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## RYAN-RIVLIN PLAN WOULD END GUARANTEED MEDICARE, SHIFT MEDICAID COSTS TO STATES AND BENEFICIARIES

By Paul N. Van de Water

Rep. Paul Ryan (R-WI), chair of the House Budget Committee, and Alice Rivlin, former director of the Congressional Budget Office and the Office of Management and Budget, issued a proposal in November that would make deep reductions in Medicare and Medicaid benefits and fundamentally alter the nature of those programs.<sup>1</sup> The proposal differs in some respects but is similar in others both to Rep. Ryan's *Roadmap for America's Future* and the health care recommendations of the Rivlin-Domenici Bipartisan Policy Center Task Force.<sup>2</sup>

Under the Ryan-Rivlin proposal, Medicare beneficiaries would no longer have access to a guaranteed set of health benefits but would instead receive a voucher to be used to purchase private health insurance. Similarly, the federal government would no longer pay a specified share of states' Medicaid costs but would pay each state only a fixed amount, or block grant. The amount of the Medicare voucher and the Medicaid block grant would grow less rapidly than costs and hence would become increasingly inadequate over time. The proposal would also repeal the Community Living Assistance Services and Support (CLASS) Act — a new, voluntary long-term care insurance program that fills an important gap in the social safety net. These changes would profoundly impair health care coverage for the elderly, people with disabilities, and people with low incomes.

### Eliminating Traditional Medicare for People Now Age 55 or Under

For people who are now age 55 or under, the Ryan-Rivlin proposal would eliminate traditional fee-for-service Medicare, replace the program with vouchers, and raise the age at which people become eligible for the program. For those now over 55, who would stay in traditional Medicare, the Ryan-

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<sup>1</sup> Alice Rivlin and Paul Ryan, *A Long-Term Plan for Medicare and Medicaid*, November 17, 2010, <http://paulryan.house.gov/UploadedFiles/rivlinryan.pdf>. Rivlin and Ryan presented their proposal to the National Commission on Fiscal Responsibility and Reform, of which they were members. The commission did not adopt the proposal.

<sup>2</sup> For an analysis of Rep. Ryan's *Roadmap*, see Paul N. Van de Water, *The Ryan Budget's Radical Priorities*, Center on Budget and Policy Priorities, July 7, 2010, <http://www.cbpp.org/files/3-10-10bud-rev7-7-10.pdf>. For an analysis of the Rivlin-Domenici proposal, see James Horney, Paul N. Van de Water, and Robert Greenstein, *Rivlin-Domenici Deficit Reduction Plan Is Superior to Bowles-Simpson in Most Areas, But Health Proposal Is Very Troubling*, Center on Budget and Policy Priorities, November 30, 2010, <http://www.cbpp.org/files/11-30-10bud.pdf>.

Rivlin proposal would increase the amount of cost-sharing that most beneficiaries are required to pay for covered health services.

### *Eliminating Traditional Fee-for-Service Medicare*

Although Ryan and Rivlin have not fully specified the details of their Medicare proposal, it is similar to Rep. Ryan's *Roadmap for America's Future*. Traditional Medicare would be gradually phased out. People who turn 65 in 2021 and later would no longer have access to a guaranteed set of benefits from participating health care providers. Instead, they would receive a voucher to help them purchase private health insurance in a new Medicare Exchange. The amount of the voucher would be adjusted by income, with higher-income beneficiaries receiving a reduced payment.<sup>3</sup> Beneficiaries with incomes over \$80,000 (\$160,000 for a couple) would receive a voucher for half the basic amount or less.

The value of the basic voucher in 2021 and later years would be set equal to the average cost of benefits for a Medicare enrollee back in 2012 (net of premiums), increased by the annual rate of growth of gross domestic product (GDP) per capita plus one percentage point. This formula would likely produce little budgetary savings, at least initially, since the recent health reform legislation (the Affordable Care Act, or ACA) already limits the growth of Medicare spending per beneficiary to the rate of growth of GDP per capita plus one percentage point starting in 2018.<sup>4</sup>

Nonetheless, for several reasons, many beneficiaries would find that their voucher would not allow them to purchase a package of benefits comparable to that which Medicare now provides. First, privatizing Medicare (as the proposal would do) would tend to *raise* health costs, since traditional Medicare generally pays less to providers and incurs lower administrative expenses than private insurance. When the new arrangement begins in 2021, a 65-year-old would receive a voucher worth around \$6,000 (in 2011 terms), but private insurance is likely to cost significantly more than that amount plus current Medicare premiums, which average about \$1,700 a year. As a result, according to the Congressional Budget Office, "Voucher recipients would probably have to purchase less extensive coverage or pay higher premiums than they would under current law."<sup>5</sup>

Second, insurers would be allowed to charge older and sicker Medicare beneficiaries higher premiums. Medicare would endeavor to adjust each person's already inadequate voucher annually to reflect his or her health status, with those in poorer health receiving a larger voucher and those in better health getting a smaller one.<sup>6</sup> But since risk adjustment is highly imperfect, the adjustments to the voucher are likely to be insufficient to cover the higher premiums that insurers would charge to sicker people. In addition, insurers would surely attempt to shun enrollees in poor health (who cost

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<sup>3</sup> The means-testing of the voucher amount is apparently intended to replace the means-tested Medicare premiums in current law.

<sup>4</sup> Section 3403 of the Affordable Care Act creates an Independent Payment Advisory Board, which will make recommendations to limit the rate of growth of Medicare spending per beneficiary to specified rates. The board's recommendations will go into effect automatically unless Congress passes an alternative version that achieves the same amount of savings. Starting in 2018, the target growth rate equals the rate of growth of GDP per capita plus one percentage point, although the amount of the reduction the board may require is limited to 1.5 percent of projected Medicare spending in any year.

<sup>5</sup> Douglas W. Elmendorf, Director, Congressional Budget Office, Letter to the Honorable Paul D. Ryan, November 17, 2010, [http://www.cbo.gov/ftpdocs/119xx/doc11966/11-17-Rivlin-Ryan\\_Preliminary\\_Analysis.pdf](http://www.cbo.gov/ftpdocs/119xx/doc11966/11-17-Rivlin-Ryan_Preliminary_Analysis.pdf).

<sup>6</sup> Rivlin and Ryan, *A Long-Term Plan for Medicare and Medicaid*.

much more), as private plans do today in the Medicare Advantage program.

Third, the Ryan-Rivlin proposal sets no specific benefit standards for the private plans offered in the Medicare Exchange. The plans would therefore likely vary widely, presenting a potentially bewildering set of choices to many people who are very old or frail. Seniors and people with disabilities would receive only whatever benefits they could afford to purchase with their voucher and personal resources.

Finally, low-income individuals eligible for both Medicare and Medicaid would no longer receive help with their Medicare premiums and cost-sharing through Medicaid. Instead they would be given a lump-sum amount in a medical savings account to pay for their out-of-pocket costs, and the lump-sum amount would initially be set at a level *below* what would be needed to pay for all of their premiums and potential cost-sharing. That would mean that some of the most vulnerable low-income Medicare beneficiaries who are the sickest and incur the most health care costs — including poor, frail people who are very old and poor people afflicted with severe disabilities — would be unable to afford needed care. Like the amount of the voucher, the amount of this payment would be increased at the rate of growth of GDP per capita plus one percentage point, which is slower than private health care costs have been rising in recent decades. Since the Medicare cost-containment provisions in the ACA do not apply to private health insurance, the voucher amounts and cost-sharing assistance thus would likely become steadily more inadequate over time.

#### *Increasing Medicare's Eligibility Age*

The Ryan-Rivlin proposal would raise the age of eligibility for the vouchers that would replace Medicare for everyone now age 55 and under. Starting in 2021, the age of eligibility would increase by two months a year from its current level of 65 until it reached 67 in 2032.

Although 65- and 66-year-olds would be eligible to obtain health insurance coverage through the health insurance exchanges that will be established under the health reform law, their costs would increase substantially. An elderly individual with an income of \$43,560 (in 2011 dollars) — the highest income level at which subsidies will be available through the exchanges under the health reform law — would have to pay about \$2,400 *a year more* in premiums than what he or she would pay in Medicare. And many 65- and 66-year-olds who lost Medicare but were *not* eligible for subsidies would end up uninsured because they would not be able to afford coverage in the exchange, which could easily cost \$8,500 or \$9,000 (in 2011 terms) for an elderly individual and twice that for a couple.

Adding 65- and 66-year olds to the health insurance exchanges would also raise premiums for everyone else in the exchanges and jeopardize the success of the health insurance market reforms and the viability of the exchanges themselves. Under the health reform law, insurers in the exchanges may not charge the oldest enrollees more than three times as much as the youngest ones. But the average cost of covering the oldest enrollees is *over five times* the cost of covering the youngest. As premiums for everyone in the exchange rose because of the influx of 65- and 66-year-olds, some of the healthiest unsubsidized participants would drop coverage, which would increase premiums further for everyone else. If this process proceeded very far, the requirement for people to have health insurance and the market reforms would become far more difficult to maintain.

Moreover, if health reform were repealed, as Rep. Ryan favors, increasing Medicare's eligibility age would leave many 65- and 66-year-olds unable to obtain health insurance at *any* price because of

chronic medical conditions that would render them uninsurable. (The Affordable Care Act assures that everyone will have access to coverage at rates that do not depend on their health status.) Even if they could find insurance, their premiums would be extremely high because the ACA's limit on age-rating would no longer apply.

### *Increasing Cost-Sharing in Traditional Medicare*

Starting in 2013, for those who are allowed to remain in traditional Medicare, the Ryan-Rivlin proposal would save \$110 billion over ten years by increasing the amount of cost-sharing that they would have to pay. It would establish a single deductible of \$600 for Medicare-covered services and require beneficiaries to pay 20 percent of all costs above the deductible, while establishing a catastrophic cap (a limit on total out-of-pocket spending) of \$6,000 a year. The proposal would also prohibit Medicare supplemental insurance (Medigap) plans from offering first-dollar coverage and limit Medigap coverage of Medicare cost-sharing.

Although adding a catastrophic limit to Medicare is a much-needed improvement, some of the other proposed changes raise serious concerns. The higher deductibles and coinsurance would increase costs for most beneficiaries, especially for those who experience a hospital stay. (At present, beneficiaries pay a deductible of \$1,132 and no coinsurance for a hospital stay of up to 60 days.) The Medicare benefit package is already much less generous than that of the typical large employer-sponsored health insurance plan, paying an average of only about 74 percent of covered health services.<sup>7</sup> As a result of the proposed increase in cost sharing, many sicker beneficiaries with incomes above 100 percent of the federal poverty line — which is only \$10,890 for an elderly person living alone — would face higher costs and likely have less access to needed care.<sup>8</sup>

As Drew Altman, the highly respected president of the Kaiser Family Foundation, recently explained, many of these modest-income Social Security and Medicare beneficiaries “have low incomes and already pay a significant share of their incomes for health care today. It will be difficult if not impossible to ask the majority of beneficiaries to pay more or make do with less. This has been the missing element in the entitlement/deficit reduction debate: Warren Buffet is not the typical Medicare beneficiary. Instead the prototype is an older woman with multiple chronic illnesses living on an income of less than \$25,000 who spends more than 15 percent of her income on health care. It is the people on these programs and the realities of their lives that have been left out of the discussion.”<sup>9</sup>

### **Converting Medicaid Into a Block Grant**

Starting in 2013, the Ryan-Rivlin proposal would turn federal Medicaid funding into a fixed-amount block grant that would grow less rapidly than health care costs. Currently, the federal government generally picks up between 50 percent and 75 percent of each state's Medicaid costs (57 percent, on

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<sup>7</sup> Dale Yamamoto, *How Does the Benefit Value of Medicare Compare to the Benefit Value of Typical Large Employer Plans?*, Kaiser Family Foundation, September 2008, <http://www.kff.org/medicare/upload/7768.pdf>.

<sup>8</sup> The Qualified Medicare Beneficiary program pays the premiums and cost sharing of beneficiaries with incomes up to the poverty level.

<sup>9</sup> Drew Altman, “The People Behind the Entitlement Debate,” *Pulling It Together*, Kaiser Family Foundation, November 11, 2010, <http://www.kff.org/pullingittogether/People-Behind-The-Entitlement-Debate.cfm>.

average), and the state is responsible for the remainder. Federal Medicaid financing is open-ended: if state Medicaid expenditures increase, the federal government shares in the increased costs. Under a block grant, the federal government would provide each state with a fixed dollar amount and states would be responsible for all remaining Medicaid costs.<sup>10</sup>

Medicaid block grants produce federal budgetary savings by giving states less federal funding each year than they would receive under the current system. Under the Ryan-Rivlin proposal, the amount of the block grant would be adjusted for growth in GDP per capita plus one percentage point and for population growth. This formula could increase the block grant funding by up to 1.5 or 2 percentage points *less* each year than projected cost growth, with the difference compounding over time. The Congressional Budget Office estimates that this change would reduce federal Medicaid funding by \$180 billion through 2020 alone.<sup>11</sup> The cuts in funding would be substantially larger in later years.<sup>12</sup>

### *Shifting Costs to States, Low-Income Beneficiaries, and Providers*

Reduced federal Medicaid funding would significantly shift costs and risks to states, low-income beneficiaries, and health care providers. States would either have to increase their Medicaid spending or, as is much more likely, cut back eligibility, benefits, and payments to providers. Moreover, with a block grant, federal funding would fail to keep pace with unanticipated cost increases stemming from an economic downturn, an epidemic, medical breakthroughs, or other factors. When those developments occurred, states would have to bear 100 percent of the added costs.

Some states may believe that they can make up for the reduction in federal funding by using the greater flexibility the proposed block grant would provide to make their program more cost-effective *without* unduly cutting eligibility, benefits, or provider payments. But the funding cuts would be so large that these hopes would almost certainly prove unrealistic. States would most likely use their additional flexibility to cap Medicaid enrollment and put people on waiting lists once the cap was reached (which they cannot do today), significantly scale back eligibility for millions of low-income children, parents, pregnant women, people with disabilities and seniors — driving many of them into the ranks of the uninsured — or cut services substantially, with the result that many of the nation's poorest and most vulnerable people could become underinsured.

The risks would likely be greatest for poor people with severe disabilities, who often need an extensive array of health services. Indeed, states would likely curtail benefits such as mental health services and therapies, many of which are critically needed by people with disabilities and children with special health care needs. States would also likely significantly raise cost sharing — Medicaid does not generally charge premiums and only requires modest co-payments today — even though research shows that cost-sharing disproportionately deters the use of needed care among people with very low incomes. Finally, states likely would have no choice other than to cut provider payment rates, even though Medicaid already pays providers much lower rates than Medicare or private health insurance. This would reduce beneficiary access by driving providers out of Medicaid and placing additional

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<sup>10</sup> For a detailed analysis of Medicaid block grant proposals, see Edwin Park and Matt Broaddus, *Medicaid Block Grant Would Shift Financial Risks and Costs to States*, Center on Budget and Policy Priorities, February 23, 2011.

<sup>11</sup> Elmendorf, Letter to the Honorable Paul D. Ryan, page 3 of attachment.

<sup>12</sup> In addition, the magnitude of the reduction in funding for state Medicaid programs under this proposal would increase quite substantially after 2020, when the federal funding for the Medicaid expansion called for under the Affordable Care Act would become subject to the overall block grant amount.

pressures on safety-net providers that will have to care for more uninsured people.

In addition, a block grant would leave state budgets highly vulnerable to economic downturns. According to modeling by the Urban Institute, a one-percentage-point increase in the unemployment rate results in a *1 million person increase* in Medicaid enrollment among children and non-elderly adults.<sup>13</sup> During the recent recession, Medicaid enrollment increased by nearly 6 million people (or 14 percent) between December 2007 and December 2009.<sup>14</sup> Under a block grant, states would have to pick up *all* of the recession-related costs of increased enrollment to the extent those costs exceed the state's federal funding cap.

A block grant would also expose states to the risk of unanticipated medical cost growth stemming from public health emergencies, lifesaving medical breakthroughs, and other factors. These cost increases can be substantial. For example, from 1997 to 2002 Medicaid drug spending grew at an annual average rate of 18 percent, mirroring an explosion in drug utilization throughout the health care system. State Medicaid programs also saw unexpected cost increases when the HIV/AIDS epidemic struck in the 1980s and early 1990s. In California, the incidence of new HIV cases increased sharply between 1986 and 1996, with the number more than doubling over a 12-month span between 1992 and 1993. Even under Medicaid's current financing structure, such large cost increases can be difficult for states to absorb; they would pose much greater risks under a block grant, since states would have to absorb all of the cost increases.<sup>15</sup>

### *Undermining Health Reform*

The block grant in the Ryan-Rivlin proposal would also shift more of the cost of the health reform law's Medicaid expansion onto the states. The Affordable Care Act requires states to provide Medicaid coverage to all non-elderly individuals up to 133 percent of the federal poverty line, and the federal government will pick up almost all the costs of newly eligible individuals. About half of the uninsured gaining coverage under the ACA — or 16 million people — would receive it through Medicaid.

Under the Ryan-Rivlin proposal, the federal government would still nominally pay the additional Medicaid costs attributable to health reform through 2020, but it would be very hard for the federal government to require states to cover millions more additional beneficiaries at the same time that it is significantly *cutting* funding to states for their current programs. Moreover, after 2020, funding for the Medicaid expansion would be folded into the block grant and would *not* keep up with health care costs, making the Medicaid expansion simply infeasible.

## **Repealing the New Long-Term Care Insurance Program**

The Ryan-Rivlin proposal would repeal the recently enacted Community Living Assistance Services

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<sup>13</sup> John Holahan and A. Bowen Garrett, *Rising Unemployment, Medicaid and the Uninsured*, Kaiser Commission on Medicaid and the Uninsured, January 2009.

<sup>14</sup> Kaiser Commission on Medicaid and the Uninsured, "Medicaid Enrollment: December 2009 Data Snapshot," September 2010.

<sup>15</sup> Park and Broaddus, *Medicaid Block Grant*.

and Support (CLASS) Act — a new, voluntary long-term care insurance program. CLASS fills a major gap in the safety net. Neither private health insurance nor Medicare covers long-term services and supports (although Medicare does cover care in a skilled nursing facility for up to 100 days following a hospitalization). Private long-term care insurance is available in the individual health insurance market, but policies tend to have high premiums and limited benefits; one large insurer announced recently that it is leaving the market.<sup>16</sup> Many families end up depleting their savings to pay for long-term care and end up turning to Medicaid, which is available to them only after they have become impoverished.<sup>17</sup>

Rep. Ryan has erroneously described CLASS as “a new unfunded entitlement”;<sup>18</sup> in reality, CLASS is designed to be self-sustaining from premiums paid by beneficiaries and interest earnings, and the Congressional Budget Office has determined that it can meet this goal.<sup>19</sup> Health and Human Services Secretary Sebelius recently outlined a series of steps for effective implementation of CLASS, including increasing public awareness of the program, increasing the amount of work required to qualify, closing payment loopholes, indexing premiums for inflation, and tailoring benefits to individual needs.<sup>20</sup> Changes such as these will keep CLASS on a sound financial footing, meeting a major national need in a fiscally responsible way.

## **Conclusion: The Importance of Slowing Cost Growth System-Wide**

Rising health care costs, along with the aging of the population, account for much of the projected long-term federal budget deficits. But it would not be prudent to count on massive additional savings from imposing much tighter limits on the growth in Medicare and Medicaid unless the growth in private health spending can also be slowed. Growth in federal health care costs is *not* driven by factors that are unique to public programs. To the contrary, for 30 years, per-beneficiary spending in Medicare and Medicaid has grown at rates *nearly identical* to those for the overall health care system. And during the past decade, Medicaid costs per beneficiary grew much more slowly than costs for employer-sponsored insurance and costs across the health care system as a whole.<sup>21</sup>

That the rates of growth in costs in the public and private sectors are nearly identical is not surprising. Whether publicly or privately financed, health care is delivered largely by the same health care providers in the same settings and relies on the same procedures and treatments. This basic truth has prompted leading experts from across the political spectrum to warn that policymakers will *not* be able to slow Medicare and Medicaid cost growth substantially without slowing the rate of growth of health-care costs system-wide, unless they are willing to create a two-tier health care system that

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<sup>16</sup> Ron Lieber, “When a Safety Net Is Yanked Away,” *New York Times*, November 12, 2010.

<sup>17</sup> Sheila P. Burke, Judith Feder, and Paul N. Van de Water (eds.), *Developing a Better Long-Term Care Policy: A Vision and Strategy for America's Future*, National Academy of Social Insurance, November 2005.

<sup>18</sup> Rivlin and Ryan, *A Long-Term Plan for Medicare and Medicaid*.

<sup>19</sup> Douglas W. Elmendorf, Director, Congressional Budget Office, Letter to the Honorable George Miller, November 25, 2009, [http://www.cbo.gov/ftpdocs/107xx/doc10769/CLASS\\_Additional\\_Information\\_Miller\\_letter.pdf](http://www.cbo.gov/ftpdocs/107xx/doc10769/CLASS_Additional_Information_Miller_letter.pdf).

<sup>20</sup> Kathleen Sebelius, Remarks prepared for delivery at Kaiser Family Foundation briefing on long-term care, February 7, 2011, <http://www.hhs.gov/secretary/about/speeches/sp20110207.html>.

<sup>21</sup> John Holahan, Lisa Clemans-Cope, Emily Lawton, and David Rousseau, *Medicaid Spending Growth over the Last Decade and the Great Recession, 2000-2009*, Kaiser Commission on Medicaid and the Uninsured, February 2011.

increasingly ration health care based on income. (See box.) Attempting to force big additional cuts in federal health spending *without* requiring comparable measures to restrain the growth of private health-care costs would shift costs and risks to beneficiaries, states, and providers. It would seriously impair the access of Medicare and Medicaid beneficiaries to doctors and hospitals and make health insurance coverage increasingly unaffordable to millions of Americans with modest incomes.

**Experts Agree That Medicare and Medicaid Costs Cannot Be Sharply Reduced Without Cost Reductions in the Overall Health Care System**

“Many analysts would agree that controlling federal costs over the long term will be very difficult without addressing the underlying forces that are also causing private costs for health care to rise.”

— **Douglas W. Elmendorf, Director, Congressional Budget Office,**  
Testimony before the Subcommittee on Health, Committee on Energy and Commerce,  
U.S. House of Representatives, March 10, 2009

“[F]ederal health spending trends should not be viewed in isolation from the health care system as a whole. For example, Medicare and Medicaid cannot grow over the long term at a slower rate than cost in the rest of the health care system without resulting in a two-tier health care system.”

— **David Walker, then Comptroller General of the United States,**  
Testimony before the Committee on the Budget, U.S. House of Representatives,  
February 9, 2005

“[S]ustaining a lower rate of spending growth per capita in Medicare will only happen if there is a comparable rate of spending growth in the private sector.”

— **Gail Wilensky, Senior Fellow, Project Hope,**  
“The Challenge of Medicare,” in *Restoring Fiscal Sanity 2007: The Health Spending Challenge*,  
Alice Rivlin *et al.* (ed.), Brookings Institution Press, 2007