Overview of Health Care Changes in the FY2013 Budget Proposal Offered by House Budget Committee Chairman Ryan

Patricia A. Davis
Specialist in Health Care Financing

Alison Mitchell
Analyst in Health Care Financing

Bernadette Fernandez
Specialist in Health Care Financing

March 29, 2012

Congressional Research Service
7-5700
www.crs.gov
R42441

CRS Report for Congress
Prepared for Members and Committees of Congress

Summary

On March 20, 2012, House Budget Committee Chairman Paul Ryan released the Chairman's mark of the FY2013 House budget resolution together with his report entitled "The Path to Prosperity: A Blueprint for American Renewal," 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 March 21, 2012, and voted to report the budget resolution to the full House. H.Con.Res. 112 was introduced in the House March 23, 2012, and was accompanied by the committee report H.Rept. 112-421. H.Con.Res. 112 was agreed to by the House on March 29, 2012.

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 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 as amended (ACA, P.L. 111-148, P.L. 111-152).

Within the 10-year budget window (FY2013-FY2022), the budget proposal assumes that certain ACA provisions would be repealed, including those that expand Medicaid coverage to the non-elderly with incomes up to 133% of the federal poverty level, and those provisions that establish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. Beyond the 10-year budget window, beginning in 2023, the budget proposal assumes an increase in the age of eligibility for Medicare and the conversion of Medicare to a fixed federal contribution program.

This report summarizes the proposed changes to Medicare, Medicaid, and private health insurance as described in H.Con.Res. 112, the accompanying committee report, Chairman Ryan's "Path to Prosperity" report, and the CBO analysis. Additionally, it briefly examines the potential impact of the proposed changes on health care spending and coverage.

Contents

Tables

Contacts

Introduction

On March 20, 2012, Representative Paul Ryan, the Chairman of the House Budget Committee, released the Chairman's mark of the FY2013 House budget resolution.[1] Additional detail on budgetary objectives and justifications was provided in Chairman Ryan's report entitled "The Path to Prosperity: A Blueprint for American Renewal," issued the same day.[2] The House Budget Committee considered the Chairman's mark on March 21, 2012, and voted 19-18 to report the budget resolution to the full House.[3] H.Con.Res. 112 was introduced in the House March 23, 2012, and was accompanied by the House Budget Committee report (H.Rept. 112-421). The House agreed to H.Con.Res. 112 on March 29, 2012, by a vote of 228 to 191.

The House budget resolution sets general budgetary parameters.[4] Among other things, it expresses the desired levels of spending for government health programs over 10 years (FY2013-FY2022), creates two health care-related reserve funds, and presents a policy statement regarding assumptions about future Medicare reforms. The budget resolution includes instructions for reconciliation to six committees, which are instructed to identify specified dollar amounts of deficit reduction.[5] 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.

The Congressional Budget Office (CBO) was asked to provide an analysis of the long-term budgetary impact of Chairman Ryan's budget proposal, and issued its report on March 21, 2012.[6] CBO was provided additional detail by the staff of the House Budget Committee regarding assumptions that should be made while conducting the analysis that were not included in the budget resolution language 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 and was asked to provide an impact analysis beyond the 10-year budgetary window.[7] To conduct its analysis, CBO used its most recent long-

[1] The Chairman's mark may be found at http://budget.house.gov/UploadedFiles/chairmans_mark_FY013.pdf.

[2] This report may be found at http://budget.house.gov/UploadedFiles/Pathtoprosperity2013.pdf.

[3] The Concurrent Resolution on the Budget as Recorded was made available on March 22, 2012, http://budget.house.gov/UploadedFiles/Concurrent_Resolution_Budget_FY_2013.pdf.

[4] For more information on the budget process, see CRS Report 98-721, *Introduction to the Federal Budget Process*, coordinated by Bill Heniff Jr.; 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 Mindy R. Levit.

[5] These committees include the Ways and Means Committee and the Energy and Commerce Committee, which have jurisdiction over different parts of Medicare. However, these committees may report legislation to change any spending and/or revenue policies within their jurisdictions as long as it lowers the deficit by the amount specified. For details on the reconciliation process, see CRS Report R41151, *Budget Reconciliation Process: Timing of Committee Responses to Reconciliation Directives*, by Megan Suzanne Lynch.

[6] Congressional Budget Office, *The Long-Term Budgetary Impact of Paths for Federal Revenues and Spending Specified by Chairman Ryan*, March 2012, http://cbo.gov/sites/default/files/cbofiles/attachments/03-20-Ryan_Specified_Paths_2.pdf.

[7] A cost estimate for legislation would require much more detailed analysis, focus on the first 10 years, and be based on (continued...)

term projections, which are based on an extension of CBO's baseline forecasts issued in March 2012.[8]

In general, the budget proposal, as outlined in Chairman Ryan's "Path to Prosperity" report, in the committee report, and in CBO's analysis, suggests a change in the structure of the Medicare and Medicaid programs; the repeal of many of the provisions in the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010 (ACA, P.L. 111-148, P.L. 111-152), including those that establish insurance exchanges; and changes to tort law governing medical malpractice.

This report provides a synopsis of the health care-related changes in Chairman Ryan's FY2013 budget proposal. This summary is based on the text of the Concurrent Resolution, the committee report, the FY2013 "Path to Prosperity" report, and the CBO analysis of the proposal.[9] The collective details are referred to in this report as the "budget proposal" or Chairman Ryan's proposal. CRS provided a similar summary of the proposed health care changes included in the FY2012 House Budget in CRS Report R41767, *Overview of Health Care Changes in the FY2012 Budget Offered by House Budget Committee Chairman Ryan*.

Medicare

Medicare is the nation's federal insurance program that pays for covered health services for most persons 65 years old and older and for most permanently disabled individuals under the age of 65. Generally, individuals are eligible for Medicare if they or their spouse worked for at least 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).[10]

In FY2012, the program will cover an estimated 50 million persons at an estimated total cost of $576 billion, accounting for approximately 3.6% of GDP. CBO estimates that federal Medicare spending (after deduction of beneficiary premiums and other offsetting receipts) will be about $492 billion in FY2012, accounting for about 13.7% of total federal spending.[11] Medicare is an

(...continued)

more recent baseline projections made by CBO (rather than those provided by the Budget Committee).

[8] For CBO's most recent baseline projections, see Congressional Budget Office, *Updated Budget Projections: Fiscal Years 2012 to 2022*, March 2012.

[9] Some of the Medicare reform assumptions underlying the FY2013 budget resolution are similar to those in a Medicare reform proposal issued jointly by Chairman Ryan and Senator Wyden in December 2011, http://paulryan.house.gov/UploadedFiles/WydenRyan.pdf. However, the FY2013 Ryan budget proposal is not the same as the Ryan/Wyden proposal. For example, see Chairman Ryan's statements at http://www.aei.org/events/2012/03/20/a-blueprint-for-american-renewal-an-address-by-house-budget-committee-chairman-paul-ryan/ @ 28.34 minutes. Therefore, the sources used in this CRS paper were limited to documentation provided in connection with the proposed FY2013 House budget resolution.

[10] ACA added an additional eligibility category; individuals with one or more specified lung diseases or types of cancer who lived for six 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.

[11] Congressional Budget Office, *Medicare Baseline*, March 2012, http://www.cbo.gov/sites/default/files/cbofiles/attachments/43060_Medicare.pdf.

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.[12]

- **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%.) ACA added an additional 0.9% hospital insurance tax on high-income taxpayers beginning in 2013.
- **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, and certain low-income enrollees receive assistance with their premiums from Medicaid. 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. About 12 million (25%) of Medicare beneficiaries are enrolled in MA.
- **Part D** covers outpatient prescription drug benefits. Funding is included in the SMI trust fund and is financed through beneficiary premiums (set to cover 25.5% of costs),[13] with the rest paid for out of general revenues and state transfer payments. High-income enrollees pay higher premiums, and low-income enrollees may receive assistance from Medicare with premiums and cost sharing. This portion of the program is also voluntary; about 60% of eligible Medicare beneficiaries are enrolled in a Part D plan, while another 13% are enrolled in an employer plan subsidized by Medicare.

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.[14]

[12] For additional detail on the Medicare program and its financing, see CRS Report R40425, *Medicare Primer*, coordinated by Patricia A. Davis, and CRS Report R41436, *Medicare Financing*, by Patricia A. Davis.

[13] Because Part D premiums are based on the cost of standard benefits (e.g., they do not include program costs associated with low-income subsidies) and about a third of enrollees do not pay premiums because they qualify for low-income assistance, only about 11% of Part D program costs are covered by premiums.

[14] Under a *prospective payment system* (PPS), Medicare payments are made using a predetermined, fixed amount based on the classification system for a particular service. CMS uses separate PPSs to reimburse acute inpatient hospitals, home health agencies, hospice, hospital outpatient, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, and skilled nursing facilities. A *fee schedule* is a listing of fees used by Medicare to pay doctors or other providers/suppliers. Fee schedules are used to pay for physician services, ambulance services, clinical (continued...)

Under Parts C and D, private insurers are paid a monthly "capitated" amount to provide enrollees with at least a minimum standard benefit.[15] 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.

Since its establishment in 1965, the Medicare program has undergone considerable change. Most recently, ACA 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.[16]

Short-Term Medicare Changes (FY2013-FY2022)

Under CBO's Medicare baseline, net Medicare outlays are expected to total approximately $6.6 trillion over the next 10 years (FY2013-FY2022).[17] The House budget resolution suggests total Medicare outlays of about 2% less than CBO's baseline over the same period. Because CBO's spending baseline is based on current law, its figures are based on the assumption that physician payment reductions[18] and the 2% reduction in Medicare spending under Budget Control Act of 2011 sequestration requirements[19] will both occur starting in 2013. Therefore, any reductions that are assumed under the proposed budget would be in addition to spending reductions already scheduled to occur (or to equivalent alternative spending reductions). The proposal did not suggest specific program changes that would reduce Medicare spending to this level over the 10-year period.[20]

The budget proposal also assumes a repeal of the Independent Payment Advisory Board (IPAB) created by the ACA (Section 3403, as modified by 10320).[21] Under current law, beginning in

(...continued)

laboratory services, and durable medical equipment, prosthetics, orthotics, and supplies.

[15] Medicare Parts C and D plans are paid a set monthly per person amount to provide covered benefits.

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

[17] CRS analysis based on figures from CBO March 2012 *Medicare Baseline* and H.Con.Res. 112.

[18] 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 Congress. Unless additional action is taken, Medicare physician payments will be reduced by approximately 27% at the end of 2012. The President's FY2013 Budget Proposal included a proposed freeze on Medicare payment rates to physicians at the 2012 levels. CBO scored this provision as costing $271 billion over 10 years, http://www.cbo.gov/publication/43083. For further information see CRS Report R40907, *Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System*, by Jim Hahn and Janemarie Mulvey.

[19] CBO estimates that under sequestration, Medicare spending will be reduced by approximately $99.3 billion from FY2013-FY2022. Congressional Budget Office, *Medicare Baseline*, March 2012, http://www.cbo.gov/sites/default/files/cbofiles/attachments/43060_Medicare.pdf. Also see CRS Report R41965, *The Budget Control Act of 2011*, by Bill Heniff Jr., Elizabeth Rybicki, and Shannon M. Mahan.

[20] The committee report suggested that a portion of the program savings over the next 10 years could come from additional means-testing of Parts B and D premiums for high-income seniors.

[21] See CRS Report R41511, *The Independent Payment Advisory Board*, by Jim Hahn and Christopher M. Davis.

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. CBO estimates that the repeal of IPAB would cost $3.1 billion over 10 years.[22] No other ACA Medicare provisions were explicitly mentioned.

In addition, the committee report (H.Rept. 112-421) notes that the budget accommodates legislation that fixes the Medicare physician payment formula for the next 10 years. Specifically, Section 403 of H.Con.Res. 112 would provide procedural flexibility to allow for the consideration within the framework of the budget resolution of legislation that would reform the sustainable growth rate system (SGR), as long as the legislation did not increase the deficit for the period FY2013-FY2022.

As a result of these reductions (and changes that begin in FY2023), CBO estimates that Medicare spending as a portion of GDP in 2023 would decrease from 3.75% under CBO's baseline to 3.50% under the budget proposal.[23]

Long-Term Medicare Changes (FY2023 and Beyond)

Starting in 2023, the Ryan budget proposal would phase in an increase in the age of eligibility for Medicare and would convert the current Medicare defined benefits program to a fixed federal contribution. Assumptions regarding the broad parameters of the new system are outlined in Section 601, the "Policy Statement on Medicare," of H.Con.Res. 112.[24] The "Path to Prosperity" document and the House report offer more specificity on suggested changes. However, as previously noted, while a budget resolution may suggest broad policy changes, separate legislation would need to be developed by the committees of jurisdiction and enacted into law to effect such changes.

Age of Medicare Eligibility

The budget proposal would gradually increase the Medicare eligibility age to 67. Beginning in 2023, the age of eligibility for Medicare would increase by two months each year until it reached 67 in 2034. Younger individuals could still qualify on the basis of disability.

Conversion of Medicare to a Premium Support System

Under the Ryan budget proposal, current Medicare beneficiaries and individuals who become eligible for Medicare prior to 2023 (i.e., those who turn 55 in 2012), would remain in the current Medicare program (described earlier). Individuals who become eligible (based either on age or disability) for Medicare beginning in 2023 would be given the option of enrolling in a private

[22] On March 21, 2012, the House passed H.R. 5, which would, among other things, repeal the ACA provisions that created IPAB. CBO estimates that enacting the provision that would repeal the IPAB would increase deficits by $3.1 billion over the FY2013-FY2022 period and would need to be offset under pay-go rules, http://www.cbo.gov/sites/default/files/cbofiles/attachments/HR_5_Rules.pdf.

[23] CBO, March 2012, "The Long-Term Budgetary Impact of Paths for Federal Revenues and Spending Specified by Chairman Ryan," Table 2, http://cbo.gov/sites/default/files/cbofiles/attachments/03-20-Ryan_Specified_Paths_2.pdf.

[24] The language in the *Medicare Reform* and *Assumptions* sections of the "Policy Statement on Medicare" in the FY2013 budget resolution H.Con.Res. 112 is identical to that contained in the FY2012 House budget, H.Con.Res. 34.

insurance plan or a traditional fee-for-service option through a newly established Medicare exchange.[25] These plans would be required to offer standard benefits that are at least actuarially equivalent to traditional fee-for-service benefits, and to accept all people eligible for Medicare who apply regardless of age or health status.

All of the plans, including the traditional fee-for-service option, would engage in an annual competitive bidding process. The lower of the second-lowest approved plan bid or fee-for-service Medicare would be used to establish the amount of the subsidy (premium support) provided by Medicare and the base premium paid by Medicare beneficiaries.[26] The amount of the subsidy would generally be the same regardless of the cost of the plan; so, for instance, if a beneficiary selects a plan whose bid is higher than the second lowest bid, the beneficiary would pay a higher premium to make up the difference between the subsidy and the base premium. Similarly, if the beneficiary enrolls in a plan that bid lower than the second-lowest approved bid, the beneficiary would be provided a rebate in the amount of the difference. The payments to plans would be geography-rated and risk-adjusted for health status. Additionally, based on annual risk reviews conducted by the Centers for Medicare and Medicaid Services (CMS), fees would be imposed on plans that enrolled a higher-than-average number of low-risk beneficiaries; those that enrolled a higher-than-average number of high-risk (expensive) enrollees would receive incentive payments funded by the fees from the low-risk plans.

In 2023, the premium subsidy would be set at $7,500, on average.[27] The amount of premium support provided to high-income individuals would be reduced.[28] Low-income beneficiaries would be provided a dedicated savings account to be used to pay premiums, co-pays, and other out-of-pocket costs. The proposal suggests that program cost growth would be mitigated through the competitive bidding process; however, should that not occur, the proposal would limit annual per capita premium support increases to nominal GDP growth plus 0.5%.[29] Should actual costs exceed this amount, Medicare beneficiaries would pay increased premiums to make up the difference. The proposal would limit the impact of these increases for low-income enrollees, with Medicaid continuing to pay for the out-of-pocket expenses for dual-eligibles (those who qualify for both Medicare and Medicaid), and additional funding would be provided in savings accounts for those who meet certain low-income limits but do not qualify for Medicaid.

Under this premium support model, CBO estimates that by 2030, 39% of Medicare beneficiaries would be enrolled in this new system and thus subject to these new spending constraints, and by 2050, this number would increase to 91%. While average spending per Medicare beneficiary is still expected to increase through time, it would do so at a slower rate. For example, in 2050, under the new system, spending for new enrollees (67 years old) would be $11,100 per year (in 2011 dollars) compared with $17,000 under CBO's baseline scenario.[30] Under this proposal, net

[25] Those who qualify for Medicare prior to 2023 would also be given the option of switching to the new system.

[26] By comparison, competitive bidding under Medicare Part D bases plan subsidies and beneficiary premiums on the national weighted average bid.

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

[28] The means-testing thresholds currently used to establish Medicare Parts B and D premiums would apply. See CRS Report R40425, *Medicare Primer*, coordinated by Patricia A. Davis.

[29] By contrast, the Ryan/Wyden proposal would limit annual premium support increases to GDP+1, http://paulryan.house.gov/UploadedFiles/WydenRyan.pdf.

[30] CBO based its projections on figures of Medicare spending amounts (through 2022) and growth rates (years 2023 and beyond) provided by Chairman Ryan and his staff. CBO did not analyze the policies that might be implemented to (continued...)

federal Medicare spending as a share of GDP would be expected to grow from 3.25% in 2011 to 4.75% in 2050, compared with 6.50% in 2050 under CBO's baseline scenario (see **Table 1**).

Table 1. Comparison of Federal Spending on Medicare Under Chairman Ryan's Proposal Versus CBO Scenarios

As a Percentage of Gross Domestic Product

	Actual	Projected			
	FY2011	**FY2023**	**FY2030**	**FY2040**	**FY2050**
CBO Extended Baseline Scenario[a]	3.25%	3.75%	4.50%	5.50%	6.50%
CBO Extended Alternative Fiscal Scenario[b]	3.25%	4.00%	5.00%	6.25%	7.25%
Chairman Ryan's Proposal	3.25%	3.50%	4.25%	4.75%	4.75%

Source: Congressional Budget Office, *The Long-Term Budgetary Impact of Paths for Federal Revenues and Spending Specified by Chairman Ryan*, March 2012.

a. As specified in law, and to provide a benchmark against which potential legislation can be measured, CBO constructs its baseline estimates of federal revenues and spending under the assumption that current laws generally remain unchanged.

b. To illustrate the budgetary consequences of maintaining the tax and spending policies that have recently been in effect, CBO has also produced projections under an "alternative fiscal scenario." That scenario incorporates the following assumptions: expiring tax provisions (excluding the current reduction in the payroll tax rate for Social Security) are extended; the alternative minimum tax is indexed for inflation after 2011; Medicare's payment rates for physicians' services are held constant at their current level (rather than dropping by an estimated 27% in January 2013 and more thereafter, as scheduled under current law); and the automatic spending reductions required by the Budget Control Act, which are set to take effect in January 2013, do not occur (although the original caps on discretionary appropriations in that law are assumed to continue).

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. Those who oppose the model express concerns over the potential for increased out-of-pocket spending for health care for the elderly, the potential for the erosion of benefit coverage, and reduced access to health care services. Some also 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).

The impact of the proposed Medicare changes on the federal government, beneficiaries, and health care plans and providers would ultimately depend on how such a premium support system is designed and implemented. Numerous decisions, ranging from fundamental social policy decisions about the appropriate nature and level of federal financial support of the elderly to detailed administrative decisions, would need to be made before such a model could become operational. For example, decisions would need to be made regarding which parts of Medicare would be financed through premium subsidies, for example, would Parts A and B (and possibly D) and their trust funds be combined; would changes be made to the voluntary nature of Parts B

(...continued)

produce these levels of Medicare spending over time.

and D (or could one opt out of Medicare entirely); and would beneficiary premiums be based on expected per capita Part B and D costs, or would they include the costs of Part A (which is now premium free for most enrollees). Decisions would also need to be made regarding whether Medicare Advantage would still be an option after 2023 for those currently age 55 and older or whether private plans would only be available through the exchanges, and whether the financial risk to private plans participating in the exchanges would be mitigated to encourage participation (e.g., Part D provides reinsurance for catastrophic costs and has risk corridors to limit losses). Additionally, as a final example, an administrative structure, including appropriate information technology systems, would need to be designed and established to support both traditional Medicare options and new options under the exchanges.

Medicaid

Medicaid is a means-tested entitlement program that finances the delivery of primary and acute medical services as well as long-term care.[31] Medicaid is jointly funded by the federal government and the states.[32] In FY2012, the Medicaid program will cover an estimated 67 million people at any point during the fiscal year, and federal Medicaid payments to states are estimated to reach $275 billion in FY2012.[33] In a typical year, the federal government covers roughly 57% of the total cost for Medicaid. Federal Medicaid spending is expected to reach about 1.7% of GDP in FY2012.[34]

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. ACA makes changes along these dimensions for the Medicaid program. Some of the changes are mandatory for states, and others may be implemented at state option. Most notable of these provisions is the expansion of Medicaid eligibility for individuals under the age of 65 with income up to 133% of the federal poverty level.[35]

The unofficial estimate provided in Chairman Ryan's "Path to Prosperity" report states that the proposed budget would reduce federal outlays for Medicaid by about $810 billion over 10 years.[36]

[31] For more information about the Medicaid program, see CRS Report RL33202, *Medicaid: A Primer*, by Elicia J. Herz.

[32] 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 Alison Mitchell and Evelyne P. Baumrucker.

[33] Congressional Budget Office, Medicaid Spending and Enrollment Detail for CBO's March 2012 Baseline, March 2012.

[34] Congressional Budget Office, The Budget and Economic Outlook: FY2012 to FY2022, January 2012.

[35] ACA 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 must 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. On November 21, 2011, President Obama signed into law P.L. 112-56, which will change the definition of income for Medicaid to include non-taxable Social Security in the definition of MAGI.

[36] House Committee on the Budget Chairman Paul Ryan, "Path to Prosperity: A Blueprint for American Renewal," FY2013 Budget Resolution, March 20, 2012.

When compared to CBO's baseline projection for federal Medicaid spending,[37] the proposal would reduce federal Medicaid outlays by 17.6% from FY2013 to FY2022.

According to CBO's long-term analysis of the proposal, when compared with long-term estimates of current law, combined federal spending for Medicaid, the State Children's Health Insurance Program (CHIP), and the exchange subsidies will be 76% to 78% lower in FY2050.[38] Since spending on CHIP and exchange subsidies is expected to be small relative to federal spending on Medicaid over this time period, most of the reduction will come from the Medicaid program.[39]

Table 2 shows a comparison of projected federal spending on Medicaid, CHIP, and exchange subsidies as a percentage of GDP under CBO's extended baseline scenario, CBO's extended alternative fiscal scenario, and Chairman Ryan's proposal. By 2023, under Chairman Ryan's proposal, Medicaid and CHIP spending would comprise 1.25% of GDP, while under both CBO scenarios federal spending on Medicaid, CHIP, and exchange subsidies would total 3.00% of GDP.

Table 2. Comparison of Federal Spending on Medicaid, CHIP, and Exchange Subsidies Under Chairman Ryan's Proposal Versus CBO Scenarios

As a Percentage of Gross Domestic Product

	Actual	Projected			
	FY2011	**FY2023**	**FY2030**	**FY2040**	**FY2050**
CBO Extended Baseline Scenario[a]	2.00%	3.00%	3.25%	4.00%	4.25%
CBO Extended Alternative Fiscal Scenario[b]	2.00%	3.00%	3.50%	4.00%	4.50%
Chairman Ryan's Proposal	2.00%	1.25%	1.25%	1.00%	1.00%

Source: Congressional Budget Office, *The Long-Term Budgetary Impact of Paths for Federal Revenues and Spending Specified by Chairman Ryan*, March 2012.

Notes: CBO: Congressional Budget Office; **CHIP:** State Children's Health Insurance Program.

a. As specified in law, and to provide a benchmark against which potential legislation can be measured, CBO constructs its baseline estimates of federal revenues and spending under the assumption that current laws generally remain unchanged.

b. To illustrate the budgetary consequences of maintaining the tax and spending policies that have recently been in effect, CBO has also produced projections under an "alternative fiscal scenario." That scenario incorporates the following assumptions: expiring tax provisions (excluding the current reduction in the payroll tax rate for Social Security) are extended; the alternative minimum tax is indexed for inflation after 2011; Medicare's payment rates for physicians' services are held constant at their current level (rather than dropping by an estimated 27% in January 2013 and more thereafter, as scheduled under current law); and the automatic spending reductions required by the Budget Control Act, which are set to take effect in January 2013, do not occur (although the original caps on discretionary appropriations in that law are assumed to continue).

[37] Congressional Budget Office, Medicaid Spending and Enrollment Detail for CBO's March 2012 Baseline, March 2012.

[38] Congressional Budget Office, The Long-Term Budgetary Impact of Paths for Federal Revenues and Spending Specified by Chairman Ryan, March 2012.

[39] According to CBO estimates of mandatory outlays in FY2022, the combined federal outlays for Medicaid, health insurance subsidies, exchanges, and related spending, and CHIP would total to $715 billion, and federal Medicaid expenditures would comprise 85% of that total amount. Congressional Budget Office, *The Budget and Economic Outlook: FY2012 to FY2022*, January 2012.

Repeal of Certain Medicaid Provisions in ACA

The Medicaid provisions of ACA represent the most significant reform to the Medicaid program since its establishment in 1965. In general, ACA (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.[40] The major expansion and reform provisions in ACA are slated to take effect in 2014.

One of the "illustrative policy options" offered in the House Budget Committee report (H.Rept. 112-421) includes repealing the Medicaid expansion included in ACA.

Conversion of Medicaid to a Block Grant System

Another "illustrative policy option" included in the House Budget Committee report (H.Rept. 112-421) is restructuring Medicaid from an individual entitlement program[41] to a block grant program.[42] Few details are available regarding the specific design of the proposed block grant. The proposal indicates that (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.

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.[43]

According to CBO, the implications of converting Medicaid to a block grant program would depend on how states respond to the change. With the added flexibility provided under Chairman Ryan's proposal, states could improve the efficiency of their Medicaid programs. However, even with significant efficiency gains, the magnitude of the federal Medicaid spending reductions under this proposal would make it difficult for states to maintain their current Medicaid programs.[44] 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, and/or

[40] For more information about the Medicaid provisions in ACA, see CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in ACA: Summary and Timeline*, by Evelyne P. Baumrucker et al.

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

[42] 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.

[43] For additional information on block grants, see CRS Report R40486, *Block Grants: Perspectives and Controversies*, by Robert Jay Dilger and Eugene Boyd.

[44] Congressional Budget Office, The Long-Term Budgetary Impact of Paths for Federal Revenues and Spending Specified by Chairman Ryan, March 2012.

restricting eligibility. These types of programmatic changes could also affect the access to and the quality of medical care for Medicaid enrollees. For example, if states reduce the Medicaid reimbursement rates to providers, such as hospitals, physician, and nursing homes, these providers may be less willing to participate in Medicaid at all or accept new Medicaid patients.

Private Health Insurance

Private health insurance covers over 195 million people in the United States.[45] 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 subject to different regulatory standards. 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.

ACA's private market provisions were designed to expand federal standards applicable to the private health insurance market,[46] and increase access to coverage, such as establishment grants for the creation of state-based exchanges to offer private health insurance options to individuals and small employers. The law 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.

ACA creates several programs to increase access and funding for targeted groups, including establishment of temporary high-risk pools for uninsured individuals with preexisting conditions, and funding for non-profit organizations offering coverage to small businesses and individuals. Other private insurance provisions include those that build on the state-based regulatory system, such as the review of proposed increases of health insurance premiums, and programs to mitigate risk across health plans (such as risk adjustment and reinsurance).

Repeal of Certain Private Health Insurance Provisions in ACA

H.Con.Res. 112 contains a reserve fund (Section 401) that would provide procedural flexibility to allow for the consideration of legislation that would repeal ACA as amended. Moreover, one of the "illustrative policy options" included in the House Budget Committee report is repeal of the "exchange subsidies created by the new health care law."[47]

[45] U.S. Census Bureau, Current Population Survey, Table HI01, Health Insurance Coverage Status and Type of Coverage by Selected Characteristics: 2010, http://www.census.gov/hhes/www/cpstables/032011/health/h01_001.htm.

[46] CRS Report R42069, *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*, by Annie L. Mach and Bernadette Fernandez.

[47] Committee on the Budget, "Concurrent Resolution on the Budget, Fiscal Year 2013," March 23, 2012, p. 93.

The unofficial estimate provided in the "Path to Prosperity" report states that more than $800 billion would be saved over 10 years (beginning FY2013) due to the repeal of the exchange subsidies and other implementation-related funding. More specifically, the repeal of funding would extend beyond the premium tax credits and cost-sharing subsidies established under ACA for certain exchange enrollees. The savings estimate also includes the grants to states for the establishment of exchanges and review of proposed premium increases, temporary high risk pools, funding program for non-profit health organizations, and payments for risk adjustment and reinsurance.[48]

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, concern about claims for medical malpractice may affect individual provider decisions, particularly through increased use of tests and procedures to protect against future lawsuits ("defensive medicine"), which may affect health care costs. The malpractice system also experiences issues with equity and access. For example, some observers have criticized the current system's performance with respect to compensating patients who have been harmed by malpractice, deterring substandard medical care, and promoting patient safety.[49]

According to the Ryan "Path to Prosperity" report, the budget proposal assumes reforms to tort law governing medical malpractice, including a cap on awards for noneconomic damages and deterrents to frivolous lawsuits.

Other Health Reforms

The "Path to Prosperity" report also suggests that the budget proposal assumes the following changes: individuals would be allowed to buy health insurance across state lines, the availability

[48] Congressional Budget Office, "Updated Estimates for the Insurance Coverage Provisions of the Affordable Care Act," March 2012, http://www.cbo.gov/sites/default/files/cbofiles/attachments/03-13-Coverage%20Estimates.pdf.

[49] CRS Report R41693, *Medical Malpractice: Overview and Legislation in the 112th Congress*, by Baird Webel, Vivian S. Chu, and Amanda K. Sarata.

of consumer-directed health plans would be expanded, and employees would be provided with the option to use their employer's health coverage contribution toward other coverage options.

Author Contact Information

Patricia A. Davis
Specialist in Health Care Financing
pdavis@crs.loc.gov, 7-7362

Bernadette Fernandez
Specialist in Health Care Financing
bfernandez@crs.loc.gov, 7-0322

Alison Mitchell
Analyst in Health Care Financing
amitchell@crs.loc.gov, 7-0152

Acknowledgments

Mindy R. Levit and Megan Suzanne Lynch also contributed to this report.