

PROPOSED CHANGES TO MEDICARE IN THE “PATH TO PROSPERITY”

OVERVIEW AND KEY QUESTIONS

APRIL 2011

On April 5, 2011, Representative Paul Ryan (R-WI), chairman of the House Budget Committee, released a budget proposal, entitled *The Path to Prosperity: Restoring America's Promise*, which reduces federal spending over the long term.¹ The proposal is projected to achieve a federal budget surplus by 2040, and would substantially reduce federal spending on major health programs, including Medicare, Medicaid, the Children's Health Insurance Program (CHIP) and Exchange subsidies by 2022.² With Medicare spending now representing 15 percent of the federal budget, reducing federal Medicare spending is a key component of Chairman Ryan's proposal.

The proposal would reduce the growth in Medicare spending by capping the growth in expenditures per enrollee, converting Medicare from a defined benefit plan to a system of defined “premium support” payments, and by gradually raising the age of Medicare eligibility from 65 to 67, beginning in 2022. The proposal would also repeal specified provisions of the 2010 health reform law.³ It would repeal the Independent Payment Advisory Board (IPAB) and provisions to close the Medicare Part D prescription drug coverage gap (the “doughnut hole”) by 2020.

This policy brief focuses only on the provisions of the proposal that would directly affect Medicare, and the elderly and disabled people covered by the program. The proposal includes other changes that could also affect seniors and people with disabilities, most notably through the Medicaid program. The description is based on information in *The Path to Prosperity*, the letter dated April 5, 2011 from the Congressional Budget Office (CBO) which provides greater detail on the specific provisions in the plan, and subsequent information provided by the CBO on April 8, 2011.⁴

Proposal Would Convert Medicare into a “Premium Support” Program

How Would the Proposal Change the Structure of the Medicare Program?

The proposal would gradually transform Medicare into what is described as a “premium support system.” Beginning in 2022, all newly-eligible Medicare beneficiaries (i.e., individuals turning 65 as well as younger, disabled individuals becoming eligible for Medicare) would only have access to health coverage through private insurance plans, rather than through the current government-run Medicare program (i.e., traditional Medicare), or under a Medicare Advantage plan. Under the new premium support system, Medicare beneficiaries would be entitled to a payment from the federal government to help defray premiums and other health care costs under the plan. The government would make payments directly to private health plans on behalf of Medicare-eligible enrollees, rather than pay hospitals, physicians, and other medical providers directly for the services provided to their Medicare-eligible patients, as is currently the case. If the government payments to plans on behalf of enrollees were insufficient to cover premiums and/or other costs, beneficiaries would be responsible for additional costs. In other words, Medicare would no longer provide coverage for medical care, but instead provide a “subsidy” toward the purchase of a private health insurance plan.

Under the premium support system, beneficiaries would be able to choose among competing private plans offered in their area through a new Medicare Exchange. Plans offered through the Medicare Exchange would be required to enroll any Medicare beneficiary who wishes to enroll, without regard to health status or income. It is not clear whether beneficiaries could apply their government contribution to a private plan offered outside the Medicare Exchange.

Elderly and disabled people who are entitled to Medicare before 2022 (generally individuals currently ages 55 and older or those with disabilities covered by Medicare before 2022) could choose to either remain in the traditional fee-for-service Medicare program, or enroll in a private plan. While the average costs for beneficiaries in traditional Medicare would increase if the younger, healthier beneficiaries enroll in private plans, the proposal would protect the older, sicker beneficiaries in the traditional Medicare program from the higher premiums that would otherwise result from higher average costs.

What Benefits Would Be Offered by Private Plans to Medicare Beneficiaries?

The proposal would require private plans in the new Medicare Exchanges to comply with “a standard for benefits” that would be approved by the Office of Personnel Management (OPM), which oversees the benefits for the Federal Employees Health Benefits Program (FEHBP).⁵ If FEHBP is the model for this approach, OPM would generally require plans to include benefits to cover certain costs, and would review proposed changes in benefits from one year to the next, but would be unlikely to require a uniform or specified defined set of benefits.⁶ This approach differs from current law, which entitles beneficiaries to a defined set of benefits, or to benefits that are at least actuarially equivalent if offered by a Medicare Advantage plan. Because payments to plans incorporate costs associated with Part D, the stand-alone Medicare Part D marketplace presumably would no longer exist.

How Would the Proposal Set Government Payments to Private Plans?

Under the proposal, the payment made on behalf of Medicare beneficiaries to private plans would be based on projected average per capita Medicare spending in 2022 that would be adjusted for health status, age, and income. According to the CBO, this approach would result in higher costs for beneficiaries than they would otherwise incur under the traditional Medicare program. Net federal premium support payments for a typical 65-year old in 2022 would be \$8,000, or 39 percent of Medicare spending per enrollee.⁷ Government contributions to plans would be risk-adjusted and thus higher for beneficiaries who are older and/or in poorer health.

Government contributions would be lower for higher-income Medicare beneficiaries: payments to plans would be reduced by 70 percent for beneficiaries in the top 2 percent of the Medicare population income distribution, and by 50 percent for those in the next 6 percent of the income distribution. Thus, government payments on behalf of enrollees would be lower for Medicare beneficiaries with relatively high incomes, resulting in these beneficiaries paying higher premiums.

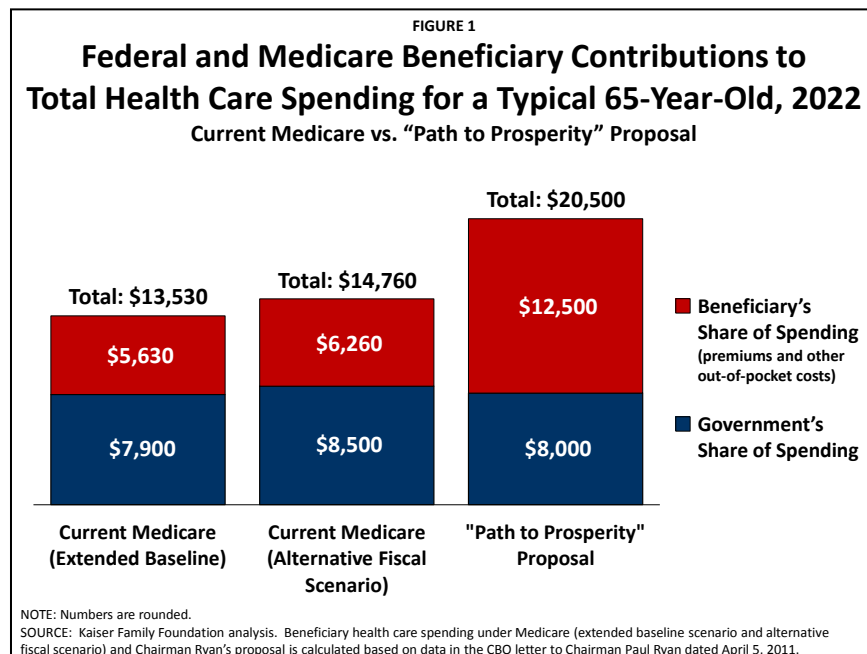
The proposal does not specify whether government contributions would be adjusted for geographic variation in costs. Given well-documented variations in Medicare costs by geography, the absence of a geographic adjustment could have significant implications for high-cost areas of the country, such as Miami or Los Angeles.

How Would the Federal Premium Support Payment Increase Each Year?

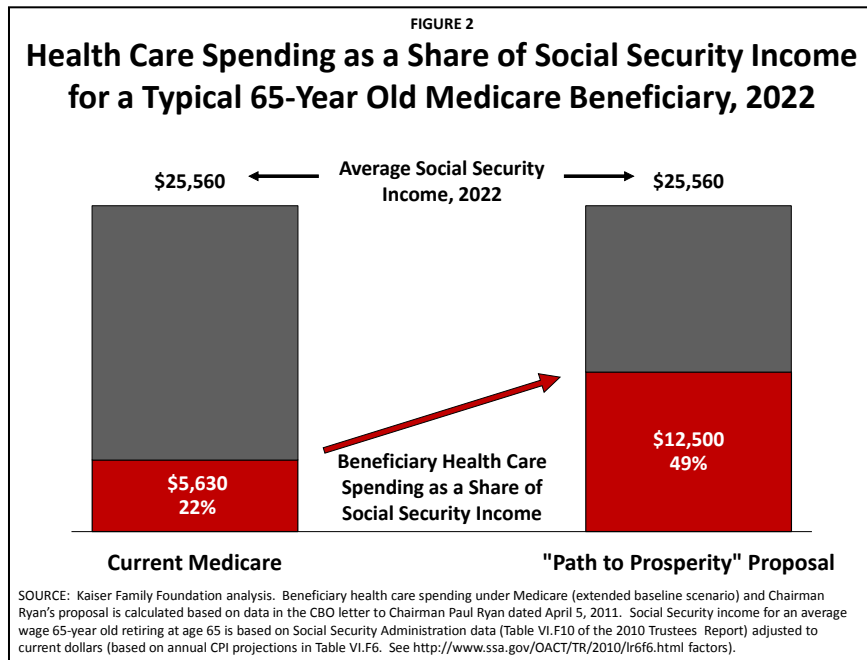
The government contribution would increase annually, based on the Consumer Price Index for all urban consumers (CPI-U). This differs from other proposals, such as the Rivlin-Ryan plan, released in November 2010, that proposed to increase federal Medicare costs by the growth in per capita Gross Domestic Product plus one percent (GDP+1%), which allows for a somewhat higher rate of annual growth than inflation.⁸ These growth rates are lower than historical growth in Medicare spending. For example, the average annual growth rate in Medicare per capita spending surpassed the average annual growth rate in the GDP and inflation between 1985 and 2009 (6.7% vs. 2.9%), and is projected to grow faster than inflation through 2021 (nearly 3% vs. 2%).⁹ By constraining the growth in Medicare payments per enrollee at inflation and by keeping growth below projected Medicare expenditures per person, the proposal limits the financial exposure of the federal government and achieves savings over the long term, but is projected to expose beneficiaries to increasingly larger out-of-pocket costs and risk over time.

How Would the Proposal Affect Beneficiaries' Costs?

Beneficiaries enrolled in private plans would be expected to pay premiums and other costs in excess of the federal premium support payment made to the plan on behalf of the Medicare enrollee. According to the CBO analysis, the total cost of providing health care benefits (premium and other costs) to a typical 65-year old in a private plan would be about \$20,500 in 2022 (Figure 1).¹⁰ The government would contribute \$8,000 or 39 percent toward the total cost, and the remaining \$12,500 would be paid by the beneficiary. The CBO projects that out-of-pocket costs for the typical 65-year old would be more than twice as large under the proposal than under traditional Medicare (\$5,630) in 2022, because the cost of providing benefits is greater under private plans than under traditional Medicare.¹¹



As illustrated in Figure 2, a typical retiring 65-year old in 2022, with average earnings, would have out-of-pocket expenses for their health care that consumed nearly half of their Social Security income that year under Chairman Ryan’s proposal, double the amount they would pay under traditional Medicare.ⁱ Beneficiaries who receive lower Social Security checks (e.g., people who retire and start receiving Social Security benefits before the age of 65) would devote a larger share of their Social Security income towards their health care expenses.



Plans would be prohibited from varying premiums based on the health status of enrollees, and would be required to charge the same premium to individuals *in the same age group*, according to the CBO.¹² This may suggest that plans would be permitted to vary premiums by age, charging higher premiums to older beneficiaries and lower premiums to younger beneficiaries. In such a scenario, 85-year olds who choose to be covered under the premium support system in 2022 could face significantly higher costs than younger Medicare beneficiaries.

Premiums would also be higher for beneficiaries with relatively high incomes because of lower government contributions to those with the highest incomes.

Would the Ryan Proposal Reduce Total Health Care Spending for Medicare Beneficiaries?

Under the proposal, federal spending for Medicare is projected to decline because per capita payments are based on a predetermined amount, rather than the true cost of providing benefits, and because government contributions are constrained by inflation. However, the total cost of providing Medicare benefits to enrollees is expected to rise under the proposal, according to the CBO. This is because private plans have higher administrative costs and typically pay higher fees to providers than Medicare. While private plans may be able to achieve lower utilization through tighter cost and care management practices, the CBO believes the total costs of providing a similar benefit package would be higher under private plans than Medicare, and that the differential between the costs under traditional Medicare and the costs under private plans would widen over time. According to the CBO, the difference would be 11 percent in 2011, widening to 34 percent in 2022.¹³

ⁱ Under the CBO’s alternative fiscal scenario, which incorporated several changes to current law that were widely expected to occur (such as projecting physician payment rates to grow at the same rate as the Medicare economic index rather than the lower rates of the sustainable growth rate mechanism), out-of-pocket health care spending under traditional Medicare is projected to be \$6,260, or 24 percent of a typical 65-year old’s Social Security income in 2022 (\$25,560).

How Would the Proposal Affect Low-Income Medicare Beneficiaries, Including Individuals Dually Eligible for Medicare and Medicaid?

Under the proposal, individuals living in poverty, with incomes below 100 percent of the federal poverty level, would be eligible for a medical savings account (MSA) in 2022 to help cover the cost of premiums, cost-sharing, and acute care services; \$7,800 would be deposited into the MSA for individuals below 100 percent of poverty in 2022, and the amount would be indexed to grow by CPI-U. Beneficiaries with incomes between 100 percent and 150 percent of the poverty level would be eligible for 75 percent of that amount (\$5,850). Individuals would be able to use their MSA to help cover premiums and cost sharing, replacing the role that Medicaid currently plays for individuals dually eligible for Medicare and Medicaid, and that Medicare currently plays in providing additional help under Part D for low-income beneficiaries.

Assuming average out-of-pocket spending of approximately \$12,500 in 2022 for a typical 65-year old under the proposal, as estimated by the CBO analysis, the government contribution to the MSA for a beneficiary living below the federal poverty level (\$7,800) would cover about two-thirds of total spending that year; individuals eligible for the MSA would be responsible for the remaining \$4,700, approximately 43 percent of the average income among beneficiaries living below the federal poverty level in 2022 (\$10,949).¹⁴ This estimate is likely to be conservative because it assumes low income individuals have the same average out-of-pocket spending as other “typical” beneficiaries; however, low-income beneficiaries, particularly those who are dually eligible for Medicare and Medicaid, tend to have greater health needs and higher than average health spending. It also does not take into account expenses that could be incurred by low income beneficiaries and that Medicaid would cover under current law, such as dental or long-term care. Separately, the proposal would transform the Medicaid program into an allotment, or block grant, which could limit Medicaid payments for long-term care services and supports for low-income beneficiaries dually eligible for Medicare and Medicaid.

The proposal marks a clear departure from the current approach for providing additional support to Medicare beneficiaries with low incomes in several ways. On the one hand, the provision provides help to those with low incomes without regard to assets, whereas current law requires low-income individuals to meet income and asset tests before qualifying for Medicaid (as dual eligibles), for Medicare Savings Programs, or for Part D Low-Income Subsidy (LIS) Benefits.¹⁵ On the other hand, the amount deposited in the MSA appears to be unrelated to actual expenses individuals are expected to incur, which could shift the burden of expenses from Medicaid (or Medicare Part D) to low-income Medicare beneficiaries, particularly those with the greatest needs and medical expenses. In contrast, under current law, Medicaid pays premiums and cost sharing for people dually eligible for Medicare and Medicaid (full duals) without a cap on government contributions.

What Happens to Medicare’s Role in Supporting Other Aspects of the Health Care System?

Under the current program, Medicare plays a number of different roles beyond serving as a payer for services rendered to beneficiaries by medical providers. For example, Medicare provides additional support to help finance medical education at teaching hospitals, and additional payments to support rural hospitals. Medicare also plays a role in promoting quality of care. For example, Medicare and Medicaid impose quality standards, such as requiring nurse-to-staff ratios for nursing homes, and due to recently-enacted changes in the 2010 health reform law, Medicare is engaged in efforts to reduce hospital-acquired infections, promote improved care coordination for post-acute services, reduce unnecessary hospital admissions, and establish quality-based incentives for Medicare Advantage plans. It is not clear what role the government would play in supporting these activities if Medicare were to evolve into a premium support system.

Proposal Would Raise the Age of Medicare Eligibility from 65 to 67, Beginning in 2022

The proposal would gradually raise the age of Medicare eligibility, beginning in 2022, from 65 to 67. This proposal would achieve additional federal savings, according to the CBO.¹⁶ The proposal would also repeal subsidies that would have otherwise been available to 65- and 66-year olds through the state-based Exchanges or Medicaid, possibly resulting in more uninsured 65- and 66-year olds, and higher costs for 65- and 66-year olds relative to what they would have paid under traditional Medicare.¹⁷

Other Proposed Changes to Medicare

The proposal would maintain many of the Medicare savings provisions in the recently enacted health reform law, but would repeal the following provisions:ⁱⁱ

- **Part D Coverage Gap.** The proposal would re-open the Part D coverage gap, also known as the “doughnut hole,” in which beneficiaries are responsible for paying all of their prescription drugs costs. Because the health reform law gradually closes the coverage gap between 2010 and 2021, this provision would affect the current Medicare population. Over time, prescription drugs would not be offered separately through private stand-alone plans but would presumably be covered under private plans, along with other medical benefits.
- **Independent Payment Advisory Board.** The Independent Payment Advisory Board (IPAB) is tasked with making recommendations for Medicare spending cuts to Congress if Medicare spending exceeds GDP+1 percent in 2015 or later years. The proposal would eliminate IPAB (though it has yet to be formed).

Additional Proposed Changes that are Likely to Affect Medicare Beneficiaries

The proposal would make changes to other programs that would indirectly affect elderly and disabled people on Medicare. In addition to the Medicaid block grant that could affect services and eligibility for dual eligibles (discussed earlier), the proposal would repeal the Community Living Assistance Services and Supports (CLASS) Act, which is a voluntary, consumer-financed, and employer-based long-term care insurance supplement. The CLASS Act is not a Medicare benefit, but is designed to provide support for individuals needing long-term care services and supports – many but not all of whom would ultimately be eligible for Medicare.

ⁱⁱ There is some question as to how the proposal would address the sustainable growth rate formula for physician payments under Medicare. According to the *Path to Prosperity*, the proposal “fixes the Medicare physician payment formula for the next ten years so that Medicare beneficiaries continue to have access to health care. It provides for a reimbursement system that fairly compensates physicians who treat Medicare beneficiaries while providing incentives to improve quality and efficiency” (page 45). However, the CBO analysis assumes no change in the sustainable growth rate formula (page 7, footnote 7).

Discussion

To address broad concerns about the federal deficit and debt, *The Path to Prosperity*, would make major changes to reduce the growth in federal spending, including proposals to slow the growth in Medicare spending. These proposals come on top of Medicare savings enacted in the 2010 health reform law that are projected to reduce the growth in Medicare per capita spending to historically low levels. Between FY2011 and FY2021, the CBO projects per capita Medicare spending to grow by about 3 percent.¹⁸ In contrast, the average annual growth in Medicare spending was 6.7 percent during the period between 1985 and 2009.¹⁹

The provisions in the proposal would mark a fundamental change in the structure of the Medicare program, and the nature of the entitlement for seniors and people with disabilities. According to the CBO, the proposal would be effective in constraining the growth in federal spending, but would increase total costs per beneficiary and increase out-of-pocket costs incurred by beneficiaries, relative to what they would have paid in traditional Medicare.

Proponents of this approach say this transformation of Medicare would help rein in federal Medicare spending by encouraging plans to compete for enrollees based on price and quality, and by giving beneficiaries greater incentive and ability to choose a plan that best meets their needs. The proponents argue that giving beneficiaries more “skin in the game” will exert more pressure on plans to reduce costs. Opponents counter that a system of federal premium support with benefits administered by private health insurers, and tight constraints on the growth in government payments, would shift costs on to beneficiaries, take away the guarantee of defined health care benefits, and increase total health care costs per beneficiary due to higher costs associated with administering Medicare benefits through private plans. Some have also questioned whether such an approach could result in seniors and people with disabilities becoming uninsured.

By establishing a specified amount to be paid by the government for each enrollee, and limiting the increase in payments over time, the proposal would be effective in limiting the exposure of the federal government to increases in Medicare spending, helping to drive down the deficit and debt, but would shift costs and risk onto future generations of Medicare beneficiaries. Such a proposal is likely to have large implications for Medicare beneficiaries, medical providers, and insurance companies.

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¹ Ryan, P. *The Path to Prosperity: Restoring America’s Promise*. House Budget Committee. April 5, 2011.

² Congressional Budget Office. *Long-Term Analysis of a Budget Proposal by Chairman Ryan*. April 5, 2011.

³ The 2010 health reform law refers to the “Patient Protection and Affordable Care Act” (P.L. 111-148) as enacted on March 23, 2010 and amended by the “Health Care and Education Reconciliation Act of 2010” (P.L. 111-152) as enacted on March 30, 2010.

⁴ See Ryan, P. *The Path to Prosperity: Restoring America’s Promise*. House Budget Committee. April 5, 2011. Also see Congressional Budget Office. *Long-Term Analysis of a Budget Proposal by Chairman Ryan*. April 5, 2011. See also Congressional Budget Office. *Additional Information on CBO’s Long-Term Analysis of a Budget Proposal by Chairman Ryan*. April 8, 2011.

⁵ Congressional Budget Office. *Long-Term Analysis of a Budget Proposal by Chairman Ryan*. April 5, 2011.

⁶ Kaiser Family Foundation. *The Federal Employees Health Benefits Program: Program Design, Recent Performance, and Implications for Medicare Reform*. May 2003.

⁷ Congressional Budget Office. *Long-Term Analysis of a Budget Proposal by Chairman Ryan*. April 5, 2011.

⁸ Rivlin, A. and Ryan, P. *A Long-Term Plan for Medicare and Medicaid*. November 17, 2010. See also Congressional Budget Office. *Preliminary Analysis of the Rivlin-Ryan Health Care Proposal*, November 17, 2010.

⁹ Congressional Budget Office. *Budget and Economic Outlook*. January 2011.

¹⁰ This estimate assumes the voucher (\$8000) would cover 39 percent of total health care spending for a typical 65-year old with a standardized health insurance benefit, as estimated by CBO and proposed in *The Path to Prosperity*. See Congressional Budget Office. *Long-Term Analysis of a Budget Proposal by Chairman Ryan*. April 5, 2011, page 22.

¹¹ This statement uses the CBO's extended-baseline scenario, which estimates that total health care spending in 2022 for a typical 65-year old with a standardized health insurance benefit would be 66 percent (or \$13,530) of the health care spending as described in *The Path to Prosperity* (\$20,500), and the average federal spending for a typical 65-year old on Medicare in 2022 will be \$7,900; the beneficiary would pay the difference (\$5,630). Under the CBO's alternative fiscal scenario, total health care spending in 2022 for a typical 65-year old with a standardized health insurance benefit would be 72 percent of the health care spending as described in *The Path to Prosperity* (\$20,500), and the average federal spending for a typical 65-year old on Medicare in 2022 will be \$8,500; the beneficiary would pay the difference (\$6,260). The difference in out-of-pocket spending under the proposal compared to under the alternative fiscal scenario is approximately \$6400. For more information, see Congressional Budget Office. *Long-Term Analysis of a Budget Proposal by Chairman Ryan*. April 5, 2011. See also Congressional Budget Office. *Additional Information on CBO's Long-Term Analysis of a Budget Proposal by Chairman Ryan*. April 8, 2011. Also see Greenstein, R. *Ryan Plan Specifies Spending Path would nearly end most of government other than social security, health care, and defense by 2050*. Center for Budget and Policy Priorities. April 7, 2011.

¹² Congressional Budget Office. *Long-Term Analysis of a Budget Proposal by Chairman Ryan*. April 5, 2011.

¹³ The differential between the costs under traditional Medicare and the costs under private plans would be 34 percent under the CBO's extended-baseline scenario, and 28 percent under the CBO's alternative fiscal scenario.

¹⁴ According to data provided by the Urban Institute's DYNASIM model, the median income among Medicare beneficiaries with incomes below the federal poverty level is projected to be \$10,949 (nominal dollars) in 2022.

¹⁵ Kaiser Family Foundation. *The Role of Medicare for People Dually Eligible for Medicare and Medicaid*. January 2011. See also Kaiser Family Foundation. *Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2007*. December 2010.

¹⁶ Congressional Budget Office. *Long-Term Analysis of a Budget Proposal by Chairman Ryan*. April 5, 2011.

¹⁷ Kaiser Family Foundation. *Raising the Age of Medicare Eligibility: A Fresh Look Following Implementation of Health Reform*. March 2011.

¹⁸ Congressional Budget Office. *The Budget and Economic Outlook: Fiscal Years 2011 to 2021*. January 2001.

¹⁹ Kaiser Family Foundation. *Medicare Spending and Financing: A Primer*. February 2011, page 2 and footnote 3.