# CBO TESTIMONY

Statement of
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on the
Impact of the Balanced Budget Act
on the Medicare Fee-for-Service Program

before the
Committee on Commerce
U.S. House of Representatives

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This statement is not available for public release until it is delivered at 10:00 a.m. (EDT), Wednesday, September 15, 1999.

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Mr. Chairman and Members of the Committee, I am pleased to represent the Congressional Budget Office (CBO) at this hearing on the fee-for-service portion of the Medicare program. After many years of rapid increases, the growth of Medicare spending has slowed sharply in the past two years. My statement discusses the reasons for that slowdown and presents CBO's assessment of future trends. I will make three main points:

- The greater-than-expected slowdown in the growth of Medicare spending stems mainly from successful efforts to combat fraud and from delays in payments to health care providers.

- With one exception, CBO's estimates of the effects of the Medicare provisions of the Balanced Budget Act (BBA) of 1997 still appear reasonable. CBO did not anticipate how home health agencies would implement the interim payment system for home health services, however, and may therefore have underestimated its savings.

- The factors that are holding down the growth of Medicare spending will play themselves out in the near future, and more rapid growth will then resume.

Between 1980 and 1997, Medicare spending increased at an average rate of 11 percent a year and expanded from 5 percent to 12 percent of the federal budget. Total outlays for Medicare rose by only 1.5 percent in 1998, however, and are expected to decline in 1999. Part of that slowdown was anticipated; the Balanced Budget Act lowered the projected growth of Medicare spending by an estimated 4 percentage points in 1998. The BBA reduced payment rates for many services and restrained the update factors for payments through 2002. Both fee-for-service providers and Medicare+Choice plans are experiencing lower increases in payments as a result.

But the actual rate of spending growth is considerably slower than the BBA provisions alone were expected to produce. Other factors appear to have contributed to the sudden flattening of Medicare expenditures, including greater compliance with Medicare payment rules and a longer time for processing claims.

Widely publicized efforts to clamp down on fraud and abuse in the program have resulted in greater compliance by providers with Medicare's payment rules. Those efforts include more rigorous screening of claims by Medicare contractors and tougher enforcement of Medicare laws by the Departments of Justice and Health and Human Services. Through investigations and lawsuits, those agencies have pursued

a wide range of providers—including hospitals, teaching physicians, home health agencies, clinical laboratories, and providers of durable medical equipment—as well as Medicare contractors themselves. Although the total reduction in spending growth attributable to the improved compliance cannot be quantified, CBO estimates that one response alone to recent enforcement efforts—less aggressive billing by hospitals—lowered growth in Medicare spending by 0.75 percentage points in 1998.

The assignment of patients with respiratory infections to diagnosis-related groups (DRGs) provides one example of the change in billing patterns. Patients with respiratory infections generally are assigned to one of two DRGs: respiratory infections, for which the Medicare payment averaged $7,400 in 1998; or simple pneumonia, for which payments averaged $4,900. From 1997 to 1998, the number of cases in the higher-paying DRG (respiratory infections) fell by 43,000, while the number of cases assigned to the lower-paying DRG (simple pneumonia) increased by 42,000. That change in coding reduced Medicare program spending by about $100 million in 1998.

In addition, the average time for processing Medicare claims rose dramatically in 1998. Expanded compliance activities, combined with major efforts to prepare computer systems for 2000, contributed to longer payment lags, which can have a substantial effect on Medicare outlays. An increase of one week, for example, in the average time for processing claims reduces Medicare outlays for the fiscal year

by about 2 percent. But that reduction is only temporary because the delay merely moves outlays into the next fiscal year.

CBO expects that improved compliance with payment rules and longer claims-processing times will have little or no effect on the rate of growth of Medicare spending in the longer run. Our projections assume that payment lags will begin to return to more typical levels late in 2000, with a catch-up in spending and a resumption of normal spending growth in 2001 and 2002. Most of the projected increase over the next few years reflects rising expenditures per enrollee. The leading edge of the postwar baby boom will not reach age 65 until after 2010.

Medicare outlays to date for fiscal year 1999 are actually lower than they were for the same period last year (see Table 1). CBO's current projections of aggregate Medicare spending, as updated in July 1999, reflect those lower-than- expected outlays and smaller-than-expected adjustments of payment rates for inflation in 2000. CBO assumes that lower payments for home health services and a drop in the case-mix index (a measure of the relative costliness of the cases treated in hospitals paid under the prospective payment system) explain most of the shortfall in Medicare spending so far this year. However, CBO does not yet have the data needed to update the detailed projections of spending by category of service that were prepared in March 1999. Therefore, my discussion of service-specific spending will reflect the March projections.

TABLE 1. MEDICARE OUTLAYS BASED ON THE JULY 1999 BASELINE
(By selected fiscal year)

| | 1990 | 1998 | 1999 | 2004 | 2009 |
|---|---|---|---|---|---|
| **In Billions of Dollars** | | | | | |
| Gross Mandatory Outlays | | | | | |
| Benefits | 107 | 210 | 208 | 297 | 440 |
| Mandatory administration and grants[a] | b | 1 | 1 | 1 | 1 |
| Total | 107 | 211 | 210 | 298 | 442 |
| Premiums | -12 | -21 | -22 | -34 | -53 |
| Mandatory Outlays Net of Premiums | 96 | 190 | 188 | 264 | 389 |
| Discretionary Outlays for Administration | 2 | 3 | 3 | 4 | 4 |
| All Medicare Outlays Net of Premiums | 98 | 193 | 191 | 267 | 393 |
| **Average Annual Growth Rate from Previous Year Shown (Percent)** | | | | | |
| Gross Mandatory Outlays | | 8.8 | -0.7 | 7.3 | 8.2 |
| Premiums | | 7.5 | 3.9 | 9.6 | 9.3 |
| Mandatory Outlays Net of Premiums | | 9.0 | -1.2 | 7.0 | 8.0 |
| Discretionary Outlays for Administration | | 1.5 | -2.6 | 6.8 | 4.0 |
| All Medicare Outlays Net of Premiums | | 8.8 | -1.2 | 7.0 | 8.0 |

SOURCE: Congressional Budget Office.

NOTE: Numbers may not add up to totals because of rounding.

a. Mandatory outlays for administration support peer review organizations, certain activities against fraud and abuse, and grants to states for premium assistance.

b. Less than $500 million.

Projections of Spending and Enrollment in the Medicare Fee-for-Service Program

CBO projects that spending in Medicare's fee-for-service program will increase from $178 billion in 1998 to $302 billion in 2009 (see Table 2). That growth will occur despite shrinkage in fee-for-service enrollment, which will decline by 1.5 million over the next decade, and cuts in the growth of payment rates for many services.

Spending growth for different services will vary considerably over the same period. The extent of the recent slowdown in spending has also varied by type of service, although spending for all services has been affected by the 1.9 percent drop in fee-for-service enrollment that occurred in 1998 and the further 0.8 percent decline expected in 1999.

Postacute Care Services. Payments for skilled nursing facility (SNF) and home health services grew very rapidly during the decade preceding passage of the Balanced Budget Act. Between 1988 and 1997, spending for skilled nursing services grew at an average annual rate of 38 percent, while growth in spending for home health services averaged 25 percent a year. That spending growth slowed significantly in 1998.

TABLE 2. OUTLAYS FOR MEDICARE BENEFITS, BY SECTOR, BASED ON THE MARCH 1999 BASELINE (By fiscal year)

| Sector | 1998 | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **In Billions of Dollars** | | | | | | | | | | | | |
| Medicare+Choice[a] | 32 | 37 | 41 | 49 | 48 | 60 | 70 | 88 | 88 | 108 | 124 | 141 |
| Fee-for-Service | | | | | | | | | | | | |
| Skilled nursing facilities | 13 | 13 | 13 | 14 | 14 | 15 | 16 | 17 | 18 | 19 | 21 | 22 |
| Home health | 15 | 15 | 17 | 16 | 17 | 18 | 20 | 21 | 23 | 24 | 26 | 28 |
| Hospice | 2 | 2 | 2 | 2 | 3 | 3 | 3 | 3 | 3 | 3 | 4 | 4 |
| Hospital inpatient[b] | 87 | 86 | 91 | 95 | 99 | 104 | 108 | 112 | 117 | 123 | 129 | 135 |
| Physicians' services | 32 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 43 |
| Outpatient facilities | 17 | 16 | 17 | 18 | 20 | 21 | 23 | 25 | 26 | 28 | 30 | 33 |
| Other professional and outpatient ancillary services | 12 | 12 | 14 | 15 | 17 | 20 | 22 | 25 | 28 | 31 | 34 | 38 |
| Subtotal | 178 | 175 | 186 | 194 | 205 | 217 | 228 | 241 | 255 | 269 | 285 | 302 |
| Baseline Revision, July 1999 | n.a. | -4 | -4 | -2 | -2 | -2 | -2 | -2 | -2 | -2 | -2 | -3 |
| Total | 210 | 208 | 223 | 242 | 252 | 275 | 297 | 326 | 341 | 375 | 407 | 440 |
| **Annual Growth Rate (Percent)** | | | | | | | | | | | | |
| Medicare+Choice[a] | 26.3 | 14.0 | 11.7 | 18.0 | -1.3 | 25.0 | 16.7 | 24.7 | 0.8 | 22.8 | 14.6 | 13.4 |
| Fee-for-Service | | | | | | | | | | | | |
| Skilled nursing facilities | 8.9 | -3.8 | 1.7 | 5.3 | 5.1 | 6.4 | 6.0 | 6.4 | 6.5 | 6.4 | 6.4 | 6.4 |
| Home health | -14.9 | 0.8 | 10.3 | -5.8 | 10.1 | 6.6 | 7.2 | 7.9 | 7.8 | 7.4 | 6.8 | 6.6 |
| Hospice | 1.0 | 2.5 | 8.6 | 6.3 | 4.6 | 5.7 | 5.3 | 5.7 | 5.8 | 5.7 | 5.8 | 5.8 |
| Hospital inpatient[b] | -2.5 | -1.5 | 5.7 | 4.7 | 4.5 | 4.7 | 3.9 | 4.1 | 4.5 | 4.6 | 4.9 | 4.8 |
| Physicians' services | 3.0 | 0.6 | 4.2 | 2.3 | 2.4 | 3.4 | 2.6 | 2.8 | 3.0 | 3.0 | 3.3 | 3.5 |
| Outpatient facilities | -5.5 | -6.6 | 8.4 | 8.5 | 7.1 | 7.7 | 7.2 | 7.4 | 7.3 | 7.3 | 7.6 | 7.9 |
| Other professional and outpatient ancillary services | 0.7 | 0.6 | 14.0 | 13.0 | 12.5 | 13.2 | 12.3 | 12.3 | 12.1 | 11.0 | 10.7 | 10.2 |
| All Fee-for-Service | -2.1 | -1.4 | 6.4 | 4.4 | 5.5 | 5.8 | 5.2 | 5.5 | 5.8 | 5.8 | 5.9 | 5.9 |
| All Medicare Benefits | 1.4 | -0.8 | 7.2 | 8.1 | 4.1 | 9.5 | 7.7 | 10.0 | 4.4 | 10.2 | 8.4 | 8.2 |

SOURCE: Congressional Budget Office.

NOTES: Numbers may not add up to totals because of rounding.

n.a. = not applicable.

a. Includes spending for health maintenance organizations paid on a cost basis, certain demonstrations, and health care prepayment plans, which are paid on a cost basis for Part B services.

b. Includes subsidies for medical education that are paid to hospitals that treat patients enrolled in Medicare+Choice plans.

The most dramatic change was in spending for home health care, which actually fell by 14.9 percent in 1998. In March 1999, CBO projected that home health spending would increase slightly in 1999. However, it now appears that spending for home health care in 1999 and 2000 will be several billion dollars lower than previously anticipated. The use of home health services seems to have dropped substantially, probably as a result of both antifraud activities and an unexpectedly cautious response by home health agencies to the limit on average payments per beneficiary under the interim payment system. That limit applies to aggregate payments: payments for individual beneficiaries may exceed the limit as long as the average payment for all beneficiaries served by an agency does not exceed the per-beneficiary limit. Some agencies, however, apparently believe that the limit applies to each beneficiary and are cutting off services to patients who have reached the per-beneficiary limit. Thus, the average payment per beneficiary is well below the allowable amount.

Medicare will replace the interim payment system for home health services with a prospective payment system in 2001. That system will remove much of the uncertainty about payments that has contributed to the current apparent drop in use of services, so spending for home health services is expected to rebound in 2001 and later years.

SNF expenditures, by contrast, continued to rise in 1998 but at less than half the rate of growth in 1997—8.9 percent compared with 21.1 percent. The slowdown in spending reflects the implementation of new prospective payment systems and increases in the time for processing claims.

The transition to prospective payment systems is expected to hold down the average annual rate of growth in these categories of spending through 2001. Spending is then projected to increase through 2009 at an average annual rate of 6.2 percent for SNF services and 7.5 percent for home health services.

Inpatient Hospital Services. Medicare payments for inpatient hospital services fell 2.5 percent in 1998, to $87 billion. The factors contributing to that drop include a decline in the volume of services provided (reflecting the drop in fee-for-service enrollment) and several provisions in the BBA that froze payment rates for most operating costs, reduced capital-related payment rates by 17.8 percent, and cut subsidies for medical education. In addition, the case-mix index fell 0.5 percent in 1998. Preliminary data suggest that the case-mix index is continuing to drop in 1999. Much of that unprecedented drop is probably attributable to widespread adoption by hospitals of less aggressive billing practices following antifraud initiatives that focused on those practices.

For most hospitals, the BBA limits cumulative increases in payment rates for operating costs to about 6 percentage points below inflation in hospital input prices over the 1999-2002 period. CBO projects that the limit on rate increases, in combination with declining fee-for-service enrollment, will result in a 1.5 percent drop in payments for hospital inpatient services in 1999. Those payments are projected to begin rising in 2000, with annual growth rates averaging 4.5 percent from 2000 through 2009.

Physicians' Services. Medicare payments for physicians' services rose 3.0 percent in 1998, to $32 billion. Payments are projected to remain flat in 1999 and to grow at an average annual rate of 2.8 percent over the next decade, reaching $43 billion in 2009. That growth rate is a result of payment formulas enacted in the BBA that tie the growth of per-enrollee expenditures for physicians' services to the growth of gross domestic product (GDP) per capita. Those formulas generate annual rate changes that oscillate widely around a smooth trend. CBO projects stable growth rates, however, because the timing of those oscillations is impossible to predict.

Outpatient Services. Payments to outpatient facilities—such as hospital outpatient departments, dialysis facilities, and rural health clinics—fell by 5.5 percent in 1998 and are projected to decline another 6.6 percent in 1999. Those reductions result largely from lower payment rates accompanying the transition to a prospective payment system for hospital outpatient services. Outpatient payments are projected

to rebound in 2000 and grow at annual rates of 7 percent or more for the rest of the decade.

Spending for outpatient therapy services and other outpatient ancillary services—including pharmaceuticals, durable medical equipment, and chiropractic care—rose only 0.7 percent in 1998 as a result of reductions in payment rates and a cap on payments for therapy services performed outside hospitals. Projected payments for nonphysician professional services and outpatient ancillary services will grow only slightly in 1999 before taking off again in 2000. Annual spending growth is expected to average 11.3 percent from 1999 through 2009.

## EFFECTS OF THE BALANCED BUDGET ACT

In January 1997, CBO projected that net mandatory outlays for Medicare would grow from $189 billion in 1997 to $288 billion in 2002. That January 1997 baseline was the basis for CBO's estimate of the savings from the BBA. CBO estimated that the BBA would reduce net mandatory spending for Medicare by $6 billion in 1998, $41 billion in 2002, and $112 billion over the 1998-2002 period. As a result, in its August 1997 analysis of the BBA, CBO projected that net mandatory outlays for Medicare would grow to $247 billion in 2002, rather than the $288 billion projected the previous January (see Table 3).

TABLE 3. COMPARISON OF AUGUST 1997 AND JULY 1999 PROJECTIONS OF NET MANDATORY OUTLAYS FOR MEDICARE (By fiscal year, in billions of dollars)

| | 1997 | 1998 | 1999 | 2000 | 2001 | 2002 |
|---|---|---|---|---|---|---|
| January 1997 Projection | 189 | 206 | 226 | 250 | 261 | 288 |
| Minus Effects of Balanced Budget Act | 0 | -6 | -16 | -29 | -20 | -41 |
| August 1997 Projection | 189 | 200 | 210 | 220 | 241 | 247 |
| July 1999 Projection | 187 | 190 | 188 | 202 | 218 | 226 |
| July 1999 Projection Minus August 1997 Projection | -1 | -9 | -22 | -19 | -23 | -22 |

SOURCE: Congressional Budget Office.

NOTE: Numbers may not add up to totals because of rounding.

CBO's current baseline, prepared in July 1999, projects that net mandatory Medicare spending will grow from $188 billion in 1999 to $226 billion in 2002. Those figures are $22 billion and $21 billion, respectively, below the levels projected in August 1997.

Why have the projections changed? Each year CBO updates its budget projections to account for legislative changes, updated economic assumptions, and other new information. Since the enactment of the BBA, the only noticeable legislative effect on Medicare spending has been the modification of home health payment rates included in last year's omnibus appropriation bill (Public Law 105-277). CBO estimated that legislation will increase Medicare outlays by $2 billion in 2000 and reduce them by $1 billion in 2001. CBO's current projections of inflation

rates are slightly lower than they were in January 1997. Those lower inflation rates account for about $3 billion to $4 billion of the annual differences between the August 1997 and July 1999 projections.

Much of the difference between the two sets of projections is attributable to new information—most notably the unanticipated slowing of spending growth in 1997 and 1998 resulting from improved compliance with Medicare payment rules. In essence, the 1997 projections were too high because CBO did not anticipate the full effects of Operation Restore Trust—Medicare's program to combat fraud. CBO also did not foresee the increasing lag in 1998 and 1999 between when services are furnished and when payment is made. In addition, CBO assumed that adjustments to Medicare+Choice payments to reflect the risks of plans' enrollees would be made in a budget-neutral way rather than in a manner that would reduce spending.

CBO has not revised its estimates of the effect of the BBA on Medicare spending. With the possible exception of the projections of the interim payment system for home health agencies, CBO believes that its estimates of the Balanced Budget Act were reasonable.

## CONCLUSION

Although Medicare spending has slowed dramatically in 1998 and 1999, CBO expects it to resume growing at an average rate of 7 percent to 8 percent in the decade after 2000. In particular, spending for home health services is likely to rebound after 2000, when the prospective payment system replaces the interim payment system.

Medicare spending is likely to grow even faster after 2010 with the influx of the baby-boom generation into the program. That growth is due both to the unprecedented increase in program enrollment and continuing increases in spending per enrollee. Assuming no change in policy, the Medicare trustees project that Medicare spending will grow from about 2.5 percent of GDP in 1998 to 4.9 percent of GDP in 2030 as the last of the baby boomers enroll in the program. Such an expansion in program spending poses an unprecedented challenge to policymakers and to the country.