KAISER FAMILY FOUNDATION
Medicare Policy

THE HENRY J. KAISER FAMILY FOUNDATION

Comparison of Medicare Provisions in Deficit and Debt Reduction Proposals

In response to concern about the nation's rising debt and deficit, and increasing apprehension about the federal budget, prominent leaders and various commissions have come forward with recommendations to strengthen the economy and bolster the nation's fiscal health. These proposals include both tax increases and spending reductions in discretionary programs, including defense, and in mandatory programs, such as Social Security, Medicaid, and Medicare.

Many of these proposals include recommendations to reduce the growth in Medicare spending over time. These proposals come on the heels of the enactment of the Patient Protection and Affordable Care Act of 2010 which slowed the growth in Medicare spending by more than $400 billion between 2010 and 2019 – reducing the average annual growth rate from 6.8 percent to 5.9 percent during this 10-year period and extending the life of the Medicare Trust Fund by 8 years, to 2024. Yet, with Medicare spending at 15 percent of the federal budget in 2011, and projected to grow both as a share of the federal budget and the overall economy due to rising health costs and an aging population, additional measures to reduce Medicare spending are on the table once again.

This document provides a side-by-side comparison of the key Medicare changes that have been recommended as part of broad-based deficit- and debt-reduction packages, including:

- **The President's Plan for Economic Growth and Deficit Reduction**, released by the Office of Management and Budget on September 19, 2011;
- **The Senate "Gang of Six" proposal**, as put forward by Senators Saxby Chambliss, Tom Coburn, Kent Conrad, Mike Crapo, Dick Durbin, and Mark Warner in "A Bipartisan Plan to Reduce Our Nation's Deficits – Executive Summary," released July 19, 2011.
- **The House Budget Committee's Budget Resolution**, as passed by the House of Representatives on April 15, 2011;
- **The Administration's National Commission on Fiscal Responsibility and Reform**, chaired by Erskine Bowles and former Senator Alan Simpson, based on the report "The Moment of Truth," released on December 1, 2010; and
- **The Debt Reduction Task Force**, chaired by Dr. Alice Rivlin and former Senator Peter Domenici, in their report "Restoring America's Future," released November 17, 2010.

In addition, the appendix provides a summary of Medicare provisions included in deficit- and debt- reduction proposals released by the following individuals and organizations: American Enterprise Institute, Cato Institute, Center for American Progress, Senator Tom Coburn, Congressional Progressive Caucus, Dr. Bill Galston and Ms. Maya MacGuineas, Heritage Foundation, Institute for America's Future, Senator Joseph Lieberman and Senator Coburn, Our Fiscal Security, Dr. Alice Rivlin and Representative Paul Ryan, Republican Study Committee, Roosevelt Institute Campus Network, and Representative Ryan.

Each proposal includes recommendations for reducing the growth in Medicare spending. Many proposals would cap the annual growth in Medicare expenditures and shift Medicare from what is now a "defined benefit" program to a "defined contribution" system. Other proposals would make one or more of the following changes: strengthen the role of the new Independent Payment Advisory Board, restructure Medicare benefits and cost-sharing requirements, eliminate first-dollar coverage in Medigap policies, increase Medicare premiums, raise the age of Medicare eligibility beyond age 65, and reduce Medicare spending through changes to the Medicare drug benefit. While several groups and individuals have offered proposals to reduce the deficit, proposals included in this side-by-side are those that include significant changes to the Medicare program.

A more detailed comparison of these proposals, based on recommendations issued to date, follows.

	President's Plan for Economic Growth and Deficit Reduction	Senate "Gang of Six"	House Concurrent Budget Resolution (H. Con. Res. 34)*	National Commission on Fiscal Responsibility and Reform (Bowles-Simpson)	Bipartisan Policy Center Debt Reduction Task Force (Domenici-Rivlin)
Date	**September 19, 2011**	**July 19, 2011**	**April 15, 2011**	**December 1, 2010**	**November 17, 2010**
Limit federal debt, federal spending, federal health care spending, or Medicare spending	Implement a sequester, including Medicare payments to providers and plans, if by 2014 the debt-to-GDP ratio is projected to exceed 2.8% for 2015-2019. Under current law, as a result of the Budget Control Act of 2011 (H.R. 2693), a sequester will be implemented unless at least $1.2 trillion in savings are approved by the Joint Select Committee on Deficit Reduction and enacted into law by December 23.	Require the Senate Budget Committee to review total federal health care spending starting in 2020, with a target of holding growth to GDP+1% per beneficiary, and require action by Congress and the President if target is exceeded. Require committees to find savings. If any committee fails to report savings, impose across-the-board cuts to programs in that committee's jurisdiction as necessary to achieve the required savings, exempting "those most in need." Require Senate Finance Committee to identify savings of $298 billion to replace the SGR formula, plus additional health savings.	Restrict federal spending and control the federal debt by capping discretionary spending and restricting conditions under which the debt limit may be increased.	Starting in 2020, set global target for total federal health care spending (Medicare, Medicaid, CHIP, FEHB, TRICARE, exchange subsidies, employer health exclusion) at GDP+1%. Require President to submit and Congress to consider reforms to lower spending, if costs grow faster than targets (on average of previous 5 years); suggestions for reducing the growth in spending include: premium support, giving CMS more authority to be an active purchaser, expanding and strengthening the IPAB, raising the Medicare eligibility age, and other suggestions that are not directly related to Medicare.	By 2020, reduce and stabilize federal debt below 60% of GDP. Starting in 2018, limit federal support per Medicare enrollee to no faster than a 5-year moving average of per capita GDP+1%. Restrain new entitlement spending with PAYGO (requiring new spending to be offset).
Premium support system	No provision.	Not specified in Executive Summary.	Convert Medicare into a "premium support" program, with additional assistance for lower-income beneficiaries and beneficiaries with greater health risks. Medicare benefits would not change for people "in and near retirement."	If costs grow faster than targets, submit/consider reforms to lower spending, including developing a "premium support" system for Medicare.	Starting in 2018, transition Medicare to a "premium support" program. • Maintain traditional Medicare as default option; • Charge beneficiaries higher premium if costs rise faster than established limits; and • Allow beneficiaries to purchase a private plan on a "Medicare Exchange".
Age of Medicare eligibility	No provision.	Not specified in Executive Summary.	No provision.	If costs grow faster than targets, submit/consider reforms to lower spending, including raising the Medicare eligibility age.	No provision.

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Date	**September 19, 2011**	**July 19, 2011**	**April 15, 2011**	**December 1, 2010**	**November 17, 2010**
Part B and Part D premiums	Increase income-related premiums under Medicare Parts B and D by 15%, with a cap at 90% of projected per capita expenditures, and maintain freeze on income-related thresholds until 25% of beneficiaries pay income-related premiums. Under current law, unmarried beneficiaries with incomes above $85,000 (and married couples with incomes above $170,000) pay higher Part B and Part D premiums (ranging from 35% to 80% of the projected per capita expenditures) than lower income beneficiaries; the income thresholds are frozen under current law until 2019.	Not specified in Executive Summary.	No provision.	No provision.	Raise Medicare Part B premiums from 25% to 35% of program costs over 5 years for those not already paying income-related premiums.
Medicare cost sharing	Increase Part B deductible for "new beneficiaries" by $25 in 2017, 2019, and 2021. Introduce a copayment for home health services of $100 per home health episode, for episodes with 5 or more visits not preceded by a hospital or post-acute care stay. Applicable to people who enroll in Medicare in 2017 or thereafter.	Not specified in Executive Summary.	No provision.	Unify cost sharing for Part A and B.[1] • Create combined annual deductible of $550; • Set single coinsurance rate of 20%; • Set coinsurance of 5% for costs between $5,550 and $7,500; and • Set annual out-of-pocket maximum of $7,500.	Unify cost sharing for Part A and B. • Create combined annual deductible of $560 in 2011; • Set single coinsurance rate of 20%; • Set annual out-of-pocket maximum of $5,250; and • Deductible and out-of-pocket max indexed to increases in per capita Medicare spending.
Medigap	Introduce a 30% surcharge on Part B premium for new beneficiaries that purchase "near first-dollar" Medigap coverage, beginning in 2017.	Not specified in Executive Summary.	No provision.	Prohibit Medigap plans from covering the first $500 of cost sharing and limit coverage to 50% of the next $5,000.[1,2]	No provision.

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Independent Payment Advisory Board (IPAB)	Lower the IPAB target rate for Medicare spending from GDP+1% to GDP+0.5%.	Not specified in Executive Summary.	No provision.	Allow IPAB to make recommendations for all providers (no exemptions). If costs grow faster than targets, submit/consider reforms to lower spending, including further expanding authority of IPAB to allow it to make recommendations for cost sharing and benefit design and to look beyond Medicare.	Require IPAB to review Medicare benefit structure every 2 years, and recommend changes to parallel developments in the private market; require recommendations to automatically become law unless Congress acts to block them.
Dual eligibles	No provision.	Not specified in Executive Summary.	No provision.	Give Medicaid full responsibility for providing health coverage to dual eligibles, with Medicare continuing to cover its share of expenses. Require Medicaid plans to place dual eligibles in Medicaid managed care plans.[1]	Eliminate barriers to enrollment for dual-eligibles in managed care options. Provide fast-track channel for waiver applications. Maintain Medicaid payment of Medicare premiums for low-income beneficiaries and the hold-harmless provision.
Prescription drugs	Require drug manufacturers to provide rebates to Part D plans that are no lower than the Medicaid minimum rebate level for drugs prescribed to dual eligibles and LIS beneficiaries under Part D, beginning in 2013.	Not specified in Executive Summary.	No provision.	Require Medicaid drug rebates for dual eligibles enrolled in Part D.[1]	Require rebates for single-source drugs as a condition of participating in Medicare Part D.
Physician payments/ sustainable growth rate (SGR)	Assume "legislative action to permanently prevent current law reductions in Medicare physician payment rates." Does not propose savings to offset costs associated with reforming the SGR formula.	Require the Senate Finance Committee to permanently reform or replace the SGR formula and fully offset the cost ($298 billion) with health savings.	No provision.	Reform the sustainable growth rate (SGR). • Replace cuts required by SGR with a freeze in payments through 2013 and a 1% cut in 2014; • Direct CMS to establish a new payment system beginning 2015; and • Eliminate exemption in PAYGO and fully offset the cost of reforming the SGR.	Accommodate a permanent fix to the SGR mechanism for physician payments. Eliminate exemption for physician payments in PAYGO and require spending to be offset with savings.

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Other Medicare provisions	Extrapolate the risk adjustment error rate found in RAD-V audits and apply the payment reduction to all Medicare Advantage plans. Improve Medicare integrity programs. Dedicate penalties for failure to use electronic health records towards deficit reduction. Reduce payments and require prior authorization for advanced imaging, beginning in 2013. Reduce bad debt payments, beginning in 2013. Reduce IME adjustments by 10%, beginning in 2013. End rural add-on payments for hospitals and other providers, beginning in 2013. Reduce payments to CAHs to 100% of reasonable costs and eliminate the designation for those within 10 miles of the nearest hospital. Reduce payments for post-acute care providers, 2014 - 2021. Equalize payments for certain conditions commonly treated in IRFs and SNFs, beginning in 2013. Raise compliance threshold for inpatient rehabilitation hospitals from 60% to 75%, beginning in 2015. Reduce SNF payments by 3% for facilities with high rates of hospital readmissions, beginning in 2015. Levy up to 100% of Medicare payments to providers with tax debts.	Require the Senate Budget Committee to achieve program integrity savings in entitlement programs to curb fraud and abuse.	No provision.	Increase the authority and funding for CMS to fight fraud, waste, and abuse.[1] Reduce payments for GME and IME, and phase-out Medicare bad debt payments.[1] Accelerate home health payment reductions in ACA.[1] Expand successful cost-containment demonstration projects by 2015.	Bundle Medicare's payments for post-acute care.

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Date	**September 19, 2011**	**July 19, 2011**	**April 15, 2011**	**December 1, 2010**	**November 17, 2010**
Community Living Assistance Services and Supports (CLASS) Act	No provision.	Repeal the CLASS Act.	No provision.	Reform or repeal the CLASS Act.	No provision.
Sources and notes	Office of Management and Budget, "Living Within Our Means and Investing in the Future: The President's Plan for Economic Growth and Deficit Reduction," September 19, 2011. The President's plan was submitted to the Joint Select Committee on Deficit Reduction (the "Super Committee") as recommendations for reducing the deficit. The OMB estimates that the Medicare savings in the President's proposal would extend the solvency of the Hospital Insurance Trust Fund (Part A) by about 3 years.	Sen. Saxby Chambliss, Sen. Tom Coburn, Sen. Kent Conrad, Sen. Mike Crapo, Sen. Dick Durbin, and Sen. Mark Warner, "A Bipartisan Plan to Reduce Our Nation's Deficits - Executive Summary," July 19, 2011.	The House of Representatives Committee on the Budget, House Concurrent Budget Resolution, H. Con. Res. 34, as passed April 15, 2011. * The House Budget Resolution does not include detailed specifications of the proposals for Medicare. The Medicare provisions in the budget resolution are similar to the set of Medicare reforms included in Chairman Ryan's "Pathway to Prosperity" proposal, released April 5, 2011, and analyzed by CBO in their April 5, 2011 memo to Chairman Ryan.	The National Commission on Fiscal Responsibility and Reform, "The Moment of Truth," December 1, 2010. [1] Provision included to help finance costs associated with reforming the sustainable growth rate (SGR). [2] The report also recommends similar provisions apply to TRICARE for Life, federal retirees, and private employer-covered retirees.	The Debt Reduction Task Force, "Restoring America's Future," November 17, 2010.

NOTE: This side-by-side does not include H.R.2560, "The Cut, Cap and Balance Act," as passed by the House of Representatives on July 19, 2011, which explicitly exempts Medicare from the spending limits it would impose; the long-term implications for Medicare spending of the proposal's cap on federal spending and balanced budget requirement are unclear.

APPENDIX: Summary of Additional Deficit and Debt Proposals with Major Medicare Provisions

AMERICAN ENTERPRISE INSTITUTE (May 25, 2011)

Limit federal debt, federal spending, federal health care spending, or Medicare spending: National debt as a share of the economy limited to 60%.

Premium support system: Convert Medicare to a premium support system over 10 or more years, with subsidies adjusted by health status and income.

Age of Medicare eligibility: Raise the age of eligibility to 67.

Part B and Part D premiums: Raise Medicare Part B and Part D premiums to cover 40% of each program's cost until the premium support program is fully implemented; Maintain income-related premiums for Part B and Part D.

Medicare cost sharing: Unify Parts A, B, and D with catastrophic coverage; combine annual deductible for Parts A and B; set single 20% coinsurance rate for all services.

Medigap: Require Medigap policyholders and anyone with other supplemental coverage (e.g., retiree coverage or Medicaid) enrolling in traditional Medicare to pay a premium surcharge.

Independent Payment Advisory Board (IPAB): Repeal IPAB.

Dual eligibles: Convert benefit payments to fixed payments for insurance for dual eligible individuals plus a contribution to a medical savings account (MSA). Dual eligibles may enroll in either a Medicaid or Medicare managed care plan.

Physician payments/sustainable growth rate (SGR): Stabilize physician payment rates and allow rates to increase with general inflation.

Other Medicare provisions: Eliminate Medicare payroll tax for workers aged 62 and older; Lift current restrictions on balance billing; permit physicians to charge any amount over the Medicare payment for their services, as long as prices are disclosed in advance; Lift restrictions on private contracting.

Community Living Assistance Services and Supports (CLASS) Act: Repeal the CLASS Act.

Source: American Enterprise Institute, "A Balanced Plan for Fiscal Stability and Economic Growth," May 25, 2011.

CATO INSTITUTE (April 1, 2011)

Premium support system: Convert Medicare to a premium support system, with subsidies to beneficiaries adjusted for health status and lifetime income; enrollees could save their voucher if they do not spend the entire amount; phase-out vouchers with Medicare beneficiaries relying entirely on HSAs over the long-term.

Age of Medicare eligibility: Gradually raise Medicare eligibility age from age 65 to 67 by two months every year, starting in 2014.

Part B and D premiums: Increase Part B premiums from 25% to 35% of program costs; extend means-testing to Part D premiums and expand means testing to higher-income enrollees.

Medicare cost sharing: Increase and conform deductibles for Part A and B and Medigap.

Dual eligibles: Convert Medicaid into a block grant, which may affect Medicaid benefits for dual eligibles.

Other Medicare provisions: Repeal the ACA, including all spending and revenues; decrease fraud, waste, and abuse; provide younger workers the freedom to create larger HSAs and deposit their Medicare payroll tax into the HSAs.

Source: CATO Institute, "A Plan to Cut Spending and Balance the Federal Budget," April 1, 2011.

CENTER FOR AMERICAN PROGRESS (May 25, 2011)

Limit federal debt, federal spending, federal health care spending, or Medicare spending: Total health care expenditure growth limited to the rate of growth of the economy, beginning in 2020; if growth in health care expenditures exceeds growth of the economy, IPAB will be empowered to extend reforms in Medicare and other public programs, and potentially to all health care plans, to meet the target growth rate.

Independent Payment Advisory Board (IPAB): Allow IPAB to make recommendations for all providers (no exemptions).

Prescription drugs: Require Medicare to negotiate reduced pharmaceutical prices; facilitate faster development of generic pharmaceuticals.

Physician payments/sustainable growth rate (SGR): Implement permanent fix of the SGR.

Other Medicare provisions: Reduce graduate medical education payments; accelerate home health payment reductions in ACA; expand CMS program integrity authority; reduce reimbursement rates for durable medical equipment.

Source: Center for American Progress, "Budgeting for Growth and Prosperity: A Long-term Plan to Balance the Budget, Grow the Economy, and Strengthen the Middle Class," May 25, 2011.

SEN. COBURN (July 18, 2011)

Age of Medicare eligibility: Gradually raise Medicare eligibility age from age 65 to 67, starting in 2014, and index for longevity thereafter.

Part B and D premiums: Raise Medicare Part B premiums from 25% to 35% of program costs over 5 years, starting in 2015; have wealthier beneficiaries (incomes greater than $150,000 for individuals and $300,000 for couples) pay the full cost of coverage.

Cost sharing: Unify Parts A and B with combined annual deductible of $550; set single coinsurance rate of 20%; set coinsurance of 5% for costs between $5,550 and $7,500; and annual out-of-pocket maximum of $7,500, with higher out-of-pocket limits for higher income beneficiaries.

Medigap: Require Medigap plans to have a $500 deductible and limit coverage to 50% of the next $5,000.

Dual eligibles: Give Medicaid full responsibility for providing health coverage to dual eligibles, with Medicare continuing to cover its share of expenses; repeal all federal restrictions on enrolling dual eligibles in Medicaid managed care plans.

Physician payments/sustainable growth rate (SGR): Freeze physician payment rates for 10 years.

Other Medicare provisions: Use funds from the Medicare Improvement Fund for deficit reduction; reduce GME and IME; accelerate home health payment reductions in ACA; phase-out bad debt payments to hospitals; allow seniors to opt-out of Part A; decrease Medicare payments for eye surgeries, chiropractic services, home oxygen equipment, and durable medical equipment for beneficiaries in nursing homes; increase efforts to curb fraud, waste, and abuse; consolidate QIOs.

Source: Senator Tom Coburn, "Back in Black," July 18, 2011.

CONGRESSIONAL PROGRESSIVE CAUCUS (April 11, 2011)

Prescription drugs: Allow Medicare to negotiate drug rebates from pharmaceutical companies for Part D.

Physician payments/sustainable growth rate (SGR): Implement proposals in President Obama's 2012 budget request that are intended to offset the cost of fixing the SGR through 2021.

Other Medicare provisions: Recover erroneous Medicare Advantage payments.

Source: Congressional Progressive Caucus, "The People's Budget," April 11, 2011.

GALSTON-MACGUINEAS (September 30, 2010)

Limit federal debt, federal spending, federal health care spending, or Medicare spending: Create a health care budget and use new (unspecified) budgetary mechanisms to ensure that health spending and revenues remain in alignment with estimates.

Age of Medicare eligibility: Gradually raise Medicare eligibility age from age 65 to 67, starting in 2014, and index for longevity thereafter.

Part B and Part D premiums: Raise Medicare Part B premiums for higher-income beneficiaries from 25% to 35% of program costs.

Medicare cost sharing: Raise Medicare copayments, with exemptions for the lowest-income beneficiaries.

Independent Payment Advisory Board (IPAB): Eliminate exemption from IPAB recommendations for hospitals, cost-sharing, and benefits; direct IPAB to find additional savings over the decade.

Source: Dr. Bill Galston and Maya MacGuineas, "The Future is Now: A Balanced Plan to Stabilize Public Debt and Promote Economic Growth," September 30, 2010.

HERITAGE FOUNDATION (May 10, 2011)

Limit federal debt, federal spending, federal health care spending, or Medicare spending: Limit Medicare payment amount for future retirees (those turning age 65 on or after Jan. 1, 2016) at 88% of the weighted average premium of regional bids of competing health plans; starting in 2021, limit Medicare payment amount to 88% of the lowest bid of competing plans in a region; cap total Medicare spending, and index spending cap to chained CPI and Medicare population growth.

Premium support system: Starting in 2016, transition Medicare to a "premium support" program; set premium support amount to 88% of the weighted average premium of regional bids of competing health plans for the first 5 years; starting in 2021, limit Medicare payment amount to 88% of the lowest bid of competing plans in a region; adjust premium support payments by income; in 2021, allow traditional Medicare to compete directly with private plans.

Age of Medicare eligibility: Gradually raise Medicare eligibility age from age 65 to 68, starting in 2021, and index for longevity thereafter.

Part B and Part D premiums: Raise Medicare Part B and Part D premiums from 25% to 35% of program costs over 5 years; retain "hold harmless" provisions for low-income seniors.

Medicare cost sharing: Combine Parts A, B, and C, starting in 2016; prior to 2016, phase in an income-related Part A premium and phase out premium subsidies for Part B and Part D; index the Part A deductible to an average of CPI and CPI-M; add 10% co-payment for home health care episodes.

Dual eligibles: Provide states the option to "top up" the Medicare defined-contribution amount for duals in a private health plan, starting in 2016; dual-eligible enrollees who stay with the Medicare fee-for-service plan continue to receive Medicaid coverage; cap federal contributions towards Medicaid spending for the elderly and disabled and grant states "considerable flexibility" to manage and administer the program.

Physician payments/sustainable growth rate (SGR): Implement permanent fix to the SGR with physician payments adjusted for inflation.

Other Medicare provisions: Eliminate the statutory and regulatory restrictions on private contracting outside of Medicare; retain Medicare savings for Medicare alone; make physician pricing fully transparent; permit balanced billing in combination with price disclosure requirement; allow new retirees to keep existing plans.

Source: The Heritage Foundation, "Saving the American Dream: The Heritage Plan to Fix the Debt, Cut Spending, and Restore Prosperity," May 10, 2011.

INSTITUTE FOR AMERICA'S FUTURE (November 30, 2010)

Prescription drugs: Establish a Part D public, federally administered plan; require Medicare to negotiate drug prices with pharmaceutical companies.

Other Medicare provisions: Fund studies to identify additional cost-saving options; assess the costs and benefits of "Medicare for All," if cost targets are not met.

Source: Institute for America's Future, "Report and Recommendations of the Citizens' Commission on Jobs, Deficits and America's Economic Future," November 30, 2010.

SENS. LIEBERMAN-COBURN (June 28, 2011)

Age of Medicare eligibility: Gradually raise Medicare eligibility age from age 65 to 67 by two months every year, starting in 2014.

Part B and Part D premiums: Gradually raise Medicare Part B premiums from 25% to 35% of program costs over 5 years, starting in 2015; have wealthier beneficiaries (incomes greater than $150,000 for individuals and $300,000 for couples) pay the full cost of coverage.

Medicare cost sharing: Unify Parts A and B with combined annual deductible of $550; set annual out-of-pocket maximum of $7,500, with higher out-of-pocket limits for beneficiaries with incomes greater than $85,000/individual, $170,000/couple.

Medigap: Prohibit Medigap plans from covering the first $550 of Medicare cost sharing and limit coverage to 50% of the remaining coinsurance up to the $7,500 out-of-pocket limit.

Physician payments/sustainable growth rate (SGR): Extend current physician payments for 3 years and allow Congress to develop a new funding mechanism to reimburse Medicare providers.

Other Medicare provisions: Improve Medicare's ability to combat waste, fraud, and abuse; reduce payments for GME and IME; phase-out Medicare bad debt payments; accelerate home health payment reductions included in ACA.

Source: Senator Joseph Lieberman and Senator Tom Coburn, "A Bipartisan Plan to Save Medicare and Reduce Debt," June 28, 2011.

OUR FISCAL SECURITY (May 23, 2011)

Limit federal debt, federal spending, federal health care spending, or Medicare spending: Implement revenue trigger to instruct Congress to limit the deductibility of corporate debt interest if federal health spending exceeds projected levels in 2025.

Prescription drugs: Allow Medicare to negotiate prescription drug prices for Part D.

Physician payments/sustainable growth rate (SGR): Prevent Medicare physician payments from being exempt from PAYGO requirements (requiring new physician spending to be offset).

Other Medicare provisions: Increase investments in health care information technology; bundle Medicare payments for single episodes of care.

Source: Our Fiscal Security, "Investing in America's Economy: A Budget Blueprint for Economic Recovery and Fiscal Responsibility," May 23, 2011.

RIVLIN-RYAN (November 17, 2010)

Limit federal debt, federal spending, federal health care spending, or Medicare spending: Limit Medicare payment amount for future retirees (those turning age 65 on or after Jan. 1, 2021) based on the average federal cost per enrollee in 2021, indexed to per capita GDP+1%.

Premium support system: Provide premium support payments to purchase private health insurance in a Medicare Exchange for people who turn 65 on or after 2021; set at premium support amount the average federal cost per Medicare enrollee in 2021, indexed to per capita GDP+1%; adjust premium support payments by income, geography, and health risk; allow enrollees eligible for Medicare before 2021 to continue on traditional fee-for-service; premiums held harmless from effects of the Medicare Exchange.

Age of Medicare eligibility: Raise the Medicare eligibility age from age 65 to 67 between 2021 and 2032.

Medicare cost sharing: Unify Parts A and B with combined deductible of $600; set single coinsurance rate of 20%; set annual out-of-pocket maximum of $6,000.

Medigap: Prohibit Medigap plans from covering the first $500 of Medicare cost sharing and limit coverage to 50% of the remaining coinsurance up to at least $2,750, starting in 2013.

RIVLIN-RYAN (November 17, 2010) (continued)

Dual eligibles: Starting in 2021, dual eligible individuals receive fully funded account from which to pay out-of-pocket expenses.

Community Living Assistance Services and Supports (CLASS) Act: Repeal the CLASS Act.

Source: Dr. Alice Rivlin and Rep. Paul Ryan, "A Long-Term Plan for Medicare and Medicaid," November 17, 2010. Congressional Budget Office, "Preliminary Analysis of the Rivlin-Ryan Health Care Proposal," November 17, 2010.

REPUBLICAN STUDY COMMITTEE (April 8, 2011)

Premium support system: Create optional private health insurance plans for beneficiaries; transition to premium support system; adjust subsidies for beneficiaries' income, health status, and geographic differences in medical costs; require plans to offer catastrophic coverage.

Age of Medicare eligibility: Raise the age of eligibility from 65 to 67, beginning in 2017.

Part B and D premiums: Raise premiums for wealthier seniors (income thresholds not specified).

Other Medicare provisions: Repeal all new spending (retain savings) in the ACA; dedicate resources to reduce fraud, waste, and abuse; increase use of health information technology; offer financial incentives to beneficiaries to improve their health or change unhealthy habits.

Source: Republican Study Committee, "Honest Solutions: Fiscal Year 2012 Budget," April 8, 2011.

ROOSEVELT INSTITUTE CAMPUS NETWORK (May 20, 2010)

Prescription drugs: Require Medicare to negotiate drug rebates with pharmaceutical companies.

Physician payments/sustainable growth rate (SGR): Update physician fees based on regional cost growth, controlling for cost of living and health outcomes; arrange regions by percentile of cost growth; update payments between GDP-4% and GDP+4%.

Other Medicare provisions: Institute bundled payments; fund comparative effectiveness research, and automatically integrate findings into Medicare payment policies; establish public funding for medical student education, and implement post-graduate repayment system that varies with physicians' gross incomes.

Source: The Roosevelt Institute Campus Network, "Budget for a Millennial America: A Federal Budget Plan that Reflects the Millennial Generation's Priorities," May 20, 2011.

CHAIRMAN RYAN (April 5, 2011)*

Limit federal debt, federal spending, federal health care spending, or Medicare spending: Starting in 2022, limit Medicare payment amount for future retirees (those turning age 65 on or after Jan. 1, 2022) based on the projected average per capita Medicare spending in 2022, indexed to the CPI-U.

Premium Support System: Transition Medicare to a premium support program, starting in 2022; provide premium support payments for beneficiaries to purchase private health insurance in a Medicare Exchange; set premium support amount equal to the projected average per capita Medicare spending in 2022 ($8,000 for a typical 65-year old in 2022), indexed to CPI-U; adjust premium support payments by health status, age, and income; reduce payments to plans for Medicare beneficiaries in the top 2% of the income distribution by 70%; reduce payments to plans for Medicare beneficiaries in the next 6% of the distribution by 50%; provide the full premium support amount for the remaining 92% of beneficiaries.

Age of Medicare eligibility: Gradually raise Medicare eligibility age from 65 to 67, starting in 2022.

Independent Payment Advisory Board (IPAB): Repeal IPAB.

CHAIRMAN RYAN (April 5, 2011)* (continued)

Dual eligibles: Starting in 2022, replace Medicaid assistance with Medicare premiums and cost-sharing with federal funding of medical savings accounts (MSAs) for dual eligibles; full duals and other Medicare beneficiaries with incomes below 100% FPL receive a MSA subsidy equal to $7,800, indexed to CPI-U; beneficiaries between 100% and 150% FPL would receive 75% of that amount.

Prescription drugs: Repeal ACA provision to close the Part D coverage gap.

Physician payments/sustainable growth rate (SGR): Fix the Medicare physician payment formula for the next 10 years.

Community Living Assistance Services and Supports (CLASS) Act: Repeal the CLASS Act.

Source: Chairman Paul Ryan, "The Path to Prosperity: Restoring America's Promise," April 5, 2011.

*Note: *Chairman Ryan's "Pathway to Prosperity" proposal, as released on April 5, 2011, does not include detailed specifications of the proposals for Medicare; details included here are based on the set of Medicare reforms analyzed by CBO in their April 5, 2011 memo to Chairman Ryan, "Long-Term Analysis of a Budget Proposal by Chairman Ryan."*

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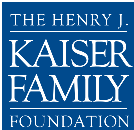

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