Center on Budget and Policy Priorities

820 First Street NE, Suite 510
Washington, DC 20002

Tel: 202-408-1080
Fax: 202-408-1056

center@cbpp.org
www.cbpp.org

March 15, 2013

Medicare in Ryan's 2014 Budget

By Paul N. Van de Water

The Medicare proposals in the 2014 budget resolution developed by House Budget Committee Chairman Paul Ryan (R-WI) are essentially the same as those in last year's Ryan budget. Once again, Chairman Ryan proposes to replace Medicare's guarantee of health coverage with a premium-support voucher and raise the age of eligibility for Medicare from 65 to 67. 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.

The Ryan budget would cut Medicare spending by $356 billion over the 2013 – 2023 period compared to CBPP's current-policy baseline. It would save $129 billion by repealing the Medicare benefit improvements in health reform (including closure of the prescription drug "donut hole"), limiting medical malpractice awards, and raising income-tested premiums. Ryan's budget also includes $138 billion in scheduled cuts from Medicare's sustainable growth rate formula for physicians and $89 billion in Medicare cuts from sequestration.

Converting Medicare to 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 a form of traditional Medicare.[1] Premium support would apply to all new beneficiaries starting in 2024 and to all other beneficiaries who chose to participate.[2]

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. 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 payment would equal the cost of a relatively inexpensive private plan, and beneficiaries would have

[1] For a detailed examination of the issues raised by premium support, 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.

[2] Paul Ryan, *The Path to Prosperity: A Responsible, Balanced Budget*, House Budget Committee, March 12, 2013, http://budget.house.gov/uploadedfiles/fy14budget.pdf.

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 2024, 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.[3] In its analysis of the similar premium support proposal in last year's Ryan budget, the Congressional Budget Office (CBO) projected that federal Medicare expenditures on behalf of an average new beneficiary would be $400 to $700 (6 to 11 percent) less than under current law in the proposal's first year, $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.[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 target of GDP growth plus one-half percentage point 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 not in a position to pay much more for their health care. The median income of Medicare beneficiaries is $25,000 a year (including their spouse's income), and only about 15 percent of Medicare beneficiaries have incomes over $50,000. Medicare households also spend three times as large a percentage of their budgets on out-of-pocket health expenses as non-Medicare households do — 15 percent compared to 5 percent. The Ryan budget would significantly raise the out-of-pocket health costs for Medicare beneficiaries with modest incomes, even as it proposes very large new tax cuts for the wealthiest Americans.

Premium support 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 2011, 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 or 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

---

[3] The House Budget Committee has provided conflicting descriptions of the proposed limit on Medicare growth. The document issued by the committee on March 12 states that "the per-capita cost once the [premium support] program has begun could not exceed nominal GDP growth plus 0.5 percent." (*The Path to Prosperity,* p. 39.) At the committee mark-up on March 13, however, staff indicated that the limit would apply to total program growth.

[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. CBO has indicated that it will not be able to update this analysis until it has revised its long-term budget projections later this year.

[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 substantially reduced funding levels. See Edwin Park, "Ryan Budget Again Includes a Medicaid Block Grant That Would Add Millions to the Ranks of the Uninsured and Underinsured," *Off the Charts Blog*, March 15, 2013.

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]

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.

Inadequate risk adjustment would mean that traditional Medicare would be only *partially* compensated for its higher-cost enrollees, which would force it to raise 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 consequence. The Ryan plan 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.

Chairman Ryan says that his proposal would not affect people age 55 and older, but this claim, too, is unlikely to be true. As fewer new beneficiaries enrolled in traditional Medicare, 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.

Raising the Age of Eligibility

Starting in 2024, the Ryan budget would raise the eligibility age for Medicare — now 65 — by two months per year until it reaches age 67 in 2035. 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

[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.

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.

Repealing Improvements in Medicare Benefits

The Ryan budget would repeal health reform's provisions that improve Medicare benefits, including closure of the Medicare prescription drug donut hole and coverage of preventive services without cost sharing.[7] These repeals would adversely affect current Medicare beneficiaries as well as those not yet eligible.

Health reform has begun to close the donut 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. Starting in 2011, seniors in the coverage gap began receiving a discount on brand-name and generic prescription drugs. These discounts and Medicare coverage will gradually increase until 2020, when the entire donut hole is closed. The Ryan budget would reopen the drug donut hole.

Health reform also 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. The Ryan budget would reinstate cost sharing in Medicare for these preventive benefits.

Limiting Malpractice Awards

The Ryan budget would impose limits on medical malpractice litigation along the lines of H.R. 5, which the House passed on March 22, 2012. H.R. 5 would have capped awards for punitive damages and required that a claimant initiate a claim within a year after he or she discovers or should have discovered an injury, whichever is earlier.

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 (since medical providers, facing less pressure from malpractice suits, would order fewer unnecessary services).[8] 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.[9]

---

[7] U.S. House of Representatives, Committee on the Budget, *Medicare Questions*, http://budget.house.gov/fy2014/medicarequestions.htm, accessed March 13, 2013.

[8] 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.

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

Raising Income-Related Premiums

The Ryan budget 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 $104.90 a month in 2013, but beneficiaries with incomes above $85,000 (twice that amount for couples) must pay an extra amount that ranges from $42.00 to $230.80 a month.

High-income beneficiaries also must pay more for their Medicare prescription drug benefit, with the same income thresholds as for the income-related Part B premium. The additional premium amounts for the drug benefit range from $11.60 to $66.60 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 percent and freezing the income thresholds until 25 percent of Medicare beneficiaries are subject to the income-related premiums. The Ryan budget says its proposal in this area is similar to the Administration's but provides no further detail.

Retaining the Sustainable Growth Rate 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, $138-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 underestimated the increase in the volume and complexity of doctors' services, the formula requires deep cuts in physician payments. In 2014, the SGR calls for reducing physician payments rates by about 25 percent, though Congress is expected to prevent this cut from taking effect. The Medicare Payment Advisory Commission (MedPAC), Congress' expert advisory body on Medicare payment policy, finds that "Such reductions in physician payment rates, if they take place, would threaten beneficiaries' access to physician services."[11]

---

[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.

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

Retaining Sequestration

The Ryan budget retains the 2-percent "sequestration" cuts in Medicare that the 2011 Budget Control Act (BCA) requires for 2013 through 2021 (it would repeal the sequestration cut in defense spending). 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 — takes effect in March and April 2013 and is scheduled to run through 2021.

The BCA limits the Medicare sequestration cut to 2 percent each year, to be achieved 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 sequestration of Medicare and other programs.