions, the estimated monthly premium in 2016 for these other beneficiaries is \$159.30. That means that, unless the Administration figures out some work-around, the base Part B premium would rise from \$104.90 to \$159.30 – a 52-percent increase.

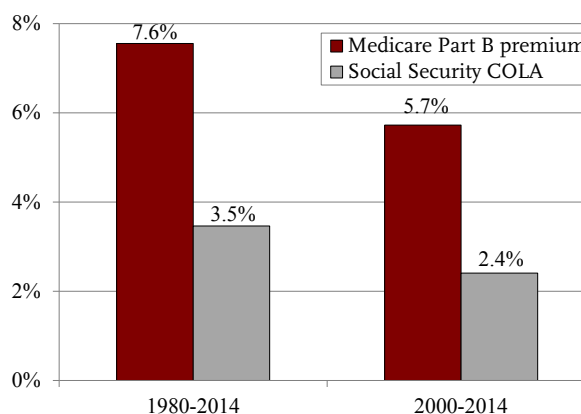
Higher income participants would then pay multiples of \$159.30 depending on their income level. For example, each member of a married couple with household income between \$170,000-\$214,000 would pay a Part B premium in 2016 of \$223.00 (see Table 1). Premiums would top out at \$509.80 per person for couples with income of more than \$428,000.<sup>6</sup> Clearly political pressure will build for some kind of work-around.<sup>7</sup>

## The Broader Issue of Medicare Premiums

This year's Medicare flap highlights a broader issue concerning the difference between Social Security's COLA and the percentage increase in the Medicare premium. If the two increases were equal, the disposable income beneficiaries had for non-health items, such as food, shelter, and clothing, would automati-

cally keep pace with non-health inflation. But the premium has on average risen over twice as fast as the benefit (see Figure 4). Even this difference would not be a problem in a perfectly indexed world, where the increase in the Medicare premium reflected the increase in the medical care component of the CPI-W. In such a world, if medical care prices grew at a faster pace than prices of other goods, medical care would account for a larger fraction of all goods purchased. This increase in the relative expenditure weight allocated to medical care would, in turn, cause the growth in medical costs to have a larger impact on the growth of the index. A higher index would produce a higher COLA, which would both compensate for the higher health care costs and allow non-health-care spending to remain unchanged.

FIGURE 4. AVERAGE ANNUAL INCREASE IN MEDICARE PART B PREMIUM AND AVERAGE SOCIAL SECURITY COLA, 1980-2014 AND 2000-2014



Sources: Centers for Medicare and Medicaid Services (2015a); and U.S. Social Security Administration (2015c).

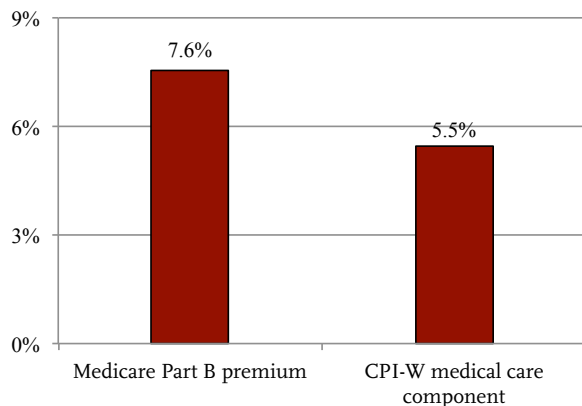
TABLE 1. INCOME-RELATED MEDICARE PART B PREMIUMS

	Income thresholds				
	<\$85,000	\$85,000-\$107,000	\$107,000-\$160,000	\$160,000-\$214,000	>\$214,000
Single	<\$85,000	\$85,000-\$107,000	\$107,000-\$160,000	\$160,000-\$214,000	>\$214,000
Married	<\$170,000	\$170,000-\$214,000	\$214,000-\$320,000	\$320,000-\$428,000	>\$428,000
2015	\$104.90	\$146.90	\$209.80	\$272.70	\$335.70
2016 - Held harmless	104.90				
2016 - Not held harmless	159.30	223.00	318.60	414.20	509.80
Premium level	Standard premium	1.4 x standard premium	2.0 x standard premium	2.6 x standard premium	3.2 x standard premium

Sources: Centers for Medicare and Medicaid Services (2015a, b).

The problem is that the system is less than perfectly indexed for three reasons. The first is that the increase in the Part B premium is not tied to the medical care component of the CPI-W, but rather is based on cost projections built up from assumptions about general price inflation, excess medical inflation, changes in utilization of services, and changes in the complexity of services. Based on these cost projections, premiums are then set so that they account for 25 percent of required Part B revenues. Over the period 1980-2014, the premiums increased at an average annual rate of 7.6 percent while the medical care component of the CPI-W rose by only 5.5 percent (see Figure 5).

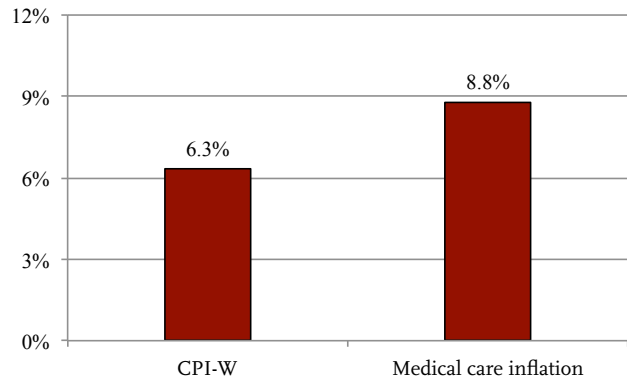
FIGURE 5. AVERAGE ANNUAL INCREASE IN MEDICARE PART B PREMIUM AND IN MEDICAL CARE COMPONENT OF CPI-W, 1980-2014



Sources: Centers for Medicare and Medicaid Services (2015a) and U.S. Bureau of Labor Statistics (2015b).

The second factor is that the CPI-W does not increase the fraction of the market basket attributable to medical care costs on a timely basis.<sup>8</sup> That is, as medical care costs grow faster than the prices of other goods, they should account for a larger fraction of all goods purchased. While the weights used for medical care in the CPI-W have increased, the weights fail to fully reflect the impact of medical care inflation (see Figure 6). When the weights are not fully adjusted, reported inflation is less than it should be and the COLA is inadequate to cover previous medical care and non-medical care spending.

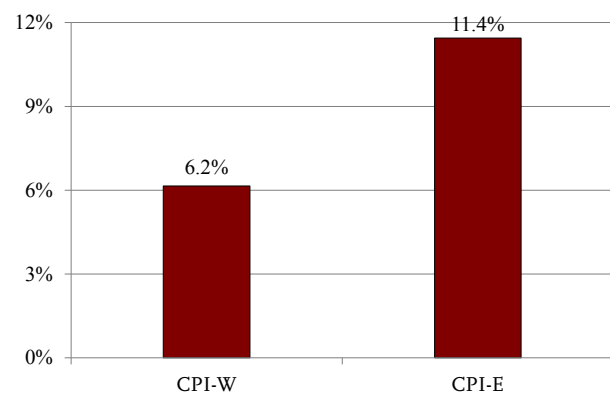
FIGURE 6. ACTUAL 2014 RELATIVE EXPENDITURE WEIGHT FOR MEDICAL CARE IN CPI-W AND THAT BASED ON MEDICAL CARE INFLATION 1980-2014



Sources: Authors' calculations from U.S. Bureau of Labor Statistics (2015b, c).

Third, even if the weights in the CPI-W were kept up to date for the population as a whole, the COLA would not fully protect the spending of the elderly. According to an experimental price index, developed by the U.S. Bureau of Labor Statistics, that covers people age 62 and older (the CPI-E), the elderly allocate roughly twice as much of their budget to medical care as the population as a whole (see Figure 7). Thus, using an index for the whole population does not compensate the elderly for the extra dollars they need to pay for their medical costs, forcing them to cut back on their non-medical-care spending.

FIGURE 7. RELATIVE IMPORTANCE OF MEDICAL CARE IN THE CPI-W AND THE CPI-E, 2013



Source: U.S. Bureau of Labor Statistics (2014a, b).

The implication of these three deviations from perfect indexing is that the rapid increase in Part B premiums has an adverse effect on the ability of the elderly to maintain their overall living standard.

## Conclusion

Social Security is an extremely valuable source of retirement income. It is payable for life and benefits are adjusted to keep pace with inflation. No COLA is expected to be paid in 2016 because the CPI-W in the third quarter of 2015 will likely fall below the level in the third quarter of 2014.

The anticipated lack of a COLA has caused a flap in the Medicare program because higher Medicare Part B premiums cannot be passed on to most beneficiaries when they do not get a raise in their Social Security benefits. This flap also highlights the complicated interaction between Medicare premiums, which are deducted automatically from Social Security benefits, and the *net* benefit. Because the system is not perfectly indexed, rapidly rising Medicare premiums undermine the ability of the elderly to maintain their non-medical-care spending

In short, even Social Security does not fully insulate older households from the erosive impact of inflation, and this concern is serious given that other sources of retirement income offer virtually no inflation protection.

## Endnotes

1 In calculating workers' initial benefits, past earnings are indexed not to inflation but to past earnings in the economy so that Social Security benefits keep pace with wage growth over time and the replacement rate (benefits as a percentage of pre-retirement earnings) remains stable.

2 Indeed, this was the case with the U.S. Social Security program from its origin in 1935 until 1975 when automatic indexing was adopted.

3 Extensive background information on the Social Security COLA is available online at: <http://ssa.gov/news/cola>.

4 Part D enrollees may elect to waive this deduction and pay their premiums via other mechanisms.

5 At the inception of Medicare in 1966, the Part B premium was set to cover 50 percent of the per capita costs of the program. Legislation in 1972 linked increases in the Part B premium to Social Security's annual COLA. In several years during the 1980s, Congress overruled this legislation and voted to make the Part B premium 25 percent of the per capita costs of the program. In the early 1990s, the Omnibus Budget Reconciliation Acts of 1990 and 1993 set the premium at 25 percent of the program's costs through 1998. Finally, the Balanced Budget Act of 1997 permanently set the Part B premium at 25 percent of the program's per capita costs. See Davis (2014) for a more detailed history of the Part B premium.

6 In April 2015, Congress passed The Medicare Access and CHIP Reauthorization Act of 2015. This legislation included provisions to increase Medicare premiums for some higher-income beneficiaries. Beginning in 2018, individuals with income between \$133,501-160,000 will shift from paying 2 times the standard premium to 2.6 times the standard premium. All individuals currently paying 2.6 times the standard premium (those with incomes between \$160,000-214,000) will pay 3.2 times the standard premium under the new law.

7 In 2009, the House passed a bill that eliminated higher premiums for everyone, but the bill never made it through the Senate. So those not protected under the "hold-harmless" provision did see their premiums rise, with the standard premium increasing from \$94.40 in 2009 to \$110.50 in 2010 and \$115.40 in 2011.

8 The CPI has a three-year lag in adjusting its relative expenditure weights (U.S. Bureau of Labor Statistics 2010). For example, expenditures reported in 2011 and 2012 updated to December 2013 became the basic weights for use in the CPI from January 2014 to December 2015.

## References

- Centers for Medicare and Medicaid Services. 2015a. *Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. Washington, DC: Government Printing Office.
- Centers for Medicare and Medicaid Services. 2015b. "Medicare 2015 Costs at a Glance." Washington, DC: Department of Health and Human Services.
- Davis, Patricia A. 2014. *Medicare: Part B Premiums*. CRS Report R40082. Washington, DC: Congressional Research Service.
- U.S. Bureau of Labor Statistics. 2010. *Measuring Price Change for Medical Care in the CPI*. Washington, DC.
- U.S. Bureau of Labor Statistics. 2014a. *Relative Importance of Components in the Consumer Price Indexes: U.S. City Average, December 2013*. Washington, DC.
- U.S. Bureau of Labor Statistics. 2014b. *Unpublished Relative Importance of Components in the Experimental Consumer Price Index for Americans 62 Years of Age and Older: U.S. City Average, December 2013*. Washington, DC.
- U.S. Bureau of Labor Statistics. 2015a. *Consumer Price Index: Wage and Clerical Workers*. Washington, DC.
- U.S. Bureau of Labor Statistics. 2015b. *Consumer Price Index-Medical Care: Wage and Clerical Workers*. Washington, DC.
- U.S. Bureau of Labor Statistics. 2015c. *Relative Importance of Components in the Consumer Price Indexes: U.S. City Average, December 2014*. Washington, DC.
- U.S. Social Security Administration. 2015a. *Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Disability Insurance Trust Funds*. Washington, DC: U.S. Government Printing Office.
- U.S. Social Security Administration. 2015b. "Latest Cost-of-Living Adjustments." Washington, DC.
- U.S. Social Security Administration. 2015c. "Cost-of-Living Adjustments, 1975-2014." Washington, DC.



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*The Center for Retirement Research thanks BlackRock, Capital Group, Citigroup, Fidelity & Guaranty Life, Goldman Sachs, Mercer, National Association of Retirement Plan Participants, Prudential Financial, State Street, and TIAA-CREF Institute for support of this project.*

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