Overview of Health Care Changes in the FY2012 Budget Offered by House Budget Committee Chairman Ryan

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Summary

On April 5, 2011, House Budget Committee Chairman Paul Ryan released the Chairman's mark of the FY2012 House budget resolution together with his report entitled "The Path to Prosperity: Restoring America's Promise," which outlines his budgetary objectives. On the same day, CBO issued an analysis of the long-term budgetary impact of Chairman Ryan's budget proposal based on specifications provided by House Budget Committee staff. The House Budget Committee considered and amended the Chairman's mark on April 6, 2011, and voted to report the budget resolution to the full House. H.Con.Res. 34 was introduced in the House April 11, 2011, and was accompanied by the committee report (H.Rept. 112-158). On April 15, 2011, the House voted 235-193 to pass H.Con.Res. 34.

A budget resolution provides general budgetary parameters; however, it is not a law. Changes to programs that are assumed or suggested by the budget resolution would still need to be passed by separate legislation. Chairman Ryan's budget proposal, as outlined in his report, the committee report, and in the CBO analysis, suggests short-term and long-term changes to federal health care programs including Medicare, Medicaid, and the health insurance exchanges established by the Patient Protection and Affordable Care Act (PPACA, P.L. 111-148).

Within the 10-year budget window (FY2012-FY2021), the budget proposal assumes that certain PPACA provisions would be repealed, including those that provide additional coverage under the Medicare prescription drug benefit, that expand Medicaid coverage to the non-elderly with incomes below 133% of the federal poverty level, and those provisions that establish health insurance exchanges. The proposal would also restructure Medicaid from an individual entitlement program to a block grant program beginning in FY2013.

Beyond the 10-year budget window, beginning in 2022, the budget proposal assumes an increase in the age of eligibility for Medicare, the conversion of Medicare to a fixed federal contribution program, and a restructuring of coverage for the elderly under Medicaid.

This report summarizes the proposed changes to Medicare, Medicaid, and private health insurance as described in H.Con.Res. 34, Chairman Ryan's "Path to Prosperity" report, the House Budget Committee report, and the CBO analysis. Additionally, it briefly examines the potential impact of the proposed changes on health care spending and coverage.

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Introduction

On April 5, 2011,[1] Representative Paul Ryan, the Chairman of the House Budget Committee, released the Chairman's mark of the FY2012 House budget resolution.[2] Additional detail on budgetary objectives and justifications was provided in Chairman Ryan's report entitled "The Path to Prosperity: Restoring America's Promise," issued the same day. [3] The House Budget Committee considered and amended the Chairman's mark on April 6, 2011 and voted 22-16 to report the budget resolution to the full House.[4] H.Con.Res. 34 was introduced in the House on April 11, 2011, and was accompanied by the House Budget Committee Report, H.Rept. 112-58.[5] On April 15, 2011, the House passed H.Con.Res. 34 by a vote of 235-193.

The House budget resolution sets general budgetary parameters.[6] Among other things, it expresses the desired levels of spending for government health programs over 10 years (FY2012-FY2021), it creates two health care related reserve funds, and presents a policy statement regarding assumptions about future Medicare reforms. The budget resolution does not include instructions for reconciliation.[7] A budget resolution is not intended to establish details of spending or revenue policy and does not provide levels of spending for specific agencies or programs; it is not a law and is not signed by the President. Rather, the budget resolution provides the framework for the consideration of other legislation. While the House budget resolution suggests and assumes certain health care related policy changes, separate legislation would need to be developed (by the committees of jurisdiction) and passed to actually modify federally funded health care programs.

CBO was asked to provide an analysis of the long-term budgetary impact of Chairman Ryan's budget proposal, and issued its report on April 5, 2011.[8] CBO was provided additional detail by the staff of the House Budget Committee regarding assumptions that should be made while conducting the analysis that was not included in the budget resolution or the accompanying report. CBO's analysis, however, does not provide an official cost estimate for legislation that might implement the proposal, as it did not conduct its analysis using actual legislative language

[1] The Obama Administration released its FY2012 budget on February 14, 2011; it may be found at http://www.whitehouse.gov/omb/budget.

[2] The Chairman's mark may be found at http://budget.house.gov/UploadedFiles/chairmansmark.pdf.

[3] This report may be found at http://budget.house.gov/UploadedFiles/PathToProsperityFY2012.pdf.

[4] An amendment in the nature of a substitute, that incorporates changes made during the mark-up, was made available April 9, 2011, http://budget.house.gov/UploadedFiles/managersamendment04082010.pdf.

[5] The accompanying House report, H.Rept. 112-58, may be found at http://www.gpo.gov/fdsys/pkg/CRPT-112hrpt58/pdf/CRPT-112hrpt58.pdf.

[6] For more information on the budget process, see CRS Report 98-721, *Introduction to the Federal Budget Process*, coordinated by (name redacted); CRS Report R40472, *The Budget Resolution and Spending Legislation*, by Megan Suzanne Lynch; and CRS Report R41685, *The Federal Budget: Issues for FY2011, FY2012, and Beyond*, by (name red acted).

[7] For details on the reconciliation process, see CRS Report R41151, *Budget Reconciliation Process: Timing of Committee Responses to Reconciliation Directives*, by Megan Suzanne Lynch.

[8] CBO April 5, 2011, Letter to Rep. Paul Ryan, "Long-Term Analysis of a Budget Proposal by Chairman Ryan," http://cbo.gov/ftpdocs/121xx/doc12128/04-05-Ryan_Letter.pdf. CBO issued a supplementary document on April 8, 2011 in response to frequently asked questions, "Additional Information on CBO's Long-Term Analysis of a Budget Proposal by Chairman Ryan," http://cbo.gov/ftpdocs/121xx/doc12128/Responding_to_questions_about_estimate_for_Ryan.pdf.

and was asked to provide an impact analysis beyond the 10-year budgetary window.[9] CBO's most recent long-term projections, which were the basis for its analysis, were issued in June 2010 and were derived from the agency's March 2010 baseline projections.[10]

In general, Chairman Ryan's budget proposal, as outlined in his "Path to Prosperity," in the Committee Report, and in CBO's analysis, suggests a change in the structure of the Medicare and Medicaid programs, the repeal many of the provisions in the Patient Protection and Affordable Care Act (PPACA, P.L. 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) including those that establish insurance exchanges, and changes to tort law governing medical malpractice.[11] Chairman Ryan provided unofficial 10-year spending estimates in the "Path to Prosperity" report.[12] These estimates suggest that the budget plan would reduce federal health care spending about $2.2 trillion over FY2012-FY2021 from CBO's baseline estimate.[13] This would include a reduction of approximately $1.4 trillion that would have been spent to implement PPACA health insurance reforms,[14] and a reduction of $771 billion for Medicaid and $30 billion for Medicare during this time period.[15] In its long–term analysis of the proposal, CBO estimated that government mandatory spending for healthcare would be about 6% of GDP in 2030, 5.75% in 2040, and 4.75% in 2050, compared to 8.75%, 10.75% and 12.25% for the same years under CBO's baseline current-law projections.[16]

This report provides a synopsis of the health care related changes in Chairman Ryan's FY2012 budget proposal. Our summary is based on the text of H.Con.Res. 34, the Chairman's "Path to Prosperity" report, the House Budget Committee Report, and the CBO analysis of the proposal. The collective details are referred to in this report as the "budget proposal" or Chairman Ryan's proposal.

Medicare

Medicare is the nation's federal insurance program that pays for covered health services for most persons 65 years and older and for most permanently disabled individuals under the age of 65 years. Generally, individuals are eligible for Medicare if they or their spouse worked for at least

[9] A cost estimate for legislation would require much more detailed analysis, focus on the first 10 years, and would be based on more recent baseline projections.

[10] CBO, "The Long-Term Budget Outlook," (June 2010; revised August 2010) http://www.cbo.gov/ftpdocs/115xx/doc11579/06-30-LTBO.pdf.

[11] See CRS Report R41664, *PPACA: A Brief Overview of the Law, Implementation, and Legal Challenges*, by (name redacted) et al.

[12] As noted, CBO did not provide an official cost estimate of the budget proposal. The "Path to Prosperity" report did not provide details on the methodology and assumptions used to calculate the spending estimates presented in that report.

[13] House Committee on the Budget Chairman Paul Ryan, "Path to Prosperity: Restoring America's Promise," FY2012 Budget Resolution, April 5, 2011, Table S-4.

[14] This includes a reduction of $725 billion associated with the repeal of the health insurance exchange subsidies.

[15] It is not clear from the information provided whether cost increases associated with increases to Medicare physician payments are included in the Budget Committee's estimate.

[16] CBO's baseline estimates of mandatory health care spending include Medicare, Medicaid, exchange subsidies, and the State Children's Health Insurance Program (CHIP); CBO April 5, 2011, Letter to Rep. Paul Ryan, Long-Term Analysis of a Budget Proposal by Chairman Ryan http://cbo.gov/ftpdocs/121xx/doc12128/04-05-Ryan_Letter.pdf, Table 2, page 16.

40 quarters in Medicare-covered employment, are 65 years old, and are a citizen or permanent resident of the United States. Individuals under the age of 65 may also qualify for coverage if they have a permanent disability, have End-Stage Renal disease, or have amyotrophic lateral sclerosis (ALS).[17]

In FY2011, the program will cover an estimated 48 million persons at an estimated total cost of about $569 billion, accounting for approximately 3.7% of GDP. CBO estimates that federal Medicare spending (after deduction of beneficiary premiums and other offsetting receipts) will be about $485 billion in FY2011, accounting for over 15% of total federal spending.[18] Medicare is an entitlement program, which means that it is required to pay for covered services provided to eligible persons so long as specific criteria are met. Spending under the program (except for a portion of the administrative costs) is considered mandatory spending and is not subject to the appropriations process.

The Medicare program has four parts, each responsible for paying for different benefits, subject to different eligibility criteria and financing mechanisms.[19]

- **Part A** (Hospital Insurance, or HI) covers inpatient hospital services, skilled nursing care, and home health and hospice care. The HI trust fund is mainly funded by a dedicated payroll tax of 2.9% of earnings, with employers and workers each paying 1.45%. (The self-employed pay 2.9%.) PPACA added an additional 0.9% hospital insurance tax on high-income taxpayers.
- **Part B** (Supplementary Medical Insurance, or SMI) covers physician services, outpatient services, and some home health and preventive services. The SMI trust fund is funded through beneficiary premiums (set at 25% of estimated program costs for the aged) and general revenues (the remaining amount, approximately 75%). High income enrollees pay higher premiums. Enrollment in Part B is voluntary, with over 90% of Medicare beneficiaries choosing this option.
- **Part C** (Medicare Advantage, or MA) is a private plan option for beneficiaries that covers all Part A and B services, except hospice. Individuals choosing to enroll in Part C must also enroll in Part B. Part C is funded through both the HI and SMI trust funds.
- **Part D** covers prescription drug benefits. Funding is included in the SMI trust fund and is financed through beneficiary premiums (about 25.5%) and general revenues (about 74.5%). High income enrollees pay higher premiums. This portion of the program is also voluntary; about 60% of eligible Medicare beneficiaries are enrolled in a Part D plan, while another 14% are enrolled in an employer plan subsidized by Medicare.

[17] PPACA added an additional eligibility category; individuals with one or more specified lung diseases or types of cancer who lived for 6 months during a specified period prior to diagnosis in an area subject to a public health emergency declaration by the Environmental Protection Agency (EPA) as of June 17, 2009 are also entitled to Medicare benefits.

[18] CBO, Medicare Baseline, March 2011, http://www.cbo.gov/budget/factsheets/2011b/medicare.pdf.

[19] For additional detail on the Medicare program and its financing, see CRS Report R40425, *Medicare Primer*, coordinated by (name redacted) and CRS Report R41436, *Medicare Financing*, by (name redacted).

Under traditional Medicare, Parts A and B, services are generally paid directly by the government on a "fee-for-service" basis, using different prospective payment systems or fee schedules. Under Parts C and D, private insurers are paid a monthly "capitated" amount to provide enrollees with at least a minimum standard benefit. Premium amounts may vary depending on which plan the enrollee selects. The capitated payment is adjusted to reflect the higher relative cost of older or sicker beneficiaries, but is not adjusted for the actual amount of health care used.

Since its establishment in 1965, the Medicare program has undergone considerable change. Most recently, PPACA made numerous changes to the Medicare program that modify provider reimbursements, provide incentives to improve the quality and efficiency of care, and enhance certain Medicare benefits.[20]

Short-Term Medicare Changes (FY2012-FY2021)

Chairman Ryan's budget proposal would repeal certain Medicare provisions in PPACA while retaining others. Additionally, his proposal calls for a fix to the Medicare physician payment system. According to unofficial House Budget Committee estimates, the proposal would reduce Medicare spending by $30 billion over FY2012-FY2021 compared with CBO baseline estimates.[21]

Repeal of Certain Medicare Provisions in PPACA

The budget proposal would repeal some of the Medicare related changes made by PPACA while it would retain others. Specifically the proposal would repeal:

- Provisions that created the Independent Payment Advisory Board (IPAB; Section 3403, as modified by 10320).[22] Under current law, beginning in 2014, the IPAB is required to develop proposals to reduce the Medicare per capita expenditure growth rate if Medicare spending is projected to exceed a certain target.[23]
- Subsidizes related to closing the Part D prescription drug benefit coverage gap (doughnut hole). Prior to PPACA , under the standard benefit, most enrollees paid all of their drug costs during a period between an initial coverage limit and a catastrophic threshold when there was a gap in coverage. PPACA (Section 3301) and the Reconciliation Act (Section 1101) phase out the doughnut hole until it is closed in 2020. At that time, 75% of the cost of generic drugs and 25% of the cost of brand name drugs incurred during the coverage gap would be subsidized by Medicare.[24] Also beginning in 2011, drug manufacturers are required to

[20] For details on individual Medicare provisions in PPACA, see CRS Report R41196, *Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA): Summary and Timeline*, coordinated by (name redacted).

[21] House Committee on the Budget Chairman Paul Ryan, "Path to Prosperity: Restoring America's Promise," FY2012 Budget Resolution, April 5, 2011, Table S-4. It is not clear from the information provided whether cost increases associated with increases to Medicare physician payments are included in the Budget Committee's savings estimate.

[22] See CRS Report R41511, *The Independent Payment Advisory Board*, by (name redacted) and (name redacted).

[23] In its March 2011 Medicare Baseline, CBO estimated that the target would not be exceeded during the next 10 years; therefore IPAB would not be expected to make recommendations during this time. Thus, the elimination of the IPAB could be expected to have little impact on the budget during this 10-year period, http://www.cbo.gov/budget/factsheets/2011b/medicare.pdf.

[24] In 2010 as required by PPACA, Part D enrollees who reached the doughnut hole each received $250. The doughnut (continued...)

provide a 50% discount to enrollees off the cost of brand name drugs during the doughnut hole phase; it is unclear whether this discount would be retained or repealed under the budget proposal.[25]

- The high-income payroll taxes. Under current law, employers and employees each pay a payroll tax of 1.45% to finance Medicare Hospital Insurance (Part A). Section 9015 of PPACA includes an additional 0.9% hospital insurance tax on high-income taxpayers levied on wages over $200,000 for single filers and $250,000 for joint filers effective for taxable years after December 31, 2012.[26] Section 1402 of the Reconciliation Act also imposes a 3.8% surtax on unearned income, which includes interest, dividends, non-qualified annuities, royalties, rents, and taxable net capital gains for households with modified adjusted gross income (MAGI) over $200,000 for single filers and $250,000 for joint filers. This surtax is effective for taxable years after December 31, 2012.[27]

The CBO analysis indicated that most of the other changes that PPACA and the Reconciliation Act made to the Medicare program would be retained. This would include provisions that reduce payments to various types of health care providers. None of the four documents (budget resolution, Chairman's "Path to Prosperity" report, the Committee report, or CBO analysis) provided sufficient detail regarding specific provisions that would be repealed or retained to determine the disposition of provisions related to the quality and efficiency of health care (in Title III of PPACA), such as those creating value-based purchasing programs, quality reporting systems, and demonstrations and pilot programs that would test various patient care models including accountable care organizations.[28] Additionally, no details were provided that would indicate how provisions related to the health care workforce (Title V of PPACA), and program integrity (Title VI of PPACA) would be affected.[29]

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hole phase-out began in January 2011; in 2011, beneficiaries who reach the doughnut hole receive a 50% discount off of the price of brand name drugs from the manufacturers of the drugs, and Medicare subsidizes 7% of the cost of generic drugs. Medicare subsidies for brand name drugs will be phased in starting in 2013 until they reach 25% in 2020. (In 2020, the 25% government subsidy combined with the 50% manufacturer discount will cover 75% of beneficiaries' costs for brand name drugs during the coverage gap.) The amount of the Medicare subsidy for generic drugs is to increase 7% each year starting in 2011 until it reaches 75% in 2020.

[25] In its March 20, 2010 score of PPACA as modified by the Reconciliation Act, CBO indicated that closing the Part D coverage gap would cost $42.6 billion for the 10-year period FY2010-FY2019; the 10-year estimated savings for repealing this provision would be expected to be higher as it would include estimates for years further in the future, FY2012-FY2021, when costs are expected to grow, http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf.

[26] In its February 18, 2011 cost estimates of H.R. 2 that would repeal PPACA and the Reconciliation Act, CBO indicated that the repeal of the additional hospital insurance tax would result in decreased revenues of $259 billion over 2012-2021, http://www.cbo.gov/ftpdocs/120xx/doc12069/hr2.pdf.

[27] See CRS Report R41128, *Health-Related Revenue Provisions in the Patient Protection and Affordable Care Act (PPACA)* , by (name redacted).

[28] See CRS Report R41474, *Accountable Care Organizations and the Medicare Shared Savings Program*, by (name redacted).

[29] These provisions are described in CRS Report R40943, *Public Health, Workforce, Quality, and Related Provisions in the Patient Protection and Affordable Care Act (P.L. 111-148)*, coordinated by (name redacted) and (name re dacted).

Medicare Physician Payment System[30]

Medicare payments for Part B services provided by physicians and certain non-physician practitioners are made on the basis of a fee schedule, a list of over 7,000 tasks and services for which physicians bill Medicare. The sustainable growth rate (SGR) system was established because of the concern that the Medicare fee schedule itself would not adequately constrain overall increases in spending for physicians' services. Each year since 2002, the SGR has resulted in a reduction in the reimbursement rates. With the exception of 2002, when a 4.8% decrease was applied, Congress has passed a series of bills to override the reductions. However, these actions have required almost yearly attention from the Congress. Unless additional action is taken, Medicare physician payments will be reduced by approximately 30% at the end of 2011.[31]

Chairman Ryan's "Path to Prosperity" report specified that one of the objectives of the budget resolution is to "fix the Medicare physician payment formula for the next ten years so that Medicare beneficiaries continue to have access to health care."[32] The physician payment system would be designed so that physicians who treat Medicare beneficiaries would be provided incentives to improve quality and efficiency. The Committee Report (H.Rept. 112-158) notes that the inclusion of the SGR reserve fund in the budget resolution accommodates a fix to the SGR.[33] The reserve fund created by Section 304 of H.Con.Res. 34 would provide procedural flexibility to allow for the consideration within the framework of the budget resolution of legislation that would reform SGR, as long as the legislation did not increase the deficit for the period FY2012-FY2021. CBO indicated, however, that on the basis of specifications provided by House Budget Committee staff, its analysis of the long-term budgetary impacts of the proposal did not include a change in the sustainable growth rate mechanism for payments to physicians under Medicare.[34]

Long-Term Medicare Changes (2022 and Beyond)

Starting in 2022, the proposal would phase in an increase in the age of eligibility for Medicare and would convert the current Medicare entitlement program to a fixed federal contribution. CBO estimates that these changes would result in a reduction of federal Medicare spending as a portion of GDP from 4.25% in 2022 to 3.75% in 2050 compared to the projected 7.5% in 2050 under CBO's baseline scenario.[35]

[30] See CRS Report R40907, *Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System*, by (name redacted).

[31] The President's FY2012 Budget Proposal included a proposed freeze on Medicare payment rates for physician services at the 2011 level; CBO scored this proposal as costing $298 billion over 10 years, http://www.cbo.gov/budget/factsheets/2011b/Presidents_Budget_ReEstimate_HealthProvisions.pdf.

[32] House Committee on the Budget Chairman Paul Ryan, "Path to Prosperity: Restoring America's Promise," FY2012 Budget Resolution, April 5, 2011, page 44, http://budget.house.gov/UploadedFiles/PathToProsperityFY2012.pdf#page=44.

[33] Report of the Committee on the Budget, House of Representatives, page 105, http://www.gpo.gov/fdsys/pkg/CRPT-112hrpt58/pdf/CRPT-112hrpt58.pdf.

[34] CBO April 5, 2011, Letter to Rep. Paul Ryan, Long-Term Analysis of a Budget Proposal by Chairman Ryan, page 7, footnote 7, http://cbo.gov/ftpdocs/121xx/doc12128/04-05-Ryan_Letter.pdf#page=9.

[35] CBO, April 8, 2011, "Additional Information on CBO's Long-Term Analysis of a Budget Proposal by Chairman Ryan," http://cbo.gov/ftpdocs/121xx/doc12128/Responding_to_questions_about_estimate_for_Ryan.pdf.

Age of Medicare Eligibility

The budget proposal would gradually increase the Medicare eligibility age to 67. Beginning in 2022, the age of eligibility for Medicare would increase by two months each year until it reached 67 in 2033. Younger individuals could still qualify on the basis of disability.

Conversion of Medicare to a Premium Support System[36]

Under the budget proposal, current Medicare beneficiaries and individuals who become eligible for Medicare prior to 2022 would remain in the current Medicare program (described earlier). Those who are age 55 or older by the end of 2011 or qualify to receive Medicare benefits based on disability prior to 2022 would not see a change. Individuals who become eligible (based either on age or disability) for Medicare in 2022 and later years would not be able to enroll in the current Medicare program. Instead, they would be given the option of enrolling in a private insurance plan through a newly established Medicare exchange.[37] These plans would be required to offer standard benefits set by the Office of Personnel Management, to accept all people eligible for Medicare who apply, and to charge the same premiums for all enrollees of the same age. Those covered under traditional Medicare would also have the option of switching to the new system beginning in 2022.[38]

Under the new system, Medicare would pay a portion of the beneficiaries' premiums, i.e., provide "premium support." The payments would be adjusted for age, health status, and income and would be paid directly by the government to the insurance plan selected by the Medicare beneficiary. In addition, plans with healthier enrollees, would be required to help subsidize plans with less healthy enrollees. In 2022, the premium subsidy would be set at $8,000, on average.[39] The amount of premium support provided to high-income individuals would be reduced.[40] Beneficiaries would pay the difference, if any, between the actual plan premium and the subsidy amount. Premium support payments would increase each year based on increases in the consumer price index for all urban consumers (CPI-U) and the age of the enrollee (under the assumption that older beneficiaries tend to be less healthy and require more and higher cost care). Additionally, for individuals with low income (including "dual-eligibles" – Medicare beneficiaries who also qualify for Medicaid), the federal government would establish medical savings accounts (MSAs) beginning in 2022. Eligibility for MSA payments would be determined annually and be based on income relative to federal poverty levels.[41] The 2022 contribution to an

[36] Assumptions regarding the general parameters of this new system are outlined in the Policy Statement on Medicare, Section 501 of H.Con.Res. 34.

[37] Beginning in 2022, new enrollees would not be required to participate in Medicare; however, there would no longer be separate voluntary portions of Medicare as under the current system (i.e., Parts B and D).

[38] CBO assumed that no one would choose to switch; however, this option could lead to adverse selection in the traditional program if it were to be more cost effective for healthier enrollees to switch into the new program.

[39] This is approximately the same amount as projected net federal spending per capita for 65-year-olds in traditional Medicare that year.

[40] Specifically, those in the top 2% of annual income distribution would receive 30% of the premium support amount, and those in the next 6% of the distribution would receive 50% of the amount. The remaining 92% would receive the full premium support.

[41] In its April 8, 2011 document "Additional Information on CBO's Long-Term Analysis of a Budget Proposal by Chairman Ryan," CBO specified that Medicare beneficiaries with incomes below the federal poverty level would receive the full MSA deposit, and Medicare beneficiaries with incomes between 100% and 150% of the federal poverty level would receive 75% of the amount, http://cbo.gov/ftpdocs/121xx/doc12128/
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MSA would be $7,800, in addition to the $8,000 premium subsidy, and the annual amounts in subsequent years would grow with the CPI-U.

Because the new system will be phased in over time, two separate Medicare systems would need to operate simultaneously as long as those aged 55 and older as of the end of 2011 are still living.[42] In its analysis, CBO noted potential concerns with both systems. For example, CBO projects that restraints to payments to providers of health care services under the current system could lead to fewer providers willing to accept Medicare patients. Additionally, as the average age of individuals in traditional Medicare increased through time (because younger ones would be enrolling in a different system), the average per capita costs of individuals remaining in this system would be expected to increase as well (Medicare Part B and D premiums calculations are based on a percentage of costs).[43]

Under the premium support model, CBO estimates that Medicare beneficiaries participating in the new system would bear a much larger share of their health care costs than they would under the current program. First, private plans would cost more than traditional Medicare because of differences in payment rates for providers, administrative costs and utilization of health care services. For example, in 2011, CBO estimates that average spending in traditional Medicare for a typical 65-year-old would be 11% less than the spending that would occur if that same package of benefits were purchased from a private insurer.

Additionally, CBO projects that the premium support payments would not keep pace with increases in health care costs and leave larger portions for beneficiaries to pay. CBO estimates that by 2030, beneficiaries' spending on premiums and out-of-pocket share of health care spending for a typical Medicare beneficiary would increase from projections of 25% under current law, or 30% under CBO's alternative fiscal scenario,[44] to 68% for benefits similar to those currently provided by Medicare. The differences in specified growth rates are the fundamental reason why CBO projects that deficits and debt will be much smaller than under CBO's long-term budget scenarios.

Those who support converting the current system to a premium support model note that it sets a limit for the federal portion of Medicare spending and that an overhaul of the Medicare program is needed in order to avoid a debt crisis. Supporters also suggest that the new system would add price incentives at the consumer level and plans would be incentivized to control costs in order to be competitive. In addition to concerns over increased out-of-pocket spending for health care for the elderly and the potential for the erosion of benefit coverage, those who oppose the model

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[42] CBO estimates that, in 2022, 6% of Medicare beneficiaries will be in the new system; 45% in 2030, 77% in 2040, and 93% in 2050.

[43] Under the proposal, enrollee premiums would be adjusted so that enrollees would pay premiums based on expected costs under current law rather than on the actual higher average per capita costs.

[44] In its "Long-Term Budget Outlook," (June 2010; revised August 2010), http://www.cbo.gov/ftpdocs/115xx/doc11579/06-30-LTBO.pdf.], CBO made projections based on two different assumptions. Its "extended-baseline" scenario was constructed on the assumption that current law would continue without change. Its "alternative fiscal" scenario incorporated several changes to current law that would be expected to occur or that might be difficult to sustain for a long period. Those assumed changes include the extension of certain tax cuts, an increase in Medicare payment rates for physicians, and, after 2020, the repeal of some PPACA policies designed to restrain Medicare spending.

maintain that the proposal does not address the main reason for the growth in Medicare spending, i.e., excessive costs in the health care delivery system.

Medicaid

In FY2011, the Medicaid program will cover an estimated 69.5 million people. Medicaid is a means-tested entitlement program that finances the delivery of primary and acute medical services as well as long-term care.[45] Medicaid is jointly funded by the federal government and the states.[46] Federal Medicaid payments to states are estimated to reach $275 billion in FY2011, which would include $12 billion as a result of increased federal medical assistance percentage funding that Congress provided through the American Recovery and Reinvestment Act (P.L. 111-5).[47] In a typical year, the federal government covers roughly 57% of the total cost for Medicaid. As a percent of GDP, federal Medicaid spending is expected to reach about 1.9% of GDP in FY2011.[48]

Each state designs and administers its own version of Medicaid under broad federal rules. While states that choose to participate in Medicaid must comply with all federal mandated requirements, state variability is the rule rather than the exception in terms of eligibility levels, covered services, and how those services are reimbursed and delivered. PPACA makes changes along these dimensions for the Medicaid program. Some of the changes are mandatory for states and others are available at state option. Most notable of these provisions is the expansion of Medicaid eligibility levels for individuals under the age of 65 with incomes up to 133% of the federal poverty level.[49]

Estimates provided in Chairman Ryan's "Path to Prosperity" report suggest that the proposed budget would reduce federal outlays for Medicaid by about $771 billion from FY2012-FY2021 compared to CBO's baseline projection.[50] According to CBO's long-term analysis of the proposal,

[45] For more information about the Medicaid program, see CRS Report RL33202, *Medicaid: A Primer*, by (name reda cted).

[46] The amount of federal funds states receive for their Medicaid programs is determined by the federal medical assistance percentage (FMAP) formula. The FMAP is the federal government's share of a state's expenditures for most Medicaid services. For more information about FMAP, see CRS Report RL32950, *Medicaid: The Federal Medical Assistance Percentage (FMAP)*, by (name redacted).

[47] States are currently receiving a temporary Federal Medical Assistance Percentage (FMAP) increase that was included in the American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5) and later extended by H.R. 1586 (which was signed into law as P.L. 111-226). It runs for 11 quarters, from the first quarter of FY2009 through the third quarter of FY2011 (i.e., October 2008 through June 2011), subject to certain requirements. These provisions will result in an estimated $107 billion in increased FMAP assistance (CBO, The Budget and Economic Outlook: An Update, August 2010, p. 13, http://www.cbo.gov/ftpdocs/117xx/doc11705/08-18-Update.pdf; and CBO, Budgetary Effects of Senate Amendment 4575, August 4, 2010, http://www.cbo.gov/ftpdocs/117xx/doc11756/sa4575.pdf).

[48] CBO, The Budget and Economic Outlook, FY2011 to FY2021, January 2011, http://www.cbo.gov/ftpdocs/120xx/doc12039/01-26_FY2011Outlook.pdf.

[49] PPACA establishes 133% of federal poverty level (FPL) based on modified adjusted gross income (MAGI) as the new mandatory minimum Medicaid income eligibility level. The law also specifies that an income disregard in the amount of 5% FPL will be deducted from an individual's income when determining Medicaid eligibility based on MAGI, thus the effective upper income eligibility threshold for such individuals in this new eligibility group will be 138% FPL.

[50] House Committee on the Budget Chairman Paul Ryan, "Path to Prosperity: Restoring America's Promise," FY2012 Budget Resolution, April 5, 2011, Table S-4.

when compared to long-term estimates of current law, federal spending for Medicaid would be 35% lower in FY2022 and 49% lower in FY2030.[51]

Repeal of Certain Medicaid Provisions in PPACA

The Medicaid provisions of PPACA represent the most significant reform to the Medicaid program since its establishment in 1965. In general, PPACA (1) raises Medicaid income eligibility levels for nonelderly individuals up to 133% of the federal poverty level, (2) adds both mandatory and optional benefits to Medicaid, (3) increases the federal matching payments for certain groups of beneficiaries and for particular services provided, (4) provides new requirements and incentives for states to improve quality of care and encourage more use of preventive services, and (5) makes a number of other Medicaid program changes.[52] The major expansion and reform provisions in PPACA are slated to take effect in 2014.

According to CBO's long-term analysis of the budget proposal, all the Medicaid provisions enacted under PPACA would be repealed.[53]

Conversion of Medicaid to a Block Grant System

In an "illustrative policy option," the House Budget Committee Report (H.Rept. 112-58) suggests restructuring Medicaid from an individual entitlement program[54] to a block grant program,[55] starting in FY2013. Few details are available regarding the specific design of the proposed block grant; these include (1) federal funding to states would increase annually according to inflation (CPI-U) and population growth, and (2) states would be provided additional flexibility to design and administer their Medicaid programs. According to CBO, in FY2022, the proposal would further reform the Medicaid program by reducing the Medicaid block grant amounts to reflect the elimination of acute care benefits for elderly individuals. While Medicaid benefits to the elderly would be reduced in FY2022, as discussed above in the Medicare section, beginning in FY2022, "dual-eligibles" (i.e. those individuals eligible for both Medicaid and Medicare) would receive full Medicare premium support plus federally-funded medical savings accounts (MSAs).

Proponents of the block grant model suggest that this design would make federal Medicaid spending more predictable and provide states with stronger incentives to control the cost of their Medicaid programs. Additionally, this design could relieve some of the cost burden to states by removing certain federal Medicaid requirements.

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[51] CBO April 5, 2011, Letter to Rep. Paul Ryan, Long-Term Analysis of a Budget Proposal by Chairman Ryan http://cbo.gov/ftpdocs/121xx/doc12128/04-05-Ryan_Letter.pdf, Page 26.

[52] For more information about the Medicaid provisions in PPACA, see CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in PPACA: Summary and Timeline*, coordinated by (name redacted).

[53] CBO, Long-Term Analysis of a Budget Proposal by Chairman Ryan, April 5, 2011, Page 26.

[54] Individual entitlement means that individuals who meet state eligibility requirements, which must also meet federal minimum requirements, are entitled to Medicaid.

[55] Historically, the term block grant has been used to mean programs for which the federal government provides state governments with a fixed amount of federal funds generally for administering and providing certain services to targeted groups of individuals.

However, this proposal would shift the responsibility for the growth in Medicaid spending over the federal block grant amount to states. According to CBO, the magnitude of the federal Medicaid spending reductions under this proposal would make it difficult for states to maintain their current Medicaid programs. As a result, states would have to weigh the impact of maintaining current Medicaid service levels against other state priorities for spending. They could choose to constrain Medicaid expenditures by reducing provider reimbursement rates, limiting benefit packages, or restricting eligibility. These types of programmatic changes could also impact access to and the quality of medical care for Medicaid enrollees. For example, if states reduced the Medicaid reimbursement rates to providers, such as hospitals, physician, and nursing homes, these providers may be less willing to accept Medicaid patients.

Private Health Insurance

Private health insurance covers about 195 million people in the United States.[56] Workers and their families often receive health insurance as a fringe benefit from their employers. Some individuals and families purchase private insurance on their own, where premiums and benefits may be based on health status and may be more limited than in the employer market.

Reflecting the attributes of these different "customers" for insurance (larger firms, smaller firms, and individuals), the private health insurance market is made up of three different segments: the large group market, the small group market, and the nongroup (individual) market. Each of these market segments offer distinct insurance products, and each is governed by different regulatory structures. Traditionally, the primary regulators of private insurance have been the states. However, overlapping federal requirements complicate the regulation of this industry and enforcement of insurance standards.

PPACA increases access to health insurance coverage, expands federal private health insurance market requirements, and requires the creation of health insurance exchanges to provide individuals and small employers with access to insurance.[57] PPACA also increases access to health insurance coverage by subsidizing private insurance premiums and cost-sharing for certain lower-income individuals enrolled in exchange plans, among other provisions. These costs are projected to be offset by reduced spending for public coverage, and by increased taxes and other revenues, such as a 40% excise tax on health insurers and health plan administrators for coverage that exceeds certain thresholds in 2018.[58]

The law creates several temporary programs to increase access and funding for targeted groups. They include (1) temporary high-risk pools for uninsured individuals with preexisting conditions; (2) a reinsurance program to reimburse employers for a portion of the health insurance claims' costs for their 55- to 64-year-old retirees and their dependents; and (3) small business tax credits for firms with fewer than 25 full-time equivalents (FTEs) and average wages below $50,000 that choose to offer health insurance.

[56] U.S. Census Bureau, Current Population Survey, Table HI01, Health Insurance Coverage Status and Type of Coverage by Selected Characteristics: 2009, http://www.census.gov/hhes/www/cpstables/032010/health/h01_001.htm.

[57] See CRS Report R40942, *Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (PPACA)*, by (name redacted), (name redacted), and (name redacted).

[58] CRS Report R41128, *Health-Related Revenue Provisions in the Patient Protection and Affordable Care Act (PPACA)* , by (name redacted).

Also, most individuals will be required to have insurance or pay a penalty ("individual mandate"). Certain employers with more than 50 employees who do not offer health insurance may be subject to penalties. While most employers who offer health insurance will meet the law's requirements, some may be required to also pay a penalty if any of their full-time workers enroll in exchange plans and receive premium subsidies.

Repeal of Certain Private Health Insurance Provisions in PPACA

The budget resolution creates a health care reform reserve fund (Section 303 H.Con.Res. 34) that would provide procedural flexibility to allow for the consideration, within the framework of the budget resolution, of legislation that would repeal PPACA and the Reconciliation Act, as long as the legislation did not increase the deficit for the period FY2012-FY2021.

According to the CBO analysis of the Ryan budget proposal, the proposal would repeal the following PPACA provisions related to private health insurance:[59]

- Individual mandate;
- Employer requirements and penalties;
- Health insurance exchanges and the premium credits and cost-sharing subsidies for exchange coverage;
- Temporary high risk pool program;
- Early retiree reinsurance program;
- Small business tax credits; and
- Tax on "high cost" plans.

The Ryan "Path to Prosperity" report suggests that $725 billion would be saved over 10 years due to the repeal of the exchange subsidies and implementation-related funding.[60]

The CBO analysis does not specifically address the status of the other private health insurance provisions in PPACA, such as the requirement to extend dependent coverage to children under age 26. These remaining market reforms include requirements on certain health insurance issuers to, for example, accept every applicant for insurance without regard to health ("guaranteed issue"), provide coverage for preexisting health conditions, and establish rates without regard to health factors ("community rating"). Such requirements simultaneously may constrain the ability of issuers to minimize the risk they bear, and create greater incentives for less healthy individuals to obtain insurance. Under a voluntary insurance system, such incentives could lead to an insured population that is disproportionately sicker and in need of more and/or more intensive health care, potentially leading to higher health insurance prices and greater spending overall.[61]

[59] CBO April 5, 2011, Letter to Rep. Paul Ryan, Long-Term Analysis of a Budget Proposal by Chairman Ryan http://cbo.gov/ftpdocs/121xx/doc12128/04-05-Ryan_Letter.pdf.

[60] House Committee on the Budget Chairman Paul Ryan, "Path to Prosperity: Restoring America's Promise," FY2012 Budget Resolution, April 5, 2011, page 30.

[61] For example, see the following documents regarding the impact of similar market reforms enacted at the state level: L. Wachenheim and H. Leida, "The Impact of Guaranteed Issue and Community Rating Reforms on Individual Insurance Markets," Milliman, Inc., August 2007; and D. Chollet, "State Regulation and Initiatives to Expand Small Group Coverage," Testimony submitted to the Senate Committee on Finance, April, 6, 2006.

Other Health Care Proposals

Medical Malpractice

Medical malpractice has attracted congressional attention numerous times over the past few decades, particularly in the midst of three "crisis" periods for medical malpractice liability insurance in the mid-1970s, the mid-1980s, and the early 2000s. These periods were marked by sharp increases in medical liability insurance premiums, difficulties in finding any liability insurance in some regions and among some specialties as insurers withdrew from providing coverage, reports of providers leaving areas or retiring following insurance difficulties, and a variety of public policy measures at both the state and federal levels to address the market disruptions. In each case, attention receded to some degree after a few years as premium increases moderated and market conditions calmed.

The overall medical liability insurance market is not currently exhibiting the same level of crisis as in previous time periods. Nonetheless, problems with the affordability and availability of malpractice insurance persist, especially in particular regions and physician specialties (e.g., obstetricians). In addition, the fear of claims for medical malpractice may affect individual provider decisions particularly through increased use of tests and procedures to protect against future lawsuits ("defensive medicine") and drive up the overall cost of health care.[62]

According to the CBO analysis of the Ryan budget proposal, the proposal assumes reforms to tort law governing medical malpractice.[63] The tort reforms would include:

- A cap of $250,000 on awards for noneconomic damages;
- A cap on awards for punitive damages of $500,000 or two times the award for economic damages, whichever is greater;
- Modification of the "collateral source" rule to allow evidence of income from such sources as health and life insurance, workers' compensation, and automobile insurance to be introduced at trials or to require that such income be subtracted from awards decided by juries;
- A statute of limitations—one year for adults and three years for children—from the date of discovery of an injury; and
- Replacement of joint-and-several liability with a fair-share rule, under which a defendant in a lawsuit would be liable only for the percentage of the final award that was equal to his or her share of responsibility for the injury.[64]

[62] CRS Report R41693, *Medical Malpractice: Background and Legislation in the 112th Congress*, by (name redacted), (name redacted), and (name redacted).

[63] CBO April 5, 2011, Letter to Rep. Paul Ryan, Long-Term Analysis of a Budget Proposal by Chairman Ryan http://cbo.gov/ftpdocs/121xx/doc12128/04-05-Ryan_Letter.pdf, page 10.

[64] A 2009 CBO score of the same malpractice reform proposal estimated that such reforms collectively would lead to a 10% reduction in malpractice insurance premiums and "reduce total national health care expenditures by about 0.2 percent," equivalent to $54 billion over a 10-year period (FY2010-FY2019). Congressional Budget Office, letter to the Honorable Orrin G. Hatch about CBO's analysis of the effects of proposals to limit costs related to medical malpractice, October 9, 2009. Moreover, CBO conducted a recent estimate of federal tort reform legislation (H.R. 5) introduced during this current congressional session. In its analysis of the potential impact of H.R. 5 on the federal (continued...)

Long-Term Care Insurance

PPACA established a federally administered voluntary long-term care insurance program entitled the Community Living Assistance Services and Supports (CLASS) program.[65] Under this program, active workers will be able to purchase long-term care insurance, usually through one's employer, and premiums are to be set to cover the full cost of the program. The budget proposal would repeal the CLASS Act.[66]

Prevention and Public Health Activities

The CBO analysis indicated that a number of mandatory grant programs including funds for prevention and public health activities created by PPACA would be repealed. [67] However, insufficient detail was provided to identify the specific PPACA provisions that would be repealed.

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budget deficit, CBO estimated that the deficit would be reduced by approximately $40.1 billion over 10 years (FY2012-FY2021).

[65] CRS Report R40842, *Community Living Assistance Services and Supports (CLASS) Provisions in the Patient Protection and Affordable Care Act (PPACA)*, by (name redacted) and (name redacted).

[66] In its February 18, 2011 cost estimates of H.R. 2 that would repeal PPACA and the Reconciliation Act, CBO indicated that the repeal of CLASS would result in increased costs of $86 billion over 2012-2021, http://www.cbo.gov/ftpdocs/120xx/doc12069/hr2.pdf.

[67] See CRS Report R41278, *Public Health, Workforce, Quality, and Related Provisions in PPACA: Summary and Timeline*, coordinated by (name redacted) and (name redacted).