Overview of Health Care Changes in the FY2014 Budget Proposal Offered by House Budget Committee Chairman Ryan

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Summary

On March 12, 2013, House Budget Committee Chairman Paul Ryan released the chairman's mark of the FY2014 House budget resolution together with his report entitled *The Path to Prosperity: A Responsible Balanced Budget*, which outlines his budgetary objectives. The House Budget Committee considered and amended the chairman's mark on March 13, 2013, and voted to report the budget resolution to the full House. H.Con.Res. 25 was introduced in the House March 15, 2013, and was accompanied by the committee report (H.Rept. 113-17). H.Con.Res. 25 was agreed to by the House on March 21, 2013.

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 enacted in separate legislation. Chairman Ryan's budget proposal, as outlined in his report and in the committee report, suggests short-term and long-term changes to federal health care programs including to 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Within the 10-year budget window (FY2014-FY2023), the budget proposal assumes that certain ACA provisions would be repealed, including those that expand Medicaid coverage to the non-elderly with incomes up to 133% of the federal poverty level, and those provisions that establish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 also suggests restructuring Medicaid from an individual entitlement program to a block grant program. Beyond the 10-year budget window, beginning in 2024, 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. 25, the accompanying committee report, and Chairman Ryan's *Path to Prosperity* report. Additionally, it briefly examines the potential impact of the proposed changes on health care spending and coverage.

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Introduction

On March 12, 2013, Representative Paul Ryan, the chairman of the House Budget Committee, released the chairman's mark of the FY2014 House budget resolution.[1] Additional detail on budgetary objectives and justifications was provided in Chairman Ryan's report entitled *The Path to Prosperity: A Responsible Balanced Budget*, issued the same day.[2] The House Budget Committee considered the chairman's mark on March 13, 2013, and voted 22-17 to report the budget resolution to the full House. H.Con.Res. 25 was introduced in the House March 15, 2013, and was accompanied by the House Budget Committee Report (H.Rept. 113-17).[3] The Congressional Budget Office (CBO) did not provide an analysis of the long-term effects of the proposed FY2014 budget, as they had in prior years.[4] The House agreed to H.Con.Res. 25 on March 21, 2013, by a vote of 221 to 207.

The House budget resolution sets general budgetary parameters.[5] Among other things, it expresses the desired levels of spending for government health programs over 10 years (FY2014-FY2023), creates four health care-related reserve funds, and presents a policy statement regarding assumptions about future Medicare reforms. The budget resolution includes instructions for reconciliation to eight committees, which are each instructed to develop and report legislation that would achieve a certain dollar amount of deficit reduction.[6] 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, a 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, passed by Congress, and signed by the President in order for such changes to be made to these federally funded health care programs.

In general, the budget proposal, as outlined in Chairman Ryan's *Path to Prosperity* report and in the committee report, 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.

[1] The press release may be found at http://budget.house.gov/news/documentsingle.aspx?DocumentID=323563.

[2] This report may be found at http://budget.house.gov/uploadedfiles/fy14budget.pdf.

[3] These documents may be found at http://www.gpo.gov/fdsys/pkg/BILLS-113hconres25rh/pdf/BILLS-113hconres25rh.pdf and http://www.gpo.gov/fdsys/pkg/CRPT-113hrpt17/pdf/CRPT-113hrpt17.pdf.

[4] CBO provided a long-term analysis of the FY2012 and FY2013 House Budget proposals, but did not provide a similar analysis for the FY2014 proposal. See March 11, 2013 letter from CBO Director, Douglas W. Elmendorf to Chairman Ryan at http://www.cbo.gov/sites/default/files/cbofiles/attachments/43987_Letter-%20HonorablePaulRyan_L-TBO.pdf and CBO's March 11, 2013 blog entitled "CBO's Role in Budget Resolutions" at http://www.cbo.gov/publication/43988.

[5] For more information on the budget process and budget resolutions, see CRS Report 98-721, *Introduction to the Federal Budget Process*, coordinated by Bill Heniff Jr., and CRS Report R40472, *The Budget Resolution and Spending Legislation*, by Megan S. Lynch.

[6] 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 S. Lynch.

111-152), including those that establish insurance exchanges; and changes to tort law governing medical malpractice.

This CRS report provides a synopsis of the health care related changes in Chairman Ryan's FY2014 budget proposal. This summary is based on the text of the Concurrent Resolution, the committee report, and the FY2014 *Path to Prosperity* report. The collective details are referred to in this report as the "budget proposal" or Chairman Ryan's proposal. CRS provided similar summaries of the health care changes suggested in the FY2013 and FY2012 House budget proposals.[7]

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. In FY2013, the program will cover an estimated 52 million persons at an estimated total cost of $598 billion. CBO estimates that federal Medicare spending (after deduction of beneficiary premiums and other offsetting receipts) will be about $508 billion in FY2013, accounting for about 14% of total federal spending and 3% of GDP.[8] 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.[9] Medicare Part A covers inpatient hospital services, skilled nursing care, some home health and hospice care. Part A services are paid for out of the Hospital Insurance Trust Fund (HI) which is mainly funded by a dedicated payroll tax of 2.9% of earnings of current workers, shared equally between employers and workers. Part B covers physician services, outpatient services, medical equipment, ambulance services, laboratory tests, and some home health services; and Part D covers outpatient prescription drugs. Parts B and D benefits are paid for out of the Supplementary Insurance Trust Fund (SMI), which is primarily funded through beneficiary premiums and federal general revenues. High-income beneficiaries pay higher premiums for Parts B and D, and certain low-income beneficiaries may receive assistance from Medicare and/or Medicaid with premiums and cost-sharing. Part C, called Medicare Advantage, is a private health plan option for beneficiaries that covers all Part A and B services, except hospice, and is funded through both the HI and SMI trust funds.[10]

[7] CRS Report R42441, *Overview of Health Care Changes in the FY2013 Budget Proposal Offered by House Budget Committee Chairman Ryan*, and CRS Report R41767, *Overview of Health Care Changes in the FY2012 Budget Offered by House Budget Committee Chairman Ryan*. As CBO had provided analyses for the FY2013 and FY2012 budget proposals based on additional information given to them by Budget Committee staff, and did not provide a similar analysis for FY2014, the prior reports provide more details on certain assumptions.

[8] Congressional Budget Office, *Medicare Baseline*, February 2013, http://www.cbo.gov/sites/default/files/cbofiles/attachments/43894_Medicare2.pdf.

[9] For additional detail on the Medicare program and its financing, see CRS Report R40425, *Medicare Primer*, coordinated by Patricia A. Davis and Scott R. Talaga.

[10] About 27% of Medicare beneficiaries are enrolled in MA.

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.[11] Under Parts C and D, private insurers are paid a monthly "capitated" amount to provide coverage to enrollees.[12] Premium amounts may vary depending on which plan the enrollee selects. The capitated payment is adjusted to reflect the higher relative costs of sicker beneficiaries.

Since its enactment in 1965, the Medicare program has undergone considerable change. Because of its rapid growth, both in terms of aggregate dollars and as a share of the federal budget, the Medicare program has been a major focus of deficit reduction legislation passed by Congress.[13] With a few exceptions, reductions in program spending have been achieved largely through freezes or reductions in payments to providers, primarily hospitals and physicians, and by making changes to beneficiary premiums and other cost-sharing requirements. Most recently, the 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.[14]

Short-Term Medicare Changes (FY2014-FY2023)

Under CBO's Medicare baseline, net Medicare outlays are expected to total approximately $6.87 trillion over the next 10 years (FY2014-FY2023).[15] The House Budget Resolution suggests total Medicare outlays of $6.74 trillion over 10 years, which is 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 the ACA Medicare plan and provider payment reductions are maintained; that scheduled physician payment reductions under the sustainable growth rate system (SGR) will occur beginning in 2014;[16] and that the 2% reduction in Medicare benefit spending under the Budget Control Act of 2011 sequestration requirements, which begin in FY2013,[17] will continue

[11] 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 laboratory services, and durable medical equipment, prosthetics, orthotics, and supplies in certain locations.

[12] Medicare pays Parts C and D plans a set monthly per person amount to provide covered benefits.

[13] For brief history of changes to the Medicare program, see CRS Report R40425, *Medicare Primer*, coordinated by Patricia A. Davis and Scott R. Talaga.

[14] 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.

[15] CRS analysis based on figures from CBO February 2013 *Medicare Baseline* and H.Con.Res. 25.

[16] 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. CBO estimates that it would cost $138 billion over the next 10 years to eliminate these reductions. See CBO, *The Budget and Economic Outlook: Fiscal Years 2013 to 2023*, February 5, 2013, p. 31 and Table 1-7 at http://www.cbo.gov/sites/default/files/cbofiles/attachments/43907-BudgetOutlook.pdf. For further information see CRS Report R40907, *Medicare Physician Payment Updates and the Sustainable Growth Rate (SGR) System*, by Jim Hahn and Janemarie Mulvey.

[17] CBO estimates that under sequestration, Medicare spending will be reduced by approximately $97 billion from FY2014-FY2023. Congressional Budget Office, *Medicare Baseline*, February 2013, http://www.cbo.gov/sites/default/files/cbofiles/attachments/43894_Medicare2.pdf. Also see CRS Report R41965, *The Budget Control Act of 2011*, by Bill Heniff Jr., Elizabeth Rybicki, and Shannon M. Mahan.

through 2021. 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). While the proposal did not suggest specific program changes to reduce Medicare spending to a level lower than CBO's baseline over the 10-year period, the committee report suggests 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.[18]

The budget proposal also assumes a repeal of the Independent Payment Advisory Board (IPAB) created by the ACA (Section 3403, as modified by 10320).[19] 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. CBO estimates that the repeal of IPAB would cost $3.1 billion over 10 years.[20] No other ACA Medicare provisions were explicitly mentioned. However, Section 403 of H.Con.Res. 25 would create a reserve fund to allow for the consideration of legislation that would make changes to those Medicare related provisions in ACA originally scored as savings,[21] as long as the legislation were deficit-neutral for the FY2014-FY2023 period.[22]

In addition, the committee report notes that the budget accommodates legislation that fixes the Medicare physician payment formula for the next 10 years. Specifically, Section 404 of H.Con.Res. 25 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, as long as the legislation did not increase the deficit for the period FY2014-FY2023.[23] The proposal did not suggest specific changes to the payment methodology, but indicated that the new system should provide incentives to improve the quality and efficiency of care provided to Medicare beneficiaries.

[18] H.Rept. 113-17, p. 86.

[19] This assumption was included in the FY2014 Budget Resolution *Medicare Policy Statement* (H.Con.Res. 25), but was not included in the FY2013 or the FY2012 House Budget Resolutions. For additional information on IPAB, see CRS Report R41511, *The Independent Payment Advisory Board*, by Jim Hahn and Christopher M. Davis.

[20] 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. To date, no Board members have been nominated to serve on the IPAB.

[21] See CRS General Distribution Memorandum, *Estimates of Medicare Savings in the Patient Protection and Affordable Care Act*, by Patricia A Davis, August 31, 2012, available upon request.

[22] Deficit-neutral reserve funds provide that a committee may report legislation with spending in excess of its allocations, but require the excess amounts be "offset" by equivalent amounts. For more information on reserve funds, please see CRS Report R40472, *The Budget Resolution and Spending Legislation*, by Megan S. Lynch.

[23] The language of Section 404 of H.Con.Res. 25 is almost identical to that of Section 402 of the FY2013 House Budget, H.Con.Res. 112.

Long-Term Medicare Changes (FY2024 and Beyond)[24]

Starting in 2024, 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 703, the "Policy Statement on Medicare," of H.Con.Res. 25. The *Path to Prosperity* document and the committee 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. As such, the committee report includes these proposals as "Illustrative Policy Options."[25]

Age of Medicare Eligibility

The budget proposal assumes that in 2024, the age of eligibility for Medicare would gradually increase so that it would eventually correspond to the Social Security retirement age (age 67).[26]

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 2024 (i.e., those who turn 55 in 2013) would remain in the current Medicare program (described earlier).[27] Individuals who become eligible for Medicare beginning in 2024 would be given the option of enrolling in a private insurance plan or a traditional fee-for-service option through a newly established Medicare exchange.[28] 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. Those who qualify for Medicare prior to 2024 would also be given the option of switching to the new system. Depending on which plan a beneficiary selects, Medicare would pay for all or part of the plan premium. The amount of premium support provided to high-income individuals would be reduced,[29] while low-income beneficiaries would be provided assistance to help pay premiums, co-pays, and other out-of-pocket costs.

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[24] With the exception of the proposed implementation dates (i.e., changed from 2023 to 2024), these long-term proposals are similar to those provided in the FY2013 House Budget. See CRS Report R42441, *Overview of Health Care Changes in the FY2013 Budget Proposal Offered by House Budget Committee Chairman Ryan* , by Patricia A. Davis, Alison Mitchell, and Bernadette Fernandez.

[25] H.Rept. 113-17, p. 84.

[26] This proposal is included in the committee report (H.Rept. 113-17, page 85), but is not explicitly mentioned in the text of H.Con.Res. 25 or in the *Path to Prosperity* document.

[27] The list of assumptions accompanying the Medicare Reform policy statement in the FY2013 House Budget Resolution (H.Con.Res. 112, Section 601(c)) included the assumption "(c)urrent Medicare benefits are preserved for those in and near retirement, without changes." The FY2014 Budget (H.Con.Res. 25), Section 703(c) contains the same statement, except that it does not include the phrase "without changes."

[28] The FY2014 and FY2013 budget proposals suggest retaining traditional Medicare as an option under the new premium support system, while under the FY2012 proposal, only private plan options would have been available. Section 703(c) of H.Con.Res. 25 included in the list of assumptions "Medicare will maintain traditional fee-for-service as an option;" this statement was not included in the FY2013 or FY2012 budget resolutions.

[29] The means-testing thresholds currently used to establish Medicare Parts B and D premiums would apply. See CRS Report R40082, *Medicare: Part B Premiums*, by Patricia A. Davis.

Under the proposed premium support system, 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.[30] 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 geographically rated and adjusted for enrollees' 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.

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%. 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.

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 were designed and implemented. As noted, the premium support model was suggested in the budget proposal as an "illustrative policy option," and as such, provides a starting point for further analysis and discussion. 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 as part of designing such a system. 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 and funding sources be combined; would changes be made to the voluntary nature of Parts B and D (or could one opt out of Medicare entirely); and would beneficiary premiums be based

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

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 2024 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 need to be mitigated to encourage participation (e.g., Part D provides reinsurance for catastrophic costs and has risk corridors to limit losses).[31] Finally, an administrative infrastructure, such as information technology systems, would need to be designed to administer both the old and new programs, including managing the bidding process for private plans, reimbursing plans and providers, educating and enrolling beneficiaries, and providing financial and quality of care oversight.

Medicaid

Medicaid is a means-tested entitlement program that finances the delivery of primary and acute medical services as well as long-term services and supports.[32] Medicaid is jointly funded by the federal government and the states.[33] In FY2014, the Medicaid program will cover an estimated 71 million people at any point during the fiscal year, and federal Medicaid payments to states are estimated to reach $297 billion in FY2014.[34] Federal Medicaid spending is expected to reach about 1.8% of GDP in FY2014.[35]

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.

The *Path to Prosperity* and the accompanying legislative language proposes to make two significant programmatic changes to the Medicaid program. The proposal would repeal certain Medicaid provisions in ACA and convert Medicaid into a block grant program. In addition to these programmatic changes, the budget proposal suggests significant reductions to the federal Medicaid funding.

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[31] If the model suggested in the Ryan budget proposal is used as the basis for designing a premium support system, the relationship between Medicare Advantage (current program) and private plans offered under the exchanges (premium support system) could be especially important in the early years of phasing in the new system. For example, in 2024, when individuals first start aging into the new Medicare program, private plans may be less willing to participate in both the current and new programs at a time when only a small number of beneficiaries would be enrolled in the new system. Similarly, the relationship between the traditional Medicare program under the current and premium support systems would also need to be determined. For example, if traditional Medicare is to compete with private plans on the exchanges in the premium support system, would traditional Medicare premiums under the new system be allowed to vary by geography, while those in the current system would be set at a national rate.

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

[33] For more information about Medicaid financing, see CRS Report R42640, *Medicaid Financing and Expenditures*, by Alison Mitchell.

[34] Congressional Budget Office, *Spending and Enrollment Detail for CBO's March 2013 Baseline: Medicaid*, March 2013.

[35] Congressional Budget Office, *The Budget and Economic Outlook: FY2013 to FY2023*, February 2013.

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. The most notable change is the optional expansion of Medicaid eligibility for individuals under the age of 65 with income up to 133% of the federal poverty level.[36] Other ACA provisions include (1) the addition of both mandatory and optional benefits to Medicaid, (2) an increase in the federal matching payments for certain groups of beneficiaries and for particular services provided, (3) the provision of new requirements and incentives for states to improve quality of care and encourage more use of preventive services, and (4) additional Medicaid program changes.[37] The major expansion and reform provisions in ACA are slated to take effect in 2014.

The "illustrative policy options" offered in the committee report (H.Rept. 113-17) include repealing the ACA Medicaid expansion and other associated provisions in the ACA.

Conversion of Medicaid to a Block Grant System

Another "illustrative policy option" included in the committee report is the restructuring of Medicaid from an individual entitlement program[38] to a block grant program.[39] 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. In addition, the budget proposal would merge the State Children's Health Insurance Program (CHIP)[40] into the Medicaid program.

[36] 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. Originally, the assumption was that all states would implement the ACA Medicaid expansion in 2014 as required in statute because implementing the ACA Medicaid expansion was required in order for states to receive *any* federal Medicaid funding. However, on June 28, 2012, the United States Supreme Court issued its decision in *National Federation of Independent Business (NFIB) v. Sebelius* finding that the federal government cannot terminate the federal Medicaid funding a state receives for its current Medicaid program if a state refuses to implement the ACA Medicaid expansion. If a state accepts the new ACA Medicaid expansion funds, it must abide by the new expansion coverage rules. However, based on the Court's opinion, it appears that a state can refuse to participate in the ACA Medicaid expansion without losing any of its current federal Medicaid matching funds.

[37] 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.

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

[39] 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.

[40] CHIP provides health coverage to nearly 8 million children in families with incomes too high to qualify for Medicaid. Like Medicaid, CHIP is administered by the states, and is jointly funded by the federal government and states. However, the federal matching rate for state CHIP programs is typically about 15 percentage points higher than the Medicaid matching rate for that state.

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.[41]

Block grant critics argue that block grants can undermine the achievement of national objectives and can be used as a "backdoor" means to reduce government spending on domestic issues. They also argue that the decentralized nature of block grants makes it difficult to measure block grant performance and to hold state and local government officials accountable for their decisions.

Reductions to Federal Medicaid Funding

The estimate provided in the committee report (H.Rept. 113-17) states that repealing the ACA Medicaid expansion would reduce federal Medicaid expenditures by $636 billion over the budget window (i.e., FY2014 to FY2023). In addition to the savings from repealing the ACA Medicaid expansion, the committee report assumes $810 billion in reductions to federal Medicaid expenditures over the 10-year period. Together these reductions amount to $1.4 trillion over the ten-year budget window, which is a 33% reduction in federal Medicaid funding when compared to CBO's February 2013 baseline projection for federal Medicaid spending.[42]

According to CBO's analysis of similar proposals in previous years, even with the efficiency gains that could be gained by converting Medicaid to a block grant program, the magnitude of the federal Medicaid spending reductions under this proposal would make it difficult for states to maintain their current Medicaid programs.[43] 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 restricting eligibility. These 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, physicians, and nursing homes, these providers may be less willing to participate in Medicaid at all or accept new Medicaid patients.

Private Health Insurance

Approximately 197 million people in the United States had private health insurance coverage in 2011.[44] Workers and their families often receive health insurance as a 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 other distinguishing characteristics.

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

[42] Congressional Budget Office, *Spending and Enrollment Detail for CBO's February 2013 Baseline: Medicaid*, February 2013.

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

[44] U.S. Census Bureau, "Income, Poverty, and Health Insurance Coverage in the United States: 2011," Current Population Survey Annual Social and Economic Supplement, Table C-1, http://www.census.gov/prod/2012pubs/p60-243.pdf.

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 offers 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, 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.[45] 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.[46] 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. 25 would create one reserve fund (Section 401) that would provide procedural flexibility to allow for the consideration of legislation that would repeal ACA, as amended, and another reserve fund (Section 402) that would provide procedural flexibility to allow for the consideration of legislation that would reform the health provisions in P.L. 111-148 or P.L. 111-152, as long as such reforms would not increase the deficit. Moreover, one of the "illustrative policy options" included in the committee report is repeal of the "exchange subsidies created by the new health-care law."[47]

Based on CBO estimates, the *Path to Prosperity* report states that ACA's exchange subsidies would add $1.2 trillion to the federal budget over 10 years (FY2014-FY2023). In addition to the premium tax credits and cost-sharing subsidies established under ACA, the CBO estimate cited in the report also includes grants to states for the establishment of exchanges, review of proposed premium increases, temporary high risk pools, and funding for non-profit health organizations.[48]

[45] CRS Report R42663, *Health Insurance Exchanges Under the Patient Protection and Affordable Care Act (ACA)*, by Bernadette Fernandez and Annie L. Mach.

[46] CRS Report R41137, *Health Insurance Premium Credits in the Patient Protection and Affordable Care Act (ACA)*, by Bernadette Fernandez and Thomas Gabe.

[47] House Committee on the Budget, "Concurrent Resolution on the Budget, Fiscal Year 2014," March 15, 2013, p. 81.

[48] U.S. Congressional Budget Office, *CBO's February 2013 Estimate of the Affordable Care Act on Health Insurance Coverage*, February 13, 2013, http://cbo.gov/sites/default/files/cbofiles/attachments/43900_ACAInsuranceCoverageEffects.pdf.

The committee report also stated that the budget assumes the repeal of all of the ACA tax increases as part of comprehensive tax reform.[49] However, the budget also assumes that the level of revenues in the overall budget would remain the same; this would mean that as part of tax reform, revenues would need to be increased elsewhere (e.g., through eliminating deductions or imposing new taxes) to offset the elimination of the ACA taxes.

Other Health Care Proposals

Medical Liability Reform

Medical liability insurance provides a certain level of financial protection to medical professionals against claims of medical malpractice. Over the past several decades, medical liability insurance has experienced three "crisis" periods, characterized by sharp increases in insurance premiums, difficulties in finding liability insurance in some regions and among some specialties, and reports of health care providers leaving areas or retiring following insurance difficulties. While the overall medical liability insurance market is not currently exhibiting the same level of crisis as in previous time periods, affordability and availability problems persist. In addition, concern about medical liability may lead to 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.[50]

According to the *Path to Prosperity* and committee report, the budget proposal assumes reforms to tort law governing medical malpractice, including limits on awards for noneconomic and punitive damages.

Other Health Reforms

The *Path to Prosperity* report also suggests the following reforms to make health care more patient-centered: allowing individuals to buy health insurance across state lines, expanding the availability of consumer-directed health plans, and allowing employers to provide workers the option to use their employer's health coverage contribution toward other coverage options.

[49] H.Rept. 113-17, p. 82.

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

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