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

Douglas W. Elmendorf, Director

April 5, 2011

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

Dear Mr. Chairman:

In response to your request, the Congressional Budget Office (CBO) has conducted a long-term analysis of your proposal to substantially change federal payments under the Medicare and Medicaid programs, eliminate the subsidies to be provided through new insurance exchanges under last year's major health care legislation, leave Social Security as it would be under current law, and set paths for all other federal spending (excluding interest) and federal tax revenues at specified growth rates or percentages of gross domestic product (GDP). The results of that analysis are summarized in the attachment.

CBO has not reviewed legislative language for your proposal, so this analysis does not represent a cost estimate for legislation that might implement the proposal. Rather, it is an assessment of the broad, long-term budgetary impacts of the proposal, with results spanning several decades and measured as a share of GDP. It is therefore quite different from a cost estimate for legislation, which would require much more detailed analysis, focus on the first 10 years, and be based on more recent baseline projections. (CBO's most recent long-term projections, which are the basis for this analysis, were issued in June 2010 and were derived from the agency's March 2010 baseline projections.)

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 Joyce Manchester.

Sincerely,

Douglas W. Elmendorf

Douglas W. Elmendorf

Attachment

cc: Honorable Chris Van Hollen
Ranking Member

CONGRESSIONAL BUDGET OFFICE

Long-Term Analysis of a Budget Proposal by Chairman Ryan

April 5, 2011

Over the next several decades, the continued aging of the population and the growth of health care costs will, under current law, almost certainly boost federal spending significantly relative to the output of the economy. According to the Congressional Budget Office's (CBO's) most recent long-term projections, which were issued in June 2010 and were based on the assumption that then-current law would generally remain in place, spending on Social Security and the government's major mandatory health care programs—Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and health insurance subsidies to be provided through insurance exchanges—will increase from roughly 10 percent of gross domestic product (GDP) today to about 15 percent 20 years from now.[1] If revenues and federal spending apart from those programs remain near their past levels relative to GDP, the increase in spending on Social Security and the health care programs will lead to rapidly growing budget deficits and mounting federal debt.

At the request of the Chairman of the House Budget Committee, Congressman Paul Ryan, CBO has analyzed a proposal that would substantially change federal payments under the Medicare and Medicaid programs, eliminate the subsidies to be provided through new insurance exchanges under last year's major health care legislation, leave Social Security as it would be under current law, and set paths for all other federal spending (excluding interest) and federal tax revenues based on specified growth rates or specified percentages of GDP. CBO has conducted a long-term analysis of the major provisions of the proposal as described by the Chairman's staff. The specifications may differ in some ways from the plan released today by Chairman Ryan in *The Path to Prosperity: Restoring America's Promise*.

CBO has not reviewed legislative language for the proposal, so this analysis does not represent a cost estimate for legislation that might implement the proposal. Rather, it is an assessment of the broad, long-term budgetary impacts of the proposal, with results spanning several decades and measured as a share of GDP. It is therefore quite

1. See Congressional Budget Office, *The Long-Term Budget Outlook* (June 2010, revised August 2010). For the purpose of that analysis, CBO assumed that scheduled benefits for Social Security and Part A of Medicare would continue to be paid even if the trust funds for those programs became exhausted. Mandatory spending is generally controlled through authorizing legislation by setting eligibility rules, benefit formulas, and other parameters. Discretionary spending is controlled through the annual appropriation process.

different from a cost estimate for legislation, which would require much more detailed analysis, focus on the first 10 years, and be based on more recent baseline projections.

Among other changes, the proposal would convert the current Medicare program to a system under which beneficiaries received premium support payments—payments that would be used to help pay the premiums for a private health insurance policy and would grow over time with overall consumer prices. The change would apply to people turning 65 beginning in 2022; beneficiaries who turn 65 before then would remain in the traditional Medicare program, with the option of converting to the new system.[2] Additionally, the proposal would convert the matching payments that the federal government makes to states for Medicaid costs under current law into block grants of fixed dollar amounts beginning in 2013. Those amounts would grow over time with overall consumer prices and population growth. Further, the proposal would repeal the key provisions of the major 2010 health care legislation that deal with insurance coverage and certain other provisions. Under the proposal, mandatory spending for health care would be about 6 percent of GDP in 2030 and 2040 and about 5 percent in 2050, CBO estimates.

The proposal would also make changes to other aspects of the federal budget. Social Security would not be altered by the proposal; spending on that program is projected to be relatively stable as a share of GDP from 2030 forward. The proposal specifies a path for all other spending (excluding interest) that would cause such spending to decline sharply as a share of GDP—from 12 percent in 2010 to 6 percent in 2022 and 3½ percent by 2050; the proposal does not specify the changes to government programs that might be made in order to produce that path. Total spending under the proposal would be about 21 percent of GDP in 2030 and almost 15 percent in 2050. The proposal also specifies a path for revenues relative to GDP—rising from 15 percent in 2010 to 18½ percent in 2022 and 19 percent in 2030 and beyond.

The resulting budget deficits under the proposal would be around 2 percent of GDP in the 2020s and would decline during the 2030s. The budget would be in surplus by 2040 and show growing surpluses in the following decade. Federal debt would equal about 48 percent of GDP by 2040 and 10 percent by 2050.

By 2030, total federal spending, deficits, and debt under the proposal would all be lower than under CBO's June 2010 long-term projections (see Table 1). Those projections include two scenarios—an extended-baseline scenario based on then-current law and an alternative fiscal scenario that incorporated several changes to then-current law that were widely expected to occur or that would modify some provisions of law that might be difficult to sustain for a long period. Both of those scenarios deviate significantly from the nation's past budgetary experience: In the extended-baseline scenario,

2. The traditional Medicare program refers to the benefits covered under Parts A, B, and D of Medicare and includes benefits provided both in the fee-for-service sector and by participating private plans (that is, through the Medicare Advantage program, prescription drug plans, or the Retiree Drug Subsidy program).

Table 1.

Federal Deficits or Surpluses and Debt

(Percentage of gross domestic product)

	Actual	Projected			
	2010	2022	2030	2040	2050
			Extended-Baseline Scenario		
Total Revenues	15	21	22¼	24¼	26
Total Spending	23¾	23¾	26¼	28¾	30¼
Deficit (-) or Surplus	–9	–2¾	–4	–4½	–4
Debt Held by the Public	62	67	74	84	90
			Alternative Fiscal Scenario		
Total Revenues	15	19¼	19¼	19¼	19¼
Total Spending	23¾	26¾	32¼	38½	45¼
Deficit (-) or Surplus	–9	–7½	–13	–19¼	–26
Debt Held by the Public	62	95	146	233	344
			Proposal		
Total Revenues	15	18½	19	19	19
Total Spending	23¾	20¼	20¾	18¾	14¾
Deficit (-) or Surplus	–9	–2	–1¾	¼	4¼
Debt Held by the Public	62	70	64	48	10

Source: Congressional Budget Office.

Notes: The proposal that CBO analyzed is as specified by Chairman Paul Ryan and his staff. The extended-baseline and alternative fiscal scenarios are as described in Congressional Budget Office, *The Long-Term Budget Outlook* (June 2010; revised August 2010).

Components may not add up to totals because of rounding.

both spending and revenues are well above historical norms as a share of GDP, and federal debt rises to 90 percent of GDP by 2050; under the alternative fiscal scenario, tax revenues remain within their historical range relative to GDP, but with spending above that range, federal debt skyrockets on an unsustainable path and exceeds its historical peak relative to GDP by the mid-2020s.

Government payments for health care under the proposal would become significantly more predictable than under current law but could still vary a good deal from the estimates presented here. The estimates of the budgetary effects of the proposal are very sensitive to the growth rates specified for government payments, particularly over the longer term, because of the effects of compounding. For both Medicare and Medicaid, the budgetary effects would become larger over time, because under the proposal, spending for those programs would grow more slowly than it is projected to grow under current law. Because future federal spending on health care under current law is difficult to predict, the magnitude of the changes in budgetary outcomes under the proposal is also highly uncertain, particularly in the longer term.

Under the proposal, most elderly people would pay more for their health care than they would pay under the current Medicare system. For a typical 65-year-old with average health spending enrolled in a plan with benefits similar to those currently provided by Medicare, CBO estimated the beneficiary's spending on premiums and out-of-pocket expenditures as a share of a benchmark: what total health care spending would be if a private insurer covered the beneficiary. By 2030, the beneficiary's spending would be 68 percent of that benchmark under the proposal, 25 percent under the extended-baseline scenario, and 30 percent under the alternative fiscal scenario.

Federal payments for Medicaid under the proposal would be substantially smaller than currently projected amounts. States would have additional flexibility to design and manage their Medicaid programs, and they might achieve greater efficiencies in the delivery of care than under current law. Even with additional flexibility, however, the large projected reduction in payments would probably require states to decrease payments to Medicaid providers, reduce eligibility for Medicaid, provide less extensive coverage to beneficiaries, or pay more themselves than would be the case under current law.

CBO's long-term scenarios and the proposal analyzed here are all subject to pressures over the long term that would make them difficult to sustain. Under the extended-baseline scenario, revenues would reach higher levels relative to the size of the economy than ever recorded in the nation's history, payments to physicians under Medicare would be reduced well below current rates, and payments to other Medicare providers would grow more slowly than the cost of their inputs; nevertheless, federal debt would continue to grow relative to GDP. Under the alternative fiscal scenario, revenues would be lower and Medicare's payments to physicians and other providers would be higher than under the extended-baseline scenario, but the government's debt would skyrocket to levels unprecedented in the United States. Rising tax rates or surging federal debt might accentuate concerns about the budgetary situation and thereby lead policymakers to reduce benefits under Medicare, Medicaid, or other programs.

Under the proposal analyzed here, debt would eventually shrink relative to the size of the economy—but the gradually increasing number of Medicare beneficiaries participating in the new premium support program would bear a much larger share of their health care costs than they would under the current program; payments to physicians and other providers for services provided under the traditional Medicare program would be restrained (as under the two scenarios); states would have to pay substantially more for their Medicaid programs or tightly constrain spending for those programs; and spending for federal programs other than Social Security and the major health care programs would be reduced far below historical levels relative to GDP. It is unclear whether and how future lawmakers would address the pressures resulting from the long-term scenarios or the proposal analyzed here.

The Current Long-Term Budget Outlook

CBO's most recent long-term projections were issued in June 2010. Under those projections, if revenues stay close to their average share of GDP for the past 40 years, the rise in spending that CBO projects will lead to rapidly growing budget deficits and mounting federal debt. To prevent debt from becoming unsupportable, policymakers will have to substantially restrain the growth of spending, raise revenues significantly above their historical share of GDP, or pursue some combination of those two approaches.

Extended-Baseline Scenario

The extended-baseline scenario was constructed on the assumption that, by and large, current law would continue without change—including the assumption that tax cuts originally enacted in 2001 and 2003 would expire as scheduled. Under those assumptions, revenues were projected to climb from 15 percent of GDP in 2010 to 21 percent in 2022 and 22 percent in 2030. Even with those higher revenues, federal debt held by the public was projected to rise from 62 percent of GDP at the end of 2010 to 74 percent by 2030. The projections issued in June 2010 were based on CBO's March 2010 baseline with adjustments for the effects of the major 2010 health care legislation. CBO has not yet updated those long-term projections to reflect any of the economic or technical changes that were incorporated in the agency's subsequent baselines or to reflect enactment of the 2010 tax act and other recent legislative changes.[3] However, the differences that would arise from such updates would probably be small relative to the other effects discussed here. The 10-year baseline projections that the agency issued in March 2011, which reflect those changes, show somewhat larger budget deficits and accumulated debt over the next decade than the June 2010 projections did. Debt held by the public is now projected to equal 75 percent of GDP at the end of 2020 under current law, compared with the June 2010 projection of 66 percent.

Under the extended-baseline scenario, health care costs were projected in three steps. First, the spending projections for 2011 to 2020 were taken from CBO's March 2010 baseline projections. Second, for subsequent years, the projected growth rates in spending for the government's major mandatory health care programs were based on CBO's projections of demographic and economic trends and the agency's projections about excess cost growth—that is, cost growth in spending per beneficiary (adjusted for changes in the age distribution) relative to the growth in GDP per person.[4] Third,

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3. In December 2010, lawmakers enacted the Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010 (Public Law 111-312, referred to here as the 2010 tax act).

4. Specifically, CBO assumed that, beginning in 2021, excess cost growth for Medicare would decline linearly—that is, by the same number of fractional percentage points each year—from 1.7 percent in 2021 to 1.0 percent in 2084. Similarly, the agency assumed that excess cost growth for Medicaid would decline from 1.7 percent in 2021 to zero percent in 2084. For detailed discussion of these projections, see Congressional Budget Office, *The Long-Term Budget Outlook* (June 2010; revised August 2010), Chapter 2.

the effects of the health care legislation enacted in March 2010 as estimated by CBO and the staff of the Joint Committee on Taxation (JCT) were layered on top of the projections from those first two steps. Medicare's payment rates for physicians were assumed to be reduced as specified under the so-called sustainable growth rate mechanism.[5]

Alternative Fiscal Scenario

CBO also prepared long-term budget projections last year under an alternative fiscal scenario. Whereas the extended-baseline scenario was predicated on current law, the alternative fiscal scenario incorporated several changes to current law that were widely expected to occur or that would modify some provisions of law that might be difficult to sustain for a long period. Those changes included an extension of the 2001 and 2003 tax cuts (except for rate reductions that applied to high-income taxpayers), broad relief from the alternative minimum tax, and growth in discretionary spending that matched the rate of growth in GDP, among others. Under that scenario, U.S. debt held by the public was projected to rise to unprecedented levels by 2025—exceeding its past peak of about 110 percent of GDP—and to continue growing rapidly in subsequent years. If that alternative fiscal scenario was updated to reflect the current 10-year outlook, the debt projections would be even worse.

Under the alternative fiscal scenario, Medicare spending would be higher than under the extended-baseline scenario because payment rates for physicians were projected to grow at the same rate as the Medicare economic index rather than at the lower rates of the sustainable growth rate mechanism and because several policies that would restrain spending were assumed not to be in effect after 2020. Projections of total federal spending for Medicaid, CHIP, and the exchange subsidies in the two scenarios were similar in the long run because the policies governing Medicaid and CHIP were assumed to be the same in both cases and because exchange subsidies constituted a relatively small share of GDP.

Economic Consequences of Deficits and Debt

Although deficits during a recession or the recovery that follows generally hasten economic recovery, persistent deficits and continually mounting debt would have several negative economic consequences for the United States.[6] Some of those consequences would arise gradually: A growing portion of people's savings would go to purchase government debt rather than toward investments in productive capital goods such as factories and computers; that "crowding out" of investment would lead to lower output and incomes than would otherwise be the case. In addition, if the payment of

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5. Enacted on December 15, 2010, the Medicare and Medicaid Extenders Act of 2010 (Public Law 111-309) delayed the scheduled reduction in payments to physicians under Medicare until January 1, 2012. That change does not affect CBO's long-term projections of Medicare spending.

6. For more analysis about the effects of the long-term budget imbalance, see Congressional Budget Office, *Federal Debt and the Risk of a Fiscal Crisis*, Issue Brief (July 2010) and *Economic Impacts of Waiting to Resolve the Long-Term Budget Imbalance*, Issue Brief (December 2010).

interest on the extra debt was financed by imposing higher marginal tax rates, those rates could discourage work and saving and further reduce output; alternatively, the growing interest payments might force reductions in spending on government programs. Moreover, rising debt would increasingly restrict the ability of policymakers to use fiscal policy to respond to unexpected challenges, such as economic downturns or international crises.

Beyond those gradual consequences, a growing federal debt also would increase the probability of a sudden fiscal crisis, during which investors would lose confidence in the government's ability to manage its budget and the government would thereby lose its ability to borrow at affordable rates. It is possible that interest rates would rise gradually as investors' confidence faltered, giving legislators warning of the worsening situation and sufficient time to make policy choices that could avert a crisis. Indeed, because interest rates on Treasury securities are unusually low today, such a crisis does not appear imminent in the United States. But as other countries' experiences show, investors can lose confidence abruptly, and interest rates on government debt can rise sharply and unexpectedly.

The exact point at which such a crisis might occur for the United States is unknown, in part because the ratio of federal debt to GDP is climbing into unfamiliar territory and in part because the risk of a crisis is influenced by other factors, including the government's long-term budget outlook, its near-term borrowing needs, the amount of private saving, and foreign investors' willingness to invest in U.S. assets. Thus, there is no way to predict with any confidence whether and when such a crisis might occur and no identifiable tipping point of debt relative to GDP. However, the risk of a crisis probably will increase when investors' growing confidence in the global recovery and the stability of the financial system increases their desire to hold private securities and foreign debt rather than Treasury securities. Moreover, the risk would probably become much larger if debt grew substantially more relative to GDP and if that debt-to-GDP ratio was poised to continue to rise.

Key Features of the Proposal

Chairman Ryan's proposal, as specified to CBO by his staff, encompasses changes to Medicare, Medicaid, the major 2010 health care legislation, other government spending (excluding that for Social Security), and tax law.

Medicare

Starting in 2022, the proposal would convert the current Medicare system to a system of premium support payments and would increase the age of eligibility for Medicare:[7]

- Starting in 2022, the age of eligibility for Medicare would increase by two months per year until it reached 67 in 2033.

7. On the basis of the specifications provided by Chairman Ryan's staff, CBO's analysis included no change in the sustainable growth rate mechanism for payments to physicians under Medicare.

- People who turn 65 in 2022 or later years and Disability Insurance beneficiaries who become eligible for Medicare in 2022 or later would not enroll in the current Medicare program but instead would be entitled to a premium support payment to help them purchase private health insurance.[8]

- Beneficiaries of the premium support payments would choose among competing private insurance plans operating in a newly established Medicare exchange. Those plans would have to comply with a standard for benefits set by the Office of Personnel Management. Plans would have to issue insurance to all people eligible for Medicare who applied and would have to charge the same premiums for all enrollees of the same age. The premium support payments would go directly from the government to the plans that people selected.

- The premium support payments would vary with the health status of the beneficiary. In addition, the Centers for Medicare and Medicaid Services would collect fees from plans with healthier enrollees, on average, and convey the proceeds to plans with less healthy enrollees, on average, with the goal of appropriately compensating plans for the health risks of their insured population. This risk-adjustment mechanism would be known as the risk review audit and would be budget-neutral.

- The payment for 65-year-olds in 2022 is specified to be $8,000, on average, which is approximately the same dollar amount as projected net federal spending per capita for 65-year-olds in traditional Medicare (that is, the program's outlays minus receipts from the premiums enrollees pay for Part B and Part D, expressed on a per capita basis) under current law in that year. People who become eligible for Medicare in 2023 and subsequent years would receive a payment that was larger than $8,000 by an amount that reflected the increase in the consumer price index for all urban consumers (CPI-U) and the age of the enrollee. The premium support payments would increase in each year after initial eligibility by an amount that reflected both the increase in the CPI-U and the fact that enrollees in Medicare tend to be less healthy and require more costly health care as they age. (For example, projected net federal spending per capita for all people age 65 and older in traditional Medicare would be about $15,000 in 2022, CBO estimates, in comparison with about $8,000 for 65-year-olds.)

- The premium support payments would also vary with the income of the beneficiary. People in the top 2 percent of the annual income distribution of the Medicare-eligible population would receive 30 percent of the premium support amount described above; people in the next 6 percent of the distribution would receive 50 percent of the amount described above; and people in the remaining

8. In 2022 or later, people who are newly diagnosed with end-stage renal disease or amyotrophic lateral sclerosis (ALS), commonly known as Lou Gehrig's disease, would receive premium support payments as well.

92 percent of the distribution would receive the full premium support amount described above.

- Beginning in 2022, the federal government would establish a medical savings account (MSA) for certain beneficiaries with low income. (An MSA is an account that holds deposits that can be used for medical expenses.) Eligibility for MSA payments would be determined annually by the federal government on the basis of income relative to the federal poverty thresholds. The amount of the contribution in 2022 would be $7,800, and the annual amounts in subsequent years would grow with the CPI-U.

- Eligibility for the traditional Medicare program would not change for people who are age 55 or older by the end of 2011 or for people who receive Medicare benefits through the Disability Insurance program prior to 2022. As a result, the average age and average costs of enrollees remaining in the traditional Medicare program would increase over time. However, enrollees' premiums under traditional Medicare would be adjusted to equal what they would be under current law—a so-called hold harmless provision. People covered under traditional Medicare would, beginning in 2022, have the option of switching to the premium support system.

Medicaid

The proposal would modify Medicaid as follows:

- Starting in 2013, the federal share of all Medicaid payments would be converted into block grants to be allocated to the states. The total dollar amount of the block grants would increase annually with population growth and with growth in the CPI-U.

- Starting in 2022, Medicaid block grant payments would be reduced to exclude projected spending for acute care services or Medicare premiums and cost sharing paid by Medicaid.

- States would have additional flexibility in designing their programs.

2010 Health Care Legislation

The proposal would make several changes to the Patient Protection and Affordable Care Act (or PPACA, Public Law 111-148) and the health care provisions of the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152). In general, it would repeal the provisions of those laws that deal with insurance coverage, including:

- The requirement that most legal U.S. residents obtain health insurance;

- The establishment of health insurance exchanges and the provision of subsidies for certain individuals and families who purchase coverage through the exchanges;

- The expansion of Medicaid coverage to include most nonelderly people with income below 138 percent of the federal poverty level;
- The penalties on certain employers if any of their workers obtain subsidized coverage through the exchanges; and
- The tax credits for small employers that offer health insurance.

The proposal would also change some other provisions of PPACA and the Reconciliation Act:

- It would repeal the Community Living Assistance Services and Supports (CLASS) program for long-term care insurance, as well as a number of mandatory grant programs including funds for so-called high-risk pools, reinsurance for early retirees, and prevention and public health activities.
- The proposal would repeal the provisions that created the Independent Payment Advisory Board and that expanded subsidies for the "coverage gap" in Part D (a range of spending in which many enrollees have to pay all of their drug costs, sometimes called the doughnut hole).

Most of the other changes that PPACA and the Reconciliation Act made to the Medicare program would be retained.

Tort Reform

Several changes would be made to laws governing medical malpractice, including putting in place limits on noneconomic and punitive damages.[9]

Other Spending

The path for all other federal spending excluding interest—that is, for discretionary spending and mandatory spending apart from that for Social Security and the major mandatory health care programs—was specified by Chairman Ryan's staff. The remaining part of mandatory spending includes such programs as federal civilian and military retirement, the Supplemental Nutrition Assistance Program, unemployment compensation, Supplemental Security Income, the refundable portion of the earned income and child tax credits, and most veterans' programs. Discretionary spending includes both defense spending and nondefense spending—in roughly equal amounts currently. That combination of other mandatory and discretionary spending was specified to decline from 12 percent of GDP in 2010 to about 6 percent in 2021 and then move in line with the GDP price deflator beginning in 2022, which would gen-

9. The proposed changes are the same as those analyzed in Congressional Budget Office, letter to the Honorable Orrin G. Hatch about CBO's analysis of the effects of proposals to limit costs related to medical malpractice ("tort reform") (October 9, 2009).

erate a further decline relative to GDP. No proposals were specified that would generate that path.

Revenues

The path for revenues as a percentage of GDP was specified by Chairman Ryan's staff. The path rises steadily from about 15 percent of GDP in 2010 to 19 percent in 2028 and remains at that level thereafter. There were no specifications of particular revenue provisions that would generate that path.

CBO's Approach to Analyzing the Proposal

CBO analyzed the long-term budget implications of Chairman Ryan's proposal by projecting federal spending on Medicare, Medicaid, Social Security, and other programs. That total primary (noninterest) spending plus interest on federal debt minus total revenues was used to calculate deficits or surpluses.[10] Borrowing based on those deficits or surpluses was used to calculate the total amount of debt held by the public.[11]

Because this analysis focuses on the long term and CBO's most recent update of its long-term projections occurred in June 2010—based on the agency's March 2010 baseline projections—the projections for 2011 to 2020 used in this analysis are based on the agency's March 2010 baseline and not its most recent March 2011 baseline. The latter baseline makes projections for 2011 through 2021. To avoid confusion between those two baselines, CBO reports estimates here starting in 2022.

Economic Projections

CBO projected in June 2010 that GDP would grow by an average of 4.2 percent per year in nominal dollars over the period from 2022 to 2050, with inflation-adjusted GDP growing at 2.0 percent, prices as measured by the implicit GDP price deflator growing at 2.2 percent, and prices as measured by the CPI-U growing at 2.5 percent.

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10. For details on the modeling approach, see Congressional Budget Office, *CBO's Long-Term Model: An Overview*, Background Paper (June 2009).

11. Federal debt has two main components: debt held by the public, and debt held by government trust funds and other government accounts. This analysis focuses on the former as the more meaningful measure for assessing the relationship between federal debt and the economy. Debt held by the public represents the amount that the government has borrowed in financial markets to pay for its operations and activities; in pursuing such borrowing, the government competes with other participants in credit markets for financial resources. In contrast, debt held by government trust funds and other government accounts represents internal transactions of the government. In addition to the difference between primary spending, interest payments, and revenues, several factors not directly included in budget totals also affect the government's need to borrow from the public. Those factors include reductions (or increases) in the government's cash balance as well as the cash flows reflected in the financing accounts used for federal credit programs. Changes in those factors were not modeled in this analysis.

In keeping with long-standing practice for estimating the effects of budget proposals, CBO did not incorporate in its estimates any impact of the proposal on GDP. To estimate such an impact would require information about the specific tax policies that would underlie the path of total revenues that was specified by Chairman Ryan's staff. Although that level of detail has not been provided, the proposal would hold tax revenues to a significantly smaller share of GDP than would arise under the extended-baseline scenario. To the extent that marginal tax rates on labor and capital income would be lower as a result, future output and income would be greater in the long term, all else being equal. Moreover, because the proposal would reduce federal debt relative to the extended-baseline scenario, less private saving would be absorbed by federal borrowing—which would also tend to boost future output and income. Therefore, GDP and national income would probably be higher in the long term under the proposal than under the extended-baseline scenario. Compared with the alternative fiscal scenario, the proposal would put total revenues at roughly the same share of GDP, but it would lower federal debt by a huge amount. Therefore, in the long term, GDP and national income would be higher under the proposal than under the alternative fiscal scenario.

Projections of Spending for Major Mandatory Health Care Programs

For this analysis, CBO projected spending for those beneficiaries remaining in traditional Medicare, spending on the proposed premium support payments, and spending on the proposed Medicaid block grants:

- CBO's projections of spending for those remaining in traditional Medicare are consistent with its June 2010 projections under the extended-baseline scenario and account for the decreasing number of beneficiaries covered by traditional Medicare each year after 2022.

- CBO made long-term projections—for 2022 and later—of spending on the proposed premium support payments for Medicare. The amount of the payments for each new cohort of recipients (composed each year of the people reaching the age of Medicare eligibility, which increases from 65 to 67 under the proposal) would grow with the CPI-U. The premium support payment would be adjusted for age, health status, and income.

- CBO estimated the annual block grant amounts in Medicaid on the basis of the agency's projections of the CPI-U and population growth and assuming repeal of the Medicaid provisions of PPACA and the Reconciliation Act, and adjusting for the proposal's elimination of support for acute care for elderly Americans as a covered benefit.

To simplify the analysis, CBO assumed that, after 2021, all individuals projected to enroll in Medicare under current law would, under the proposal, use the premium support payment to purchase health insurance through the newly established Medicare exchange. That assumption produces an overestimate of enrollment under the

proposal, because costs to individuals (beyond those covered by the premium support payment) would be higher under the proposal than under traditional Medicare, and some individuals would therefore choose not to purchase insurance. To the extent that fewer people enrolled, costs for the premium support program would be lower than shown in this analysis, and the number of older Americans without health insurance would be higher. The proposal includes rules that would govern the Medicare exchange—including requiring insurers to issue insurance to all people eligible for Medicare who apply, requiring that each insurer charges the same premium for all enrollees of the same age, and using a risk-adjustment mechanism. In CBO's judgment, those rules are essential for ensuring that a large fraction of eligible individuals would enroll.

In addition, CBO assumed that no individuals who were covered by the traditional Medicare program in 2022 or later would switch to the premium support system. If healthier people chose to switch, overall federal health care costs could increase, because the number of premium support payments would increase and because the rise in per capita costs in the traditional Medicare program would not affect traditional Medicare premiums owing to the hold harmless provision specified by the proposal. CBO did not model that aspect of the proposal.

As the eligibility age for Medicare rose from 65 to 67, some people who were 65 or 66 years old, or were approaching those ages, would turn to other programs for health care and income support. For example, more people might apply for disability benefits under the Disability Insurance program or under the Supplemental Security Income program. Most people on Disability Insurance receive Medicare benefits after a 24-month waiting period, and Supplemental Security Income beneficiaries receive Medicaid benefits immediately under current law. More people might also apply for the Supplemental Nutrition Assistance Program or other welfare programs. The effects of the proposal on outlays for those programs were not included in this analysis.

CBO has not analyzed the changes in health insurance coverage that would occur as a result of the repeal of the specified coverage provisions of the 2010 health care legislation, the Medicare premium support policy, and the Medicaid block grants policy. Nor has CBO assessed the proposal's effects on total national spending on health care.

Projections of Other Components of the Budget

The proposal does not involve changes to Social Security. Therefore, in this analysis, projected spending for Social Security is the same as what CBO projected last June.[12]

For all noninterest spending except that for Social Security and the major mandatory health care programs, Chairman Ryan's staff specified the share of GDP that such

12. For details, see Congressional Budget Office, *CBO's 2010 Long-Term Projections for Social Security: Additional Information* (October 2010).

spending would represent in each year through 2021. Beyond 2021, the staff specified that spending grow at the same rate as prices in the economy overall, as measured by the GDP implicit price deflator. The staff also specified a path for revenues as a share of GDP, with the share reaching 19.0 percent in 2028 and remaining at that level thereafter.

Interpreting the Projections

The nominal dollar amounts associated with almost any budget scenario or proposal would increase over time as prices in the economy increase and the number of people paying taxes and receiving government services increases. To make the budget numbers easier to interpret, CBO presents projected dollar amounts under its long-term scenarios and under this proposal as shares of GDP—the nation's total economic output. In addition, in order to convey the uncertainty about long-term budget projections, the projections for the proposal are rounded to the nearest one-quarter percent of GDP.

Long-term projections of spending or revenues as shares of GDP depend critically on any differences between the average growth rate of that spending or those revenues and the average growth rate of GDP. Under the proposal, the per capita Medicare premium support payments, the amounts of the Medicaid block grants, and other spending (apart from that for Social Security and interest payments) are all specified to grow more slowly than GDP. Those differences in specified growth rates are the fundamental reason why CBO projects that deficits and debt will be much smaller under the proposal than under either of CBO's long-term budget scenarios.

The proposal would change the nature of the entitlement under Medicare and Medicaid. Current law prescribes the health care benefits to which people are entitled, and the federal government pays whatever is needed to honor those entitlements. The proposal changes that entitlement to a fixed federal contribution: For Medicare, that contribution would be in the form of per capita payments; for Medicaid, the federal government would provide annual block grants to states that would grow from year to year on the basis of changes in prices and population. Those features of the proposal make future federal health care spending easier to model and would make such spending less uncertain. As a result, CBO is providing projections for the proposal through 2050, which is a longer time period than CBO generally includes in its projections of budget proposals. However, because projections of federal health care spending under current law depend on complex interactions among many factors that are particularly difficult to predict, the difference between future spending under the proposal and that under current law is highly uncertain, as is the difference in overall budgetary effects.

Effects of the Proposal on the Federal Budget

According to CBO's projections, Chairman Ryan's proposal would significantly reduce mandatory outlays for health care relative to the amounts projected in both of

CBO's long-term scenarios. In addition, the proposal would substantially reduce spending on other mandatory programs (other than Social Security) and discretionary programs compared with the amounts projected in CBO's long-term scenarios. Those reductions, combined with no proposed changes to Social Security and with the path of revenues specified by the Chairman's staff, would result in much lower deficits and debt in the long run than the amounts in CBO's scenarios. Under the proposal, the federal budget would show a deficit of about 2 percent of GDP in 2022, a slight surplus in 2040, and a surplus of about 4 percent of GDP in 2050. The ratio of debt to GDP would fall sharply—from about 70 percent of GDP in 2022 to about 10 percent in 2050.

Federal Spending on Major Mandatory Health Care Programs

Under the extended-baseline scenario, federal spending on Medicare, Medicaid, CHIP, and the subsidies to be provided through insurance exchanges established by the major 2010 health care legislation is projected to rise from about 7 percent of GDP in 2022 to about 12 percent of GDP in 2050. Under the alternative fiscal scenario, federal spending on those programs is projected to rise from about 8 percent of GDP in 2022 to about 14 percent of GDP in 2050 (see Table 2). Under the proposal, federal spending on Medicare, Medicaid, and CHIP would be sharply lower—about 5½ percent of GDP in 2022, rising to about 6 percent in 2030 and 2040, and falling back to about 5 percent in 2050. (As noted earlier, the proposal would eliminate the exchange subsidies specified in last year's legislation.)

The differences in the early years occur mostly because the amounts of the Medicaid block grants would grow more slowly than would federal Medicaid spending under either the extended-baseline or alternative fiscal scenarios. The differences in the later years arise mostly because spending for premium support payments would grow more slowly than spending in the current Medicare program. The budgetary savings from this aspect of the proposal build up slowly for three reasons: First, the difference between the growth rate of 65-year-olds' premium support payments and the rate of increase in costs under current law would compound over time; second, the first cohort of people to participate in the new system would become eligible in 2022, and the share of the elderly population receiving Medicare benefits through the new system would increase slowly; and third, initially the beneficiaries in the new system would be younger (and therefore would incur lower health care costs, on average) than the beneficiaries in the old system, so the transition would be slower when measured in terms of health care spending than in terms of the number of beneficiaries (see Table 3). The estimates of spending under the proposal are very sensitive to the growth rates specified for payments through the two programs, particularly over the longer term, because of the effects of compounding.

Table 2.

Federal Spending Excluding Interest

(Percentage of gross domestic product)

	Actual	Projected			
	2010	2022	2030	2040	2050
		Extended-Baseline Scenario			
Major Mandatory Health Care Programs[a]	5½	7¼	8¾	10¾	12¼
Social Security	4¾	5¼	6	6¼	6
Other Mandatory and Defense and Nondefense Discretionary Spending[b]	12	8¼	8	7¾	7½
Spending Excluding Interest	22½	20¾	22¾	24½	25¾
		Alternative Fiscal Scenario			
Major Mandatory Health Care Programs[a]	5½	7¾	9¾	12	13¾
Social Security	4¾	5¼	6	6¼	6
Other Mandatory and Defense and Nondefense Discretionary Spending[b]	12	9¾	9½	9¼	9
Spending Excluding Interest	22½	22¾	25¼	27¼	28¾
		Proposal			
Major Mandatory Health Care Programs[c]	5½	5½	6	5¾	4¾
Social Security	4¾	5¼	6	6¼	6
Other Mandatory and Defense and Nondefense Discretionary Spending[b]	12	6	5¼	4¼	3½
Spending Excluding Interest	22½	17	17½	16¼	14

Source: Congressional Budget Office.

Notes: The proposal that CBO analyzed is as specified by Chairman Paul Ryan and his staff. The extended-baseline and alternative fiscal scenarios are as described in Congressional Budget Office, *The Long-Term Budget Outlook* (June 2010; revised August 2010).

Components may not add up to totals because of rounding.

a. Includes Medicare, Medicaid, exchange subsidies, and the Children's Health Insurance Program (CHIP).

b. Incorporates collections of premiums paid by Medicare beneficiaries.

c. Includes Medicare and Medicaid as structured under the proposal and CHIP. There are no exchange subsidies under the proposal.

Much less uncertainty about future federal spending on Medicare and Medicaid would exist under the proposal than exists under current law. Under the proposal, Medicare spending over the long term would depend on the amount of the premium support payments, which would depend on the number of people who participate in Medicare and on increases in overall consumer prices. Under the proposal, Medicaid spending would depend on the amount of the block grants, which would depend on changes in consumer prices and population growth.

Table 3.

Percentage of Medicare Spending and of Beneficiaries in the Premium Support Payment System Under the Proposal

	2022	2030	2040	2050
Percentage of Medicare Spending Accounted for by Premium Support Payments	4	29	61	91
Percentage of Medicare Beneficiaries Receiving Premium Support Payments	6	45	77	93

Source: Congressional Budget Office.

Note: The proposal that CBO analyzed is as specified by Chairman Paul Ryan and his staff.

In contrast, under the current Medicare and Medicaid systems, federal spending depends not only on the number of enrollees but also on the volume and complexity of services used and on the costs of those services—all of which are highly uncertain. The amounts by which the growth rates of Medicare and Medicaid spending per beneficiary (adjusted for changes in the age distribution) have exceeded the growth rate of the economy have varied greatly from year to year during the past several decades. In both of its long-term scenarios, CBO assumed that such "excess cost growth" would slow beginning in 2022. However, the precise mechanisms that would produce that slowing are uncertain. Moreover, as the projection period lengthens, the uncertainties mount because the likelihood of significant changes in medical practice and technology increases. As a result, comparisons between projected federal health care spending under the proposal and under CBO's long-term scenarios are highly uncertain.

Although the uncertainty in future federal spending on health care would be lessened under the proposal, that uncertainty would be transferred to future beneficiaries. If the volume, complexity, and costs of medical services turned out to be greater than expected, future beneficiaries would pay higher premiums and cost-sharing amounts than are currently projected. Alternatively, beneficiaries' costs would be less than currently projected if the volume, complexity, and costs of medical services turned out to be less than expected.

Social Security Spending

Under both the extended-baseline scenario and the alternative fiscal scenario, federal spending on Social Security is projected to rise from just over 5 percent of GDP in 2022 to about 6 percent in 2030 and beyond (see Table 2 on page 16). Under the proposal, spending on Social Security is the same as that in CBO's two scenarios because the proposal includes no changes to the program.

Other Mandatory and Discretionary Spending

Under the extended-baseline scenario, discretionary spending and mandatory spending other than that for mandatory health care programs and Social Security is projected to fall from about 8 percent of GDP in 2022 to 7½ percent of GDP in 2050 (see Table 2 on page 16). Under the alternative fiscal scenario, such spending is pro-

jected to fall from close to 10 percent of GDP in 2022 to about 9 percent of GDP in 2050. Under the spending path specified by Chairman Ryan's staff, other spending would be 6 percent of GDP in 2022 and just 3½ percent of GDP by 2050.

Revenues

Under the extended-baseline scenario, revenues would rise from 21 percent of GDP in 2022 to 26 percent in 2050 (see Table 1 on page 3). The increase over that period is primarily due to the interaction of the tax system with inflation and real growth in income (which would produce higher taxes as a share of income). By contrast, the alternative fiscal scenario assumes that revenues would be about 19 percent of GDP in 2022 and beyond. Under the revenue path specified by Chairman Ryan's staff, revenues would be about 18½ percent of GDP in 2022 and would reach 19 percent in 2028 and remain at that share of GDP in future years.

Deficits

Under the extended-baseline scenario, the federal deficit is projected to rise from about 3 percent of GDP in 2022 to about 4 percent in 2050. Under the alternative fiscal scenario, the federal deficit is projected to rise from about 7½ percent of GDP in 2022 to about 26 percent in 2050 (see Table 1). Under the proposal, the federal budget would show a deficit of about 2 percent of GDP in 2022 and 2030; the federal budget would show a slight surplus in 2040 and growing surpluses in the following decade.

The improvement in the long-term budget outlook under the proposal is attributable to the sharp reduction in spending excluding interest costs, which would be lower than projected spending under the extended-baseline and alternative fiscal scenarios in 2050 by almost 12 percentage points and almost 15 percentage points of GDP, respectively. Revenues under the proposal would be about 7 percentage points of GDP below the amounts projected under the extended-baseline scenario and slightly lower than those under the alternative fiscal scenario.

Debt Held by the Public

Under the extended-baseline scenario, debt held by the public is projected to rise from about 62 percent of GDP in 2010 to about 90 percent of GDP in 2050.[13] Under the alternative fiscal scenario, the ratio of debt to GDP is projected to rise to more than 300 percent in 2050 (see Table 1 on page 3). Under the proposal, the ratio of debt to GDP would be significantly smaller over the long term—falling to 48 percent in 2040 and 10 percent in 2050.

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13. Because CBO's long-term estimates reflect current law as of March 2010 as amended by the major 2010 health legislation, the projections of the proposal and long-term scenarios reported in this analysis are not fully consistent with CBO's most recent budget baseline. In CBO's March 2011 baseline, debt held by the public in 2020 is about 9 percentage points of GDP higher than it was projected to be last year.

Key Considerations

The projected reductions in deficits and debt under the proposal depend on implementing substantial reductions in spending, relative to GDP, through a number of policies that might be difficult to sustain over a long period of time. Those policies would involve Medicare, Medicaid, and the broad category of other mandatory and discretionary spending (excluding that for Social Security).

Under the proposal, the gradually increasing number of Medicare beneficiaries participating in the new premium support program would bear a much larger share of their health care costs than they would under the traditional program. (The magnitude of that change is discussed in the following section.) That greater burden would require them to reduce their use of health care services, spend less on other goods and services, or save more in advance of retirement than they would under current law. At the same time, the proposal analyzed by CBO would leave in place provisions restraining payments to many providers under the traditional Medicare program.

In addition, federal payments for Medicaid under the proposal would be substantially smaller than currently projected amounts. (The size of that reduction is discussed later in this analysis.) Although states would have additional flexibility to design and manage their Medicaid programs and might achieve greater efficiencies in the delivery of care than they do under current law, the large projected reduction in federal payments would probably require states to reduce payments to providers, curtail eligibility for Medicaid, provide less extensive coverage to beneficiaries, or pay more themselves than would be the case under current law.

Furthermore, the proposal specifies a path for all other spending (excluding interest and Social Security) that would cause such spending to decline sharply as a share of GDP—from 12 percent in 2010 to 6 percent in 2022 and 3½ percent by 2050. For comparison, spending in this category has exceeded 8 percent of GDP in every year since World War II. The proposal does not specify the changes to government programs that might be made in order to produce that path. Because the proposal specifies that such spending would grow only at the rate of prices in the overall economy, the quantity of real government services (that is, spending adjusted for inflation) per person would decline as population increases. Moreover, that spending would not grow with real income per capita, as it has tended to over long historical periods.

CBO's long-term scenarios would also be subject to pressures that would make them difficult or impossible to sustain: In the extended-baseline scenario, revenues would reach higher levels relative to the size of the economy than ever recorded in the nation's history, payments to physicians under Medicare would be reduced well below current rates, and payments to other Medicare providers would grow more slowly than the cost of their inputs; nevertheless, federal debt would continue to grow relative to GDP. The constraints on payments to Medicare providers could lead to reduced access to care or diminished quality of care for Medicare beneficiaries. In the alternative fiscal scenario, revenues would be lower and Medicare's payments to physi-

cians and other providers would be higher than under the extended-baseline scenario, but the government's debt would skyrocket to levels unprecedented in the United States.

It is unclear whether and how future lawmakers would address the pressures resulting under those long-term scenarios or from the proposal analyzed here.

Impact of the Proposal on Spending for Health Care by Medicare Beneficiaries

Chairman Ryan's proposal would affect not only federal spending for Medicare but also Medicare beneficiaries' spending for their health care. To quantify the impact of the proposal on beneficiaries' spending, CBO followed these steps: First, the agency estimated what total health care spending (including the costs paid by health insurers and out-of-pocket expenses for covered services) would be in 2011 for a typical 65-year-old who had a private health insurance plan with a benefit package comparable to the services covered by the Medicare program.[14] That package is dubbed the "standardized benefit," and CBO used the total health care spending for a typical 65-year-old with a standardized benefit in a private plan as a benchmark for this analysis. In making that calculation, CBO estimated that the Medicare benefit provided by Parts A, B, and D has an actuarial value (Medicare's share of spending for the services covered) of approximately 76 percent, on average. Next, CBO estimated what total health care spending would be in 2022 and 2030 for a typical 65-year-old with an insurance plan having an equivalent benefit package. Finally, CBO estimated the shares of those total amounts of spending that would be paid by the federal government and by a typical 65-year-old beneficiary in 2022 and 2030 under the extended-baseline scenario, the alternative fiscal scenario, and Chairman Ryan's proposal.

CBO's analysis is necessarily stylized, but it illustrates trends in spending by the government and by a typical beneficiary under the proposal and under current laws and policies.[15] CBO did not extrapolate these calculations beyond 2030 because of the increasing uncertainty about the development of the health care and health insurance systems over more-extended periods.

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14. For the analysis in this section, CBO defined a "typical" 65-year-old beneficiary as one with average spending for health care services for that age and at the middle of the income distribution for the Medicare-eligible population. The proposal includes a provision to reduce premium support payments for beneficiaries in the top 8 percent of the income distribution and to deposit additional amounts in medical savings accounts for beneficiaries with dual eligibility for Medicare and Medicaid or with income below 150 percent of the federal poverty level.

15. By 2030, the Medicare eligibility age would be 66 and 6 months. This analysis is intended to illustrate the effects for a typical beneficiary, so CBO chose 65-year-olds as the standard of comparison because people that age would be the only ones without access to traditional Medicare in 2022.

Under the proposal, most beneficiaries who receive premium support payments would pay more for their health care than if they participated in traditional Medicare under either of CBO's long-term scenarios. CBO estimated that, in 2030, a typical 65-year-old would pay 68 percent of the benchmark under the proposal, compared with 25 percent under the extended-baseline scenario and 30 percent under the alternative fiscal scenario.

Estimates of the Shares of Spending Borne by the Government and Beneficiaries

A private health insurance plan covering the standardized benefit would, CBO estimates, be more expensive currently than traditional Medicare. Both administrative costs (including profits) and payment rates to providers are higher for private plans than for Medicare. Those higher costs would be offset partly but not fully by savings from lower utilization stemming from two sources. First, private health insurers would probably impose greater utilization management than occurs in Medicare. Second, private plans might restrict enrollees' ability to purchase supplemental insurance plans; enrollees would thus face higher out-of-pocket costs than they do in Medicare, and that increased cost sharing would encourage lower utilization. On net, for a typical 65-year-old in 2011, CBO estimates that average spending in traditional Medicare will be 89 percent of (that is, 11 percent less than) the spending that would occur if that same package of benefits was purchased from a private insurer (see Figure 1).[16]

Moreover, CBO projects that total health care spending for a typical beneficiary covered by the standardized benefit under the proposal would grow faster than such spending for the same beneficiary in traditional Medicare under either of CBO's long-term scenarios. For the period before 2030, the difference in projected growth rates occurs primarily because CBO expects that the payments to providers in Medicare will grow more slowly (especially under the extended-baseline scenario) than those in the private market.

As a result, total health care spending for a typical 65-year-old in Medicare under the extended-baseline scenario in 2022 would be 66 percent of total spending with a private plan with the standardized benefit; in 2030, the figure would be 60 percent of that benchmark. Total health care spending in Medicare under the alternative fiscal scenario would be a larger share of total spending with a private plan—72 percent in 2022 and 71 percent in 2030—because payments to providers in Medicare are assumed to grow at a faster rate than under the extended-baseline scenario.

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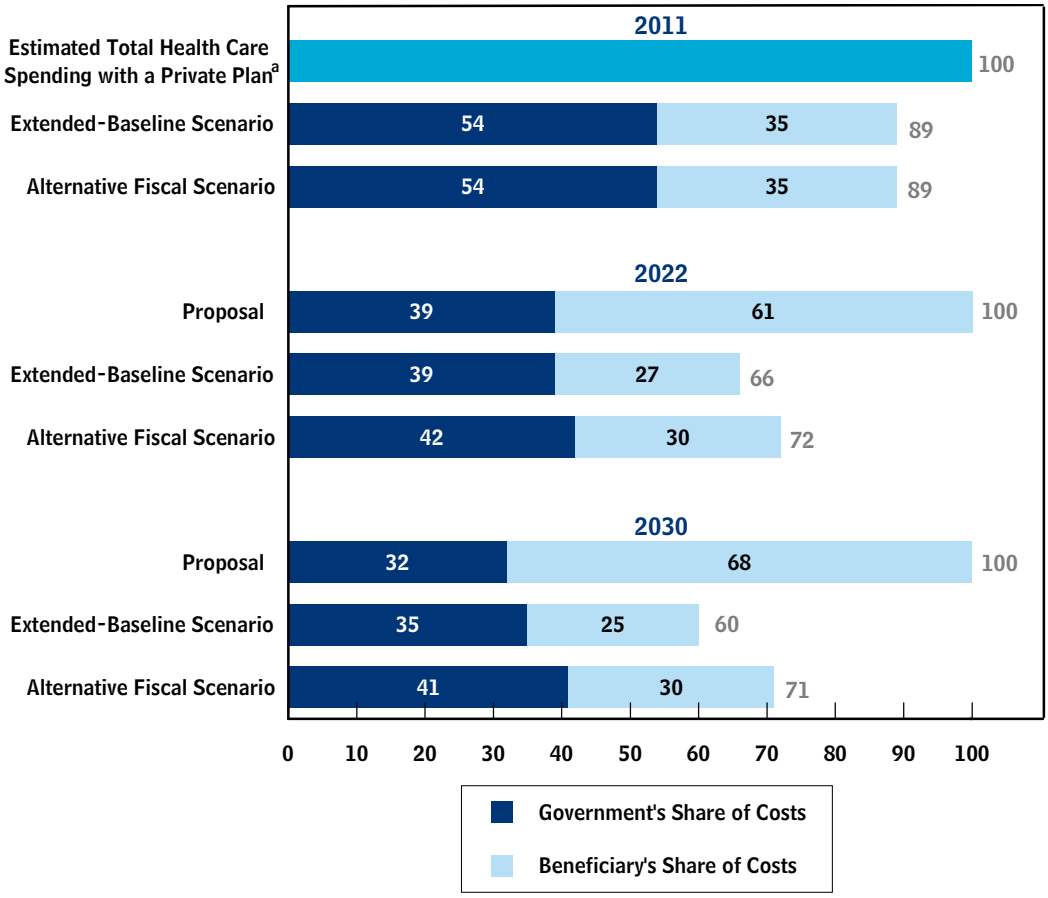
16. This calculation was conducted as if an insurance exchange offering such plans were in place in 2011, which is not part of the proposal. Since premium support payments and purchases through the exchange would not begin until 2022 under the proposal, no shares of the government's or the beneficiary's contributions were estimated for 2011.

Figure 1.

Shares of Spending on Health Care for a Typical 65-Year-Old with a Standardized Health Insurance Benefit

(Percentage of total spending with a private plan)



Source: Congressional Budget Office.

Notes: The proposal that CBO analyzed is as specified by Chairman Paul Ryan and his staff. The extended-baseline and alternative fiscal scenarios are as described in Congressional Budget Office, *The Long-Term Budget Outlook* (June 2010; revised August 2010).

The analysis includes an assumption that, under the proposal, every 65-year-old would purchase private insurance having a "standardized benefit," meaning a plan with the same actuarial value (76 percent) as the Medicare benefit provided by Parts A, B, and D in 2011.

For this analysis, the "typical" beneficiary is defined as someone with average health care spending who would not receive a reduced premium support payment (because of high income) nor additional assistance through a medical savings account (because of low income).

A beneficiary's spending includes premiums, out-of-pocket costs for covered services, and payments for any supplemental insurance.

Total spending under the traditional Medicare benefit would be 89 percent of the spending with a private plan in 2011.

a. Because the new system of private plans would not begin until 2022, the bar for 2011 is not segmented to show shares of costs.

After assessing the total costs that would be incurred for a typical 65-year-old, CBO estimated the government's share and the beneficiary's share of those costs under the proposal and under CBO's long-term scenarios. The proposal would set the premium support payment for a typical 65-year-old at $8,000 in 2022, approximately equal to government spending on the average 65-year-old beneficiary in Medicare under the extended-baseline scenario in that year. In other words, the government contribution to that beneficiary's health care costs under the proposal would be approximately equal to the government's contribution to the beneficiary's costs through Medicare under current law.[17] Hence, measured relative to the benchmark, the government's contribution in 2022 would be similar under the proposal (at 39 percent), the extended-baseline scenario (39 percent), and the alternative fiscal scenario (42 percent). However, because the benchmark would be greater than that with traditional Medicare, a typical beneficiary's spending—the sum of premiums and out-of-pocket spending—would be greater under the proposal than under traditional Medicare. Specifically, CBO estimated that a typical 65-year-old would pay 61 percent of the benchmark in 2022 under the proposal. In comparison, under the extended-baseline scenario, the typical 65-year-old would pay 27 percent of the benchmark, while under the alternative fiscal scenario, that figure would be 30 percent.

In 2030, the government's contribution under the proposal would be smaller than that under either of CBO's long-term scenarios because the premium support payment would grow at a slower rate than is projected for Medicare spending under either scenario. In that year, under the proposal, the government's contribution would cover 32 percent of a typical 65-year-old's total health care spending. In comparison, under the extended-baseline scenario, the government's contribution through traditional Medicare would equal 35 percent of that benchmark, and under the alternative fiscal scenario, the figure would be 41 percent. (As in 2022, the government's contribution under the alternative fiscal scenario would be greater because that scenario incorporates higher payments to providers in Medicare than will occur under current law.) Thus, the proposal's formula for adjusting the premium support payments over time would cause the government to spend less than it would under either scenario. When expressed as a percentage of the benchmark, the beneficiary's share in 2030 would be 68 percent under the proposal, 25 percent under the extended-baseline scenario, and 30 percent under the alternative fiscal scenario.

To summarize, a typical beneficiary would spend more for health care under the proposal than under CBO's long-term scenarios for several reasons. First, private plans would cost more than traditional Medicare because of the net effect of differences in payment rates for providers, administrative costs, and utilization of health care services, as described above. Second, the government's contribution would grow more slowly than health care costs, leaving more for beneficiaries to pay.

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17. In 2022, the government contribution under the proposal is expected to be about 1 percent more than under the extended-baseline scenario and about 6 percent less than under the alternative fiscal scenario.

Paying more for health care would be particularly challenging for elderly people with less savings and lower income. However, the proposal specifies that people with sufficiently low income would receive an additional federal contribution to a medical savings account that would help them pay for their premiums and out-of-pocket medical spending. The analysis here for a typical 65-year-old does not address the impact of those accounts on the financial burden facing low-income beneficiaries (nor does it consider the effect of lower premium support payments for high-income beneficiaries). Moreover, because CBO assumed participation of all eligible beneficiaries in the premium support program, the agency did not evaluate the possible effects on participation of those additional features of the proposal.

Uncertainty in the Estimates and Other Considerations

CBO's estimates of the impact of the proposal on Medicare beneficiaries' spending for their health care are subject to substantial uncertainty. The uncertainty arises in part because the initial difference in the cost of health care received through a private plan and through current-law Medicare is difficult to estimate. It also arises in part because the difference in growth rates of those costs will depend on the evolution of the health care and health insurance systems over time, which is hard to predict.

To demonstrate the uncertainty of these estimates, CBO examined the sensitivity of the results to variation in the two factors just mentioned: the relative cost of health care for a typical 65-year-old in Medicare or in a private insurance plan today, and the relative growth rates of those costs during the next few decades. Specifically, CBO estimated the effects of assuming that total health care spending for a typical 65-year-old in Medicare was not the 89 percent of the benchmark, as in the calculations above, but rather 94 percent or 85 percent. Similarly, CBO estimated the effects of assuming that the increase in total health care spending with private health insurance was 0.5 percentage points slower or faster per year than in the calculations above.

Using that approach, CBO found that the typical beneficiary's share under the alternative fiscal scenario in 2030 would range from 26 percent to 34 percent of the benchmark, compared with the 30 percent discussed above. Likewise, the government's share of spending would range from 36 percent to 47 percent, compared with the 41 percent discussed above. For any value within the range of estimates, a typical beneficiary's spending under the proposal would be substantially greater than it would be under the alternative fiscal scenario. Similar ranges would apply under the extended-baseline scenario in 2030, as well as under both scenarios in 2022.

For this analysis, CBO estimated the cost of a private plan with an actuarial value equal to the traditional Medicare benefit in 2011 and estimated how the cost of a private plan with that standardized benefit would evolve over time. Those costs were compared with projections of how Medicare spending would evolve under the extended-baseline and alternative fiscal scenarios. However, as the provision of medical care evolves over time, those comparisons may not have the same meaning in 2022 and 2030 as in 2011.

In particular, under CBO's long-term scenarios and the proposal, different pressures will arise that have the potential to alter the substantive benefits that enrollees would obtain. Under current law, constraints on payment rates for providers of Medicare services may result in diminished access to care and lower-quality services, although the extent of such changes is very difficult to predict. In addition, rising tax rates (under the extended-baseline scenario) and surging federal debt (under the alternative fiscal scenario) might accentuate concerns about the budgetary situation and thereby lead policymakers to reduce Medicare benefits.

Future developments under the proposal might be quite different from those under CBO's long-term scenarios. Private insurers would have flexibility—to limit benefits, change co-payment arrangements, manage utilization, and control provider networks—that does not exist in traditional Medicare, and such steps could serve as alternatives to limiting payments to providers in restraining health care costs and insurance premiums. But the significant increase in payments by Medicare beneficiaries under the proposal might also affect the quality of care that they would obtain. For example, beneficiaries' greater cost-sensitivity could result in a slower introduction or less frequent use of new, costly, but possibly beneficial, technologies and techniques than would occur under current law. Instead, technological innovation might focus increasingly on cost-saving rather than cost-increasing technologies.

Effects of the Proposal on the Medicaid Program and State Governments

The Medicaid program covers acute care and long-term care services for low-income families with dependent children, the elderly, and people with disabilities. Eligible individuals are entitled to coverage of federally mandated medical services and other optional services as determined by individual states. About two-thirds of Medicaid spending is for acute care services, and one-third is for long-term care services. In terms of the population served, about two-thirds of all Medicaid spending is for the elderly and disabled, while about one-third is for low-income families with dependent children. Under current law, the federal and state governments jointly finance the cost of Medicaid, with the federal government projected to provide about 57 percent of the total cost for Medicaid services in 2012.[18] On average, net state spending for

18. The American Recovery and Reinvestment Act of 2009 provided states with additional federal financial assistance through December 2010. Subsequent legislation (P.L. 111-226) continued enhanced matching rates for an additional six months leading to an average federal share of about 64 percent in fiscal year 2011. On average, in fiscal years 2012 and 2013, federal Medicaid payments will represent approximately 57 percent of total Medicaid payments. PPACA, which expands Medicaid coverage starting in 2014, provides enhanced federal matching rates for certain populations, leading to an average federal share for Medicaid ranging between 60 percent and 62 percent, depending on the year.

Medicaid constitutes about 12 percent of states' spending from general funds.[19] That percentage is likely to increase over time under current law as health care costs continue to rise.

Chairman Ryan's proposal would shift some of the burden of Medicaid's growing costs to the states. It would, however, relieve some of the cost burden for states by repealing the provisions related to Medicaid in PPACA and the Reconciliation Act and, starting in 2022, eliminating certain benefits for the elderly under Medicaid. On balance, federal payments to states under the proposal would be significantly lower than under current law.

CBO compared federal payments to states under the proposal with federal spending for Medicaid services that is estimated to occur if spending for provisions related to Medicaid in PPACA and the Reconciliation Act and certain benefits for the elderly are excluded. Under the proposal, CBO estimates, federal spending for Medicaid would be 35 percent lower in 2022 and 49 percent lower in 2030 than currently projected federal spending with those adjustments.

If the costs of medical services for Medicaid enrollees continued to rise faster than the growth in the block grant amounts, states would have to decide how to respond. Under the proposal, states would have additional flexibility to design and manage their programs to achieve greater efficiencies in the delivery of care. Because of the magnitude of the reduction in federal Medicaid spending under the proposal, however, states would face significant challenges in achieving sufficient cost savings through efficiencies to mitigate the loss of federal funding. To maintain current service levels in the Medicaid program, states would probably need to consider additional changes, such as reducing their spending on other programs or raising additional revenues. Alternatively, states could reduce the size of their Medicaid programs by cutting payment rates for doctors, hospitals, or nursing homes; reducing the scope of benefits covered; or limiting eligibility. To some extent, under CBO's long-run projections, the rise in health care costs under current law would cause states to implement such changes anyway. However, given the size of the reduction in federal spending under the proposal, the magnitude of the changes would probably have to be greater.

If states reduced spending for their Medicaid programs, there would be a number of potential implications for both providers and beneficiaries. Given that payment rates for providers under Medicaid are already generally lower than they are under Medicare and private insurance, if states lowered payment rates even further, providers might be less willing to treat Medicaid enrollees. As a result, Medicaid enrollees could

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19. Note that if federal spending is included in the total amount that states spend on Medicaid, Medicaid constitutes 22 percent of total spending. See National Association of State Budget Officers, *2009 State Expenditure Report*, www.nasbo.org/LinkClick.aspx?fileticket=w7RqO74llEw%3d&tabid=38.

face more limited access to care. If states reduced benefits or eligibility levels, beneficiaries could face higher out-of-pocket costs, and providers could face more uncompensated care as beneficiaries lost coverage for certain benefits or lost coverage altogether.

Under the proposal, the annual block grant amounts would grow on the basis of general population and price growth—factors that would not be expected to vary much with economic conditions (other than inflation). Medicaid spending would not automatically increase during economic downturns, as it does now under current law. By design, the approach would make funding for Medicaid more predictable from a federal perspective, but it would lead to greater uncertainty for states as to whether the federal contribution would be sufficient during periods of economic weakness.