



CONGRESSIONAL BUDGET OFFICE
U.S. Congress
Washington, DC 20515

Douglas W. Elmendorf, Director

November 17, 2010

Honorable Paul D. Ryan
Ranking Member
Committee on the Budget
U.S. House of Representatives
Washington, DC 20515

Dear Congressman:

The attachment to this letter responds to your request for analysis of the proposal that you and Alice Rivlin have put forward to substantially change federal payments under the Medicare and Medicaid programs. CBO has conducted a preliminary analysis of the major provisions of that proposal, the results of which are summarized in the attachment.

I hope this information is helpful to you. If you have any questions, please contact me or CBO staff. The primary staff contact for this analysis is Philip Ellis.

Sincerely,

A handwritten signature in black ink that reads "Douglas W. Elmendorf".

Douglas W. Elmendorf

Attachment

cc: Honorable John M. Spratt Jr.
Chairman

Congressional Budget Office

Preliminary Analysis of the Rivlin-Ryan Health Care Proposal

November 17, 2010

Congressman Ryan and his staff recently provided specifications for a proposal that would substantially change federal payments under the Medicare and Medicaid programs. Although an extensive analysis of that proposal is not feasible in the time available, CBO has conducted a preliminary analysis of its major provisions—the results of which are summarized here.

Key Features of the Proposal

MEDICARE

- People who turn 65 in 2021 or later years would not enroll in the current Medicare program but instead would receive a voucher with which to purchase private health insurance.
- Although the voucher system would not be implemented until 2021, the amount of the voucher would be calculated by taking the average federal cost per Medicare enrollee in 2012 (net of enrollee premiums) and growing that amount at the annual rate of growth in GDP per capita plus one percentage point.
 - While the voucher program is being phased in, the voucher amount would be adjusted downward to reflect the fact that eligible individuals would be younger and less costly than the average Medicare enrollee.
- Affected Medicare enrollees who are also eligible for full Medicaid benefits (“dual eligibles”) would no longer receive assistance from Medicaid with their Medicare premiums and cost-sharing; instead the federal government would establish a medical savings account for them and make an annual contribution to it. The amount of the contribution would be calculated by starting with \$6,600 in 2012 and growing that amount at the rate of GDP growth per capita plus one percentage point.
- Starting in 2021, the age of eligibility for Medicare would increase by two months per year until it reached 67 in 2032.
- Eligibility for the Medicare program would not change for people who are currently 55 or older; as a result, the average age and costs of enrollees remaining in the current Medicare program would increase over time. However, enrollee premiums under Medicare would be adjusted to equal what they would be under current law.

- The proposal would modify Medicare’s cost-sharing provisions and change the amount of the cost-sharing requirements that can be covered by supplemental insurance provided through Medigap policies. All of the amounts specified below are for 2013 and would be indexed in subsequent years to growth in spending per beneficiary for services covered by Parts A or B of Medicare.
 - Cost-Sharing Rules — Beginning in 2013, modify cost-sharing rules:
 - Establish a single deductible of \$600 for services covered under Parts A or B;
 - After satisfying the deductible, impose 20 percent coinsurance for all services covered under Parts A or B; and
 - Establish a catastrophic cap (zero cost sharing) after accruing \$6,000 in cost-sharing obligations for A&B services (the \$600 deductible counts toward the \$6,000).
 - Medigap Changes — Beginning in 2013, restrict Medigap coverage of cost sharing by:
 - Requiring the beneficiary to be subject to a \$500 deductible;
 - Requiring the beneficiary to spend at least \$2,750 before being subject to a catastrophic cap; and
 - Limiting coverage of cost sharing between the deductible and a catastrophic cap to 50 percent of Medicare’s cost-sharing requirement.

MEDICAID

- Starting in 2013, the federal share of all Medicaid payments would be converted into a block grant to be allocated among the states. The total block grant would increase annually along with currently projected growth in the Medicaid population and with growth in GDP per capita plus one percentage point.
- The federal government would fund the incremental costs of the Medicaid expansion that was enacted in March through 2020 as under current law (CBO estimated that those costs would total roughly \$500 billion over that period); in 2021, those costs would be added to the block grant amount and the block grant would subsequently grow at the same rate specified above.

OTHER PROVISIONS

- Several changes would be made to laws governing medical malpractice, including limits on noneconomic and punitive damages; those changes (and their effects on the federal budget) are described in CBO’s [October 2009 letter to Senator Hatch](#).
- The CLASS program for long-term care insurance would be repealed. (Because the program will collect premiums in excess of benefits payments during the 2011-2020 period, repealing this provision would increase deficits during the first 10 years.)

Preliminary Estimate of Budgetary Effects

NEAR-TERM EFFECTS

- Several elements of the proposal would affect the federal budget in the 2011-2020 period: the changes related to medical malpractice; the repeal of the CLASS program; the changes governing Medicare’s cost sharing and Medigap coverage; and the block grants for Medicaid.
- Overall, CBO estimates that those provisions would reduce federal budget deficits over the 2011-2020 period by about \$280 billion (rounded to the nearest \$10 billion); the total effect in 2020 would be a reduction in the deficit of approximately \$90 billion.

Provision	Change in Unified-Budget Deficits, 2011 through 2020 (\$ billions)
Change Medical Malpractice Laws	-\$60
Repeal CLASS Program	+\$70
Modify Medicare Cost Sharing	-\$110
Establish Medicaid Block Grants	<u>-\$180</u>
Total, Changes in Deficits	-\$280

LONGER-TERM EFFECTS

- Over the longer term, CBO has developed two projections of federal spending—an “extended-baseline scenario,” which adheres closely to current law, and an “alternative fiscal scenario,” which incorporates several changes to current law that are widely expected to occur or that modify some current provisions that might be difficult to sustain for a long period. (For additional discussion, see CBO’s June 2010 report entitled [*The Long-Term Budget Outlook*](#).) The projections for federal health care programs encompass Medicare, Medicaid, the Children’s Health Insurance Program (CHIP), and outlays for subsidies to be provided through the new health insurance exchanges.
- Under the extended-baseline scenario, federal spending on those programs is projected to rise from about 7 percent of GDP in 2020 to about 12 percent of GDP in 2050. Under the alternative fiscal scenario, federal spending on those programs is projected to rise from about 7 percent of GDP in 2020 to nearly 14 percent of GDP in 2050 (see table below).

Mandatory Federal Outlays for Health Care as a Percentage of GDP (rounded to the nearest ¼ percent)

	<u>2020</u>	<u>2030</u>	<u>2040</u>	<u>2050</u>
CURRENT CBO PROJECTIONS				
Extended-Baseline Scenario	7	8 ¾	10 ¾	12 ¼
Alternative Fiscal Scenario	7 ¼	9 ¾	12	13 ¾
Preliminary Estimate for				
Rivlin-Ryan Health Care Proposal /a	6 ¾	8 ¼	9 ¼	10
CHANGE IN FEDERAL OUTLAYS				
Relative to Extended-Baseline Scenario	- ½	- ½	-1 ½	-2 ½
Relative to Alternative Fiscal Scenario	- ½	-1 ¼	-2 ½	-3 ¾

NOTE: Components may not sum to totals because of rounding.

a/ Spending under the proposal would differ slightly under the two budget scenarios.

- Under the proposal, federal spending on those programs would be lower—slightly below 7 percent of GDP in 2020 and about 10 percent of GDP in 2050.
- Relative to the extended-baseline scenario, most of the savings under the proposal would initially come from Medicaid; by 2050, the savings would come about equally from Medicare and Medicaid.
- Relative to the alternative fiscal scenario—which incorporates more Medicare spending than the extended-baseline scenario—the savings would come about equally from Medicare and Medicaid in 2030 and would come primarily from Medicare in later years.
- The results are expressed here as rounded percentages of GDP both because of the difficulties that arise when comparing dollar figures over long periods and because of the greater uncertainty that attends to long-range estimates.

Key Assumptions and Caveats

- The estimates of changes in federal outlays provided here are highly uncertain, particularly for the longer term. That uncertainty largely reflects potential variations in federal spending under CBO’s two scenarios for the long-term budget; under the proposal, federal payments would become more predictable (but could still vary significantly from the estimates).
- The estimates shown here are very sensitive to the growth rate specified for federal payments, particularly over the longer term, because of compounding effects.

- For purposes of this analysis, CBO assumed that all individuals projected to enroll in Medicare would use the proposed voucher. Voucher recipients would probably have to purchase less extensive coverage or pay higher premiums than they would under current law, for two reasons. First, most of the savings for Medicare under the proposal stem from reducing the amounts that the federal government would pay for enrollees on a per capita basis, relative to the projections under current law. Second, future beneficiaries would probably face higher premiums in the private market for a package of benefits similar to that currently provided by Medicare. (For additional discussion of these issues, see CBO's [January 2010 letter to Congressman Ryan](#) about his "Roadmap" proposal.)
- Similarly, reducing federal payments for Medicaid relative to currently projected amounts would probably require states to provide less extensive coverage, or to pay a larger share of the program's total costs, than would be the case under current law.
- For both Medicare and Medicaid, the budgetary effects would become larger over time because federal payments would tend to grow more slowly under the proposal than projected costs per enrollee under current law. Although the level of expected federal spending and the uncertainty surrounding that spending would decline, enrollees' spending for health care and the uncertainty surrounding that spending would increase.
- CBO did not analyze the extent of insurance that enrollees in Medicare or Medicaid would purchase or obtain, nor did it seek to assess the effects on total health care spending stemming from the proposal.
- Because the proposal would affect other sources of health insurance, it could have indirect effects on subsidy payments made through the newly established health insurance exchanges. CBO did not attempt to estimate the proposal's effects on those subsidy payments.
- CBO did not seek to estimate the proposal's effects on federal revenues or on the federal costs of debt service.
- The analysis reflects the specifications provided, including clarifications provided by staff; the detailed provisions of legislation that would enact those specifications could have significant effects on the proposal's estimated budgetary impact.