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MEDICARE IN THE RYAN BUDGET

By Paul N. Van de Water

The budget resolution developed by House Budget Committee Chairman Paul Ryan (R-WI) would make significant changes to Medicare. It would replace Medicare's current guarantee of coverage with a premium-support voucher, raise the age of eligibility from 65 to 67, and reopen the "doughnut hole" in Medicare's coverage of prescription drugs. Together, these changes would shift substantial costs to Medicare beneficiaries and (with the simultaneous repeal of health reform) leave many 65- and 66-year olds without any health coverage at all. The plan also would likely lead to the gradual demise of traditional Medicare by making its pool of beneficiaries smaller, older, and sicker — and increasingly costly to cover.

Premium Support

The Ryan budget would replace Medicare's guarantee of health coverage with a flat premium-support payment, or voucher, that beneficiaries would use to purchase either private health insurance or traditional Medicare.¹ Premium support would apply to all new beneficiaries starting in 2023 and to all other beneficiaries who chose to participate.²

Premium Support Shifts Substantial Costs to Beneficiaries

The value of the premium-support payment would initially equal the cost of the second-lowest-cost private health insurance plan in an area or traditional Medicare, whichever is less.³ As a result, the proposal's impact on individual beneficiaries would differ significantly depending on whether traditional Medicare or private plans provided less costly coverage in their particular area of the country. In areas where Medicare incurs relatively high costs, the amount of the premium-support

¹ For a detailed examination of the main issues that premium support raises, see Paul N. Van de Water, *Converting Medicare to Premium Support Would Likely Lead to Two-Tier Health Care System*, Center on Budget and Policy Priorities, September 26, 2011, <http://www.cbpp.org/cms/index.cfm?fa=view&id=3589>. Although Chairman Ryan says the premium-support payments are not "vouchers," they meet the meaning of that term.

² U.S. House of Representatives, Committee on the Budget, *Concurrent Resolution on the Budget—Fiscal Year 2013, Report to Accompany H. Con. Res. 112*, March 26, 2012, p. 97, <http://www.gpo.gov/fdsys/pkg/CRPT-112hrpt421/pdf/CRPT-112hrpt421.pdf>.

³ Paul Ryan, *The Path to Prosperity: A Blueprint for American Renewal*, House Budget Committee, March 20, 2012, p. 52, <http://budget.house.gov/UploadedFiles/Pathtoprosperity2013.pdf>.

payment would equal the cost of a relatively inexpensive private plan, and beneficiaries would have to pay higher premiums to participate in traditional Medicare. In areas with relatively low Medicare spending, beneficiaries who wanted to enroll in a private plan would face higher premiums or fewer benefits, or might find that no private plan was available.

The Ryan budget would limit the growth rate of Medicare spending for new beneficiaries from year to year, starting in 2023, to the growth rate of gross domestic product (GDP) per capita plus one-half percentage point — an amount that will likely fall short of the actual growth of health care costs. The Congressional Budget Office (CBO) projects that under the Ryan budget, federal Medicare expenditures on behalf of an average new beneficiary would be \$400 to \$700 (6 to 11 percent) less in 2023, \$1,200 to \$2,200 (14 to 23 percent) less in 2030, and \$5,900 to \$8,000 (35 to 42 percent) less in 2050 than under current law.⁴ Since under the Ryan budget, Medicare would no longer make payments to health care providers such as doctors and hospitals, *the only way to keep Medicare cost growth within the GDP plus one-half percentage point target would be to limit the annual increase in the amount of the premium-support vouchers*. As a result, the vouchers would purchase less coverage with each passing year, pushing more costs on to beneficiaries. Over time, seniors would have to pay more to keep the health plans and the doctors they like, or they would get fewer benefits.

Most Medicare beneficiaries live on modest incomes and are in no position to pay much more for their health care. The median income of Medicare households is about \$25,000 a year, and only about 15 percent of Medicare households have total household incomes over \$50,000. Medicare households also spend three times as large a percentage of their budgets on out-of-pocket health expenses — 15 percent compared to 5 percent — as non-Medicare households do. The Ryan budget would significantly raise the out-of-pocket health costs for Medicare beneficiaries with modest incomes, even as it proposes huge new tax cuts for the wealthiest Americans.

Chairman Ryan's premium-support proposal would likely impose particularly heavy burdens on low-income beneficiaries in poor health. Although the chairman is not specific, this year's proposal is apparently similar to his version from last year, in which people enrolled in both Medicare and Medicaid under current law (the so-called "dual eligibles") would receive all of their acute health-care benefits through Medicare and would no longer be eligible for supplemental benefits not covered by Medicare and premium and cost-sharing assistance through Medicaid.⁵ Instead, the federal government would establish a medical savings account for each Medicare beneficiary with income up to the poverty line. The account would frequently prove inadequate to cover the additional costs that beneficiaries would face under premium support, however, and the proposal would substantially raise out-of-pocket costs for many dual eligibles.⁶ This year, Ryan says that "lower-income seniors

⁴ Congressional Budget Office, *The Long-Term Budgetary Impact of Paths for Federal Revenues and Spending Specified by Chairman Ryan*, March 2012, p. 8, <http://www.cbo.gov/publication/43023>. The figures cited are in 2011 dollars.

⁵ Under the Ryan budget, low-income seniors and persons with disabilities would apparently continue to be eligible for long-term supports and services through Medicaid, which Chairman Ryan would turn into a federal block grant to states at sharply reduced funding levels. See Edwin Park and Matt Broaddus, *Ryan Medicaid Block Grant Would Cut Medicaid by One-Third by 2022 and More After That*, Center on Budget and Policy Priorities, March 27, 2012, <http://www.cbpp.org/cms/index.cfm?fa=view&id=3727>.

⁶ January Angeles, *Out-of-Pocket Medical Costs Would Skyrocket for Low-Income Seniors and People with Disabilities Under the Ryan Budget Plan*, Center on Budget and Policy Priorities, April 15, 2011, <http://www.cbpp.org/cms/index.cfm?fa=view&id=3473>.

would receive additional assistance to help cover out-of-pocket costs” but provides no details.⁷ Moreover, in the specifications he provided to CBO for analyzing the long-term budgetary impact of his plan, Ryan made no dollar allowance to cover the cost of any “additional assistance.”

Chairman Ryan’s description of his plan as providing “more support for low-income seniors” has led some commentators to assume mistakenly that it does more for such beneficiaries than the current Medicare program — or at a minimum, that it does not make low-income beneficiaries significantly worse off. In fact, if the proposal is like the chairman’s previous one with respect to its treatment of dual eligible beneficiaries, it would lead to substantial cuts in support for low-income elderly and disabled individuals, especially those who are the sickest. “More support” simply means that low-income Medicare beneficiaries would receive more assistance than higher-income-Medicare beneficiaries do — something that has been true in Medicare for some time. Ryan glosses over the fact that such assistance would likely total less than what such beneficiaries receive today.

Correcting False Claims about Premium Support

Chairman Ryan makes several dubious claims to support his budget proposal. First, he claims that competition among private plans would control costs, noting that the Medicare Part D drug benefit, which private insurers provide, has cost less than CBO and the Medicare actuary expected. But this claim is misleading, since Part D’s reliance on private plans has little or nothing to do with its lower-than-expected costs.⁸ Prescription drug spending growth slowed sharply *throughout the U.S. health care system* just as Part D got up and running. That’s because fewer blockbuster drugs were coming to market, major drugs were going off-patent, and consumers were using more generic drugs. Overall U.S. prescription drug spending was about 35 percent lower in 2010 than Medicare’s Office of the Actuary projected back in 2003. Part D enrollment was also significantly lower than expected, reducing costs further. In fact, there is strong evidence that using private plans to deliver the Medicare drug benefit has actually *raised* Medicare’s costs. Private insurers providing Medicare Part D benefits have been unable to negotiate discounts from manufacturers for drugs used by dual eligibles as good as the rebates that Medicaid previously required. In fact, CBO estimates that requiring manufacturers to pay Medicaid-level discounts for drugs prescribed to low-income Medicare beneficiaries would reduce Medicare Part D costs by \$137 billion over the next ten years. And, contrary to Ryan’s claims, CBO’s analysis of his previous premium-support proposal found that replacing traditional Medicare with private insurance would raise total health care costs per beneficiary, because private insurance has higher provider payments and administrative costs.

Second, Chairman Ryan claims that his proposal “ensur[es] that traditional Medicare remains an option.” Unfortunately, that’s not the case. Under premium support, traditional Medicare would tend to attract a less healthy pool of enrollees, while private plans would attract healthier enrollees (as occurs today with Medicare and private Medicare Advantage plans). Although the proposal calls for “risk adjusting” payments to health plans — that is, adjusting them to reflect the average health status of their enrollees — the risk adjustment process is highly imperfect and captures only part of the differences in costs across plans that stem from differences in the health of enrollees.

⁷ House Committee on the Budget, *Report*, p. 97.

⁸ Edwin Park, *Lower-than-Expected Medicare Drug Costs Reflect Decline in Overall Drug Spending and Lower Enrollment, Not Private Plans*, Center on Budget and Policy Priorities, May 6, 2011, <http://www.cbpp.org/cms/index.cfm?fa=view&id=3488>.

Inadequate risk adjustment would mean that traditional Medicare would be only *partially* compensated for its higher-cost enrollees, which would force Medicare to raise beneficiary premiums to make up the difference. The higher premiums would lead more of Medicare's healthier enrollees to abandon it for private plans, very possibly setting off a spiral of rising premium costs and falling enrollment for traditional Medicare. Over time, traditional Medicare would become less financially viable and could unravel — *not* because it was less efficient than the private plans, but because it was competing on an unlevel playing field in which private plans captured the healthier beneficiaries and incurred lower costs as a result. Ryan also would allow private plans to tailor their benefit packages to attract healthier beneficiaries and deter sicker ones, which only makes this outcome more likely.

Third, Chairman Ryan says that his proposal would not affect people age 55 and older, but this claim would likely turn out untrue. As fewer new beneficiaries enrolled in traditional Medicare when they reached the eligibility age, the population in traditional Medicare would gradually get older, sicker, fewer in number, and much more expensive per person to cover. Moreover, as the size of the Medicare population shrank, administrative costs would rise relative to benefit payments, traditional Medicare's power to demand lower payment rates from providers would erode, and providers would have less incentive to participate in the program. As a result, people now age 55 and older might well face higher premiums and cost sharing for traditional Medicare, a more limited choice of providers, or both.

Raise the Age of Eligibility for Medicare

Starting in 2023, the Ryan budget would raise the eligibility age for Medicare — now 65 — by two months per year until it reaches age 67 in 2034. At the same time, the plan would repeal health reform's coverage provisions. Consequently, 65- and 66-year olds would have *neither* Medicare *nor* access to health insurance exchanges in which they could buy coverage at an affordable price and receive subsidies to help them secure coverage if their incomes are low. This change would drive 65- and 66-year olds who don't have employer-sponsored coverage into a poorly regulated individual insurance market that charges older individuals extremely high premiums. People of limited means would be affected most harshly because they would not be able to afford private coverage. In addition, 65- and 66-year olds with a pre-existing medical condition often would not be able to purchase coverage at any price. As a result, many 65- and 66-year olds would find themselves without health insurance coverage.

In addition, raising Medicare's eligibility age would not only fail to constrain health care costs across the economy; it would raise them.⁹ Medicare provides health coverage more cheaply than private health insurance plans because it has lower administrative costs and pays less to providers. Raising the Medicare age would shift costs to most of the 65- and 66-year olds who would lose Medicare coverage, to remaining Medicare beneficiaries, to employers that provide coverage for their retirees, and to states. These cost increases would, in total, more than offset the savings to the federal government. Moreover, by further shrinking Medicare's share of the health insurance market, raising Medicare's eligibility age would reduce its market power and weaken its ability to serve as a leader in controlling health care costs in the future.

⁹ Paul N. Van de Water, *Raising Medicare's Eligibility Age Would Increase Overall Health Spending and Shift Costs to Seniors, States, and Employers*, Center on Budget and Policy Priorities, August 23, 2011, <http://www.cbpp.org/cms/index.cfm?fa=view&id=3564>.

Repeal Improvements in Medicare Benefits

The Ryan budget would repeal health reform's provisions that improve Medicare benefits, including closure of the Medicare prescription drug doughnut hole and coverage of preventive services without cost sharing. These repeals would adversely affect current Medicare beneficiaries as well as those not yet eligible.

Health reform has begun to close the doughnut hole — the gap in Medicare prescription drug coverage that many seniors experienced once their annual drug costs exceeded \$2,840. Before health reform, seniors had no additional coverage until their costs hit \$6,448. Last year, seniors who were in the coverage gap received a 50-percent discount on brand-name drugs and a 7-percent discount on generic prescription drugs. This year, the generic discount jumps to 14 percent. Due to these improvements, five million Medicare beneficiaries have saved more than \$3.2 billion, according to the Department of Health and Human Services (HHS). Health reform will close the entire donut hole by 2020. The Ryan budget would reopen it.

Health reform requires both private insurance companies and Medicare to cover preventive care services without any cost sharing. Preventive care includes screenings for chronic illnesses like diabetes and cancer and routine vaccines. As a result, 32.5 million Medicare beneficiaries received preventive health care services last year at no extra cost, according to HHS. The Ryan budget would reinstate cost sharing in Medicare for these preventive benefits.

Sustainable Growth Rate (SGR) Formula

The Ryan budget establishes a “reserve fund” that would allow Congress to repeal the cuts required by Medicare's sustainable growth rate (SGR) formula for physicians in a deficit-neutral manner. It does not, however, specify how policymakers would offset the ten-year, \$300-billion cost. If Congress does not find a way to do so, the Ryan budget assumes that the SGR cuts will take effect.

Enacted as part of the 1997 Balanced Budget Act, the SGR formula determines how much Medicare pays for services that physicians provide.¹⁰ Under the SGR, cumulative Medicare spending on physicians' services is supposed to follow a target path that depends on the rates of growth in physicians' costs, Medicare enrollment, and real GDP per person. If spending exceeds the SGR target for a year, then Medicare's payments to physicians for each service they provide are supposed to shrink in the following year to move total spending back toward the target path.

Since 2003, Congress has regularly prevented the full cuts that the SGR required from taking effect, although it has not changed the underlying SGR formula or the cumulative spending targets, which remain in law. Because the SGR's designers greatly underestimated the increase in the volume and complexity of doctors' services, the formula requires cuts in physician payments that become more severe with each passing year. In 2013, the SGR calls for reducing physician payments rates by about 28 percent, though Congress is expected to prevent this cut from taking effect.

¹⁰ Paul N. Van de Water, *The Sustainable Growth Rate Formula and Health Reform*, Center on Budget and Policy Priorities, April 21, 2010, <http://www.cbpp.org/cms/index.cfm?fa=view&id=3166>.

The SGR approach is fundamentally flawed because it tries to limit Medicare spending for physicians' services by restraining payment rates *without* limiting the growth in the volume and complexity of services. The Medicare Payment Advisory Commission (MedPAC) sums up the problems this way: the SGR formula “does not provide incentives for individual physicians to control volume growth, and is inequitable to those physicians who do not increase volume unnecessarily. And it continues to call for substantial negative updates through at least 2016. Such reductions in physician payment rates, if they take place, would threaten beneficiaries' access to physician services.”¹¹

The fiscal 2013 budget resolution that House Democrats have proposed also contains a deficit-neutral reserve fund that would allow for fixing the flawed SGR formula.¹² Like the Ryan budget, it does not specify how policymakers would pay for an SGR fix. It starts from a higher level of Medicare spending than the Ryan budget, however, allowing more room to offset an SGR fix with other Medicare cuts.

Other Provisions

The Ryan budget includes a few other provisions relating to Medicare.

It would apparently allow the 2-percent “sequestration” cuts in Medicare that the 2011 Budget Control Act (BCA) requires for 2013 through 2021 to take effect. The BCA established a Joint Select Committee on Deficit Reduction to propose legislation reducing deficits by \$1.2 trillion over the 2012-2021 period and established a backup sequestration procedure. Because the Joint Committee failed to achieve its goal, sequestration — a form of automatic cuts that apply largely across-the-board — is scheduled to occur starting in January 2013 and run through 2021. The BCA limits the Medicare sequestration to 2 percent each year, with that target reached through cuts in payments to health care providers and private Medicare Advantage plans. This means that Medicare providers will continue to bill Medicare in the normal way, but Medicare will reimburse them at a rate of 98 cents on the dollar. In contrast, the Administration proposes to adopt other budgetary changes to replace the scheduled sequestration of Medicare and other programs.

The Ryan budget also would raise Medicare's income-related premiums. Currently, most Medicare beneficiaries pay premiums for Parts B and D (which cover physician services and prescription drugs, respectively) that represent about one-quarter of program costs. The standard Part B premium is \$99.00 a month in 2012, but beneficiaries with incomes above \$85,000 (twice that amount for couples) must pay an extra amount that ranges from \$40.00 to \$219.80 a month. Starting this year, high-income beneficiaries also must pay more for their Medicare prescription drug benefit. The income thresholds are the same as for the income-related Part B premium, and the additional premium amounts range from \$11.60 to \$66.40 a month. Under current law, the dollar thresholds for the income-related premiums are frozen through 2019 and adjusted annually for inflation after that. The Administration has proposed raising the income-related premiums by 15

¹¹ MedPAC, *Report to the Congress: Improving Incentives in the Medicare Program*, June 2009, p. 253.

¹² *Amendment in the Nature of a Substitute to H. Con. Res. 112 offered by Mr. Van Hollen of Maryland*, section 204, <http://www.rules.house.gov/amendments/VANHOL033Final32612180235235.pdf>.

percent and freezing the income thresholds until 25 percent of Medicare beneficiaries are subject to the income-related premiums, and the Ryan proposal is similar.

The Ryan budget also would repeal the Independent Payment Advisory Board (IPAB) — a presidentially appointed commission that health reform created to help slow the growth of Medicare costs if those costs are projected to exceed a specified target level.¹³ Other cost-control measures included in health reform will likely produce most or all of the savings needed to meet the spending targets, but IPAB serves as an important backstop to contain costs if these measures prove inadequate. Chairman Ryan incorrectly describes IPAB as a “rationing board.”¹⁴ In fact, health reform specifically prohibits the board from rationing health care, raising Medicare premiums or cost sharing, or restricting eligibility. It must focus exclusively on proposals to generate savings in the payment and delivery of health care services — not shifting costs to beneficiaries, as the Ryan budget would do.

Finally, to pay for repealing IPAB, the Ryan budget would impose limits on medical malpractice litigation along the lines of H.R. 5, which the House passed on March 22. H.R. 5 would cap awards for punitive damages and require that a claimant initiate a claim within a year after he or she discovers or should have discovered an injury. CBO estimates that these changes would lower costs for Medicare and other health programs by reducing premiums for medical malpractice insurance and reducing the use of health care services by medical providers when faced with less pressure from medical malpractice suits.¹⁵ Critics argue that these savings would come at the expense of those harmed by medical negligence, who would no longer be able to obtain full compensation for their injuries.¹⁶

¹³ Paul N. Van de Water, *Independent Payment Advisory Board Will Help Reduce Health Costs*, Center on Budget and Policy Priorities, March 15, 2012, <http://www.cbpp.org/cms/index.cfm?fa=view&id=3702>.

¹⁴ Ryan, *The Path to Prosperity*, p. 55.

¹⁵ Congressional Budget Office, *Cost Estimate, H.R. 5, Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011, as ordered reported by the House Committee on the Judiciary on February 16, 2011*, March 10, 2011, <http://www.cbo.gov/publication/22053>.

¹⁶ Congressional Budget Office, *Reducing the Deficit: Spending and Revenue Options*, March 2011, pp. 35-6.