MEDICARE RIGHTS CENTER
Getting Medicare right

Decoding the 2012 House Budget Resolution

On April 15, 2011, the U.S. House of Representatives passed a budget resolution based on a proposal from Representative Paul Ryan, chairman of the House Budget Committee. The House budget fundamentally alters Medicare and Medicaid, replacing them with schemes that would save the government money largely through shifting costs to consumers and states. Such extra costs would be a financial burden for Medicare consumers, nearly half of whom currently have annual household incomes of $20,000 or less, and half of whom in the future are estimated to have incomes below $26,400. Below is a general overview of the major changes made by the House budget resolution, including the implications for people with Medicare now and in the future.

Medicare

- Replaces the current Medicare program for those who will be Medicare-eligible beginning in 2022 with a capped amount provided by the government to be used to purchase private insurance. Any extra costs not covered by the capped amount will be the responsibility of the consumer. This proposal is also known as a "premium support," "voucher" or "defined contribution" program.
  - The amount that the government contributes toward costs for people in Medicare will be inadequate to buy coverage that is as good as what Medicare currently provides. The Congressional Budget Office (CBO) estimates that, compared to the current Medicare program, this proposal would more than double out-of-pocket costs for consumers. According to the Kaiser Family Foundation, under the House budget proposal the cost of a private plan in 2022 will be $20,500, and the government contribution would be $8,000, leaving an individual responsible for over $12,000 in out-of-pocket costs.
  - Because the amount the government will contribute toward coverage will increase according to the consumer price index for urban consumers (CPI-U), which grows more slowly than health care costs overall, the contribution will become increasingly inadequate over time.
- Increases the Medicare eligibility age from 65 to 67 beginning in 2022.
- Increases the cost of providing benefits to Medicare consumers.
  - While the House budget resolution decreases the government's share of Medicare spending by shifting costs to consumers, it would increase the total cost of providing Medicare to individuals because administrative costs are higher under plans and benefits managed by private companies.

Currently, Medicare costs 11 percent less per person than it would if the same coverage was purchased through a private insurer.

- Repeals the closure of the Part D coverage gap, also known as the “doughnut hole,” and would end the discount program on brand-name and generic drugs, according the Congressional Research Service (CRS). In addition, the House resolution leaves intact provider cuts but does not reinvest savings into improvements to Medicare or other health-related programs.

Medicaid

- Beginning in 2022, people who are Medicare-eligible and who have limited incomes would no longer be eligible for Medicaid to help offset out-of-pocket costs associated with Medicare. Instead, the government would contribute a fixed amount depending on income level to a Medical Savings Account (MSA) that could be used to pay premiums and other medical costs.
  - It is not yet clear whether this amount would be sufficient to cover the out-of-pocket costs that those with low-incomes may face. The amount the government contributes to the MSA is not based on the health needs or utilization of services of an individual, but is a capped amount.
- Converts Medicaid funding to block grants, meaning that the government would contribute a capped amount of money to states to administer the Medicaid program. This is in contrast to the current structure, which allows all individuals who meet the eligibility criteria access to the benefit.
  - Reductions in Medicaid funding would have an immediate impact on the Medicare population of today and of the future because many would lose access to long-term care services and supports. The amount of the block grant would not be enough to cover the cost of current Medicaid programs in states, meaning that state governments, which already face significant budget shortfalls, will likely need to cut benefits or provider payment rates, or change eligibility rules in order to make Medicaid viable. For example, states may limit the number of people they allow to obtain Medicaid and limit services available under Medicaid, including long-term care.
    - Medicare does not provide any coverage for long-term care. Millions of people with Medicare, both low-income and middle-income individuals, rely on Medicaid for long-term care services and supports, including nursing home services and services provided in a community setting such as a person’s home.

© 2011 Medicare Rights Center