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

April 8, 2014

Medicare in Ryan's 2015 Budget

By Paul N. Van de Water

The Medicare proposals in the 2015 budget resolution from House Budget Committee Chairman Paul Ryan (R-WI) are much the same as those in Ryan's previous budgets. 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 costs to Medicare beneficiaries and (with the simultaneous repeal of health reform) leave many 65- and 66-year-olds without health coverage.

The Ryan budget would cut Medicare spending by $129 billion over the 2015-2024 period, relative to the Congressional Budget Office's (CBO) current-law baseline, by raising Medicare's income-tested premiums, increasing cost sharing, limiting medical malpractice awards, and apparently repealing the benefit improvements in health reform (including closure of the prescription drug "donut hole," described below). Ryan's budget also includes about $140 billion in scheduled cuts from Medicare's sustainable growth rate formula for physicians and about $110 billion in future 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 fee-for-service Medicare.[1] Premium support would apply to all new beneficiaries starting in 2024 and to any other beneficiaries who chose to participate.[2]

Chairman Ryan has provided no specifications for his premium-support proposal, but his staff says that he is considering the "average-bid" model described in a recent CBO report.[3] Under this illustrative option, the value of the premium-support payment in a given region would be based on a weighted average of bids made by participating private plans and traditional Medicare in that region. (The bids would represent the amount that a plan would require to provide Medicare to a beneficiary of average health.) Beneficiaries who chose a plan with an average bid would pay only

[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: Fiscal Year 2015 Budget Resolution*, House Budget Committee, April 1, 2014, pp. 57-60, http://budget.house.gov/uploadedfiles/fy15_blueprint.pdf.

[3] Congressional Budget Office, *A Premium Support System for Medicare: Analysis of Illustrative Options,* September 2013.

the standard Medicare premium. Those who chose a plan with an above-average bid would have to pay a premium that was higher by the full amount of the difference.

The proposal's impact on individual beneficiaries would differ depending on whether traditional Medicare or private plans cost less in their region, but it would disadvantage beneficiaries in at least two ways. First, in many regions, traditional Medicare would cost more than the premium-support voucher, so beneficiaries who chose to enroll in traditional Medicare would have to pay higher premiums than under current law. Second, beneficiaries who enrolled in a private plan would not receive the federally subsidized supplemental benefits that enrollees in private Medicare Advantage plans receive under current law.[4]

Ryan's premium-support proposal would produce little budgetary savings. CBO's illustrative average-bid model places no arbitrary limit on the growth of Medicare spending, although such a limit was part of previous Ryan proposals and could easily be imposed at a later date. CBO estimates that the average-bid model would reduce net Medicare spending by 2 percent when fully phased in, but Ryan's proposal would initially save much less because it would "grandfather" (that is, not apply to) current beneficiaries. Older beneficiaries' ability to opt into the premium-support system if it is financially advantageous for them to do so would further erode the savings.

In CBO's average-bid model, premium support would not apply to people enrolled in both Medicare and Medicaid under current law, but the 2015 Ryan budget does not specify how it would treat these "dual eligibles." Previous Ryan budgets provided that they would receive all of their acute health-care benefits through Medicare and would no longer be eligible for supplemental benefits (except for long-term services and supports) or premium and cost-sharing assistance through Medicaid, so they would face substantially higher out-of-pocket costs.[5]

Chairman Ryan says that his premium-support proposal would not affect people aged 56 and older in 2014, but this claim is unlikely to be true. Under premium support, traditional Medicare would tend to attract a less healthy pool of enrollees, while private plans would attract healthier ones (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 their enrollees' health status — the risk adjustment process is highly imperfect and captures only part of the cost differences across plans that stem from differences in enrollees' health.

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.

---

[4] Congressional Budget Office, *A Premium Support System for Medicare*, pp. 4-5.

[5] 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.

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 aged 56 and older might well face higher premiums and cost sharing for traditional Medicare, a more limited choice of providers, or both.

Raising the Eligibility Age

Starting in 2024, the Ryan budget would raise Medicare's eligibility age — 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 an individual insurance market that would be poorly regulated (since the Ryan plan repeals the Affordable Care Act's insurance reforms) and would charge 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 uninsured.

All remaining Medicare beneficiaries would pay higher premiums because the removal of 65- and 66-year-olds, who are typically healthier than Medicare beneficiaries overall, would leave Medicare beneficiaries costlier to cover, on average.

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 2014, 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 range from $12.10 to $69.30 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 Ryan budget states that its proposal is the same as that in the Administration's fiscal year 2014 budget, which would raise the income-related premiums and freeze the income thresholds until 25 percent of Medicare beneficiaries are subject to the income-related premiums. (The proposal in the Administration's 2015 budget differs in its details.)

Limiting Malpractice Awards

The Ryan budget would limit medical malpractice litigation along the lines of legislation (H.R. 5) the House passed on March 22, 2012, which caps awards for punitive damages and requires claimants to initiate claims within a year after they discover, 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).[6] 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.[7]

Increasing Medicare Cost Sharing

The Ryan budget would modify cost sharing in traditional Medicare by implementing a single deductible for Parts A and B and by limiting Medicare supplemental ("Medigap") policies, although it provides no details. These changes would start in 2024 and would apparently affect all Medicare beneficiaries, not just those becoming eligible.

Unlike some other proposals to restructure Medicare's cost sharing, the Ryan proposal has two serious omissions.[8] First, it places no annual limit (or "catastrophic cap") on beneficiaries' out-of-pocket spending, which is the most substantial gap in Medicare coverage today. Second, it fails to protect low-income beneficiaries from significant increases in out-of-pocket health costs. For example, a frail elderly widow with income of only $11,700 — just above the poverty level — could be required to pay $400 more each year if the Part B deductible rose from $146 to $550, as some proposals would do.[9] Many such individuals likely would forgo some needed care as a result.

Repealing Improvements in Medicare Benefits

The Ryan budget would apparently repeal health reform improvements in Medicare benefits, including closure of the prescription drug donut hole and coverage of preventive services without cost sharing.[10] 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

---

[6] 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.

[7] Congressional Budget Office, *Options for Reducing the Deficit: 2014 to 2023,* November 2013, pp. 201-2.

[8] Erskine Bowles and Alan Simpson, *A Bipartisan Path Forward to Securing America's Future*, April 2013, pp. 21-3, http://momentoftruthproject.org/sites/default/files/Full%20Plan%20of%20Securing%20America's%20Future.pdf.

[9] Congressional Budget Office, *Options for Reducing the Deficit*, pp. 211-18.

[10] U.S. House of Representatives, Committee on the Budget, *Setting the Record Straight: Medicare Questions*, http://budget.house.gov/fy2015/settingtherecordstraight.htm, accessed April 7, 2014. The Ryan proposal is not clear on this matter; this source specifically mentions the donut hole but not the additional preventive benefits.

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 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.

Retaining the Sustainable Growth Rate Formula

The Ryan budget establishes a "reserve fund" that would allow Congress to repeal, in a deficit-neutral manner, the cuts required by Medicare's sustainable growth rate (SGR) formula for physicians. In contrast to the Administration's budget, which also calls for repealing the SGR cuts, the Ryan budget does not specify how policymakers would offset the ten-year cost of roughly $140 billion. But, if Congress does not find a way to offset the cost, the Ryan budget assumes that the SGR cuts will take effect. Congress recently voted to freeze physician payment rates through March 2015, but the SGR formula calls for reducing payments by about 25 percent when the freeze expires.

Retaining Sequestration

The Ryan budget retains the "sequestration" cuts in Medicare that the 2011 Budget Control Act (BCA) requires for 2015 through 2024. 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.[11] 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.

[11] The Budget Control Act initially imposed sequestration through 2021. Subsequent legislation has extended sequestration of mandatory programs through 2024. The Medicare cut in 2024 is 4 percent for payments in April through September and zero in October through March.