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 Finance
United States Senate

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NOTICE

This statement is not available for public release until it is delivered at 10:00 a.m. (EDT), Thursday, June 10, 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 be played out in the next few years, 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 may 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 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 2.3 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 (see Table 1). 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.

TABLE 1. MEDICARE OUTLAYS (By selected fiscal year)

	1990	1998	1999	2004	2009
In Billions of Dollars					
Gross Mandatory Outlays					
Benefits	107	210	212	298	443
Mandatory administration and grants[a]	b	1	1	1	1
Total	107	211	213	300	444
Premiums	-12	-21	-21	-34	-53
Mandatory Outlays Net of Premiums	96	190	192	266	391
Discretionary Outlays for Administration	2	3	3	4	4
All Medicare Outlays Net of Premiums	98	193	195	269	396
Average Annual Growth Rate from Previous Year Shown (Percent)					
Gross Mandatory Outlays		8.8	1.1	7.1	8.2
Premiums		7.5	3.4	9.7	9.3
Mandatory Outlays Net of Premiums		9.0	0.8	6.7	8.0
Discretionary Outlays for Administration		1.5	7.4	4.7	4.0
All Medicare Outlays Net of Premiums		8.8	0.9	6.7	8.0

SOURCE: Congressional Budget Office.

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 Medicare+Choice

Payments for Medicare+Choice plans in CBO's baseline soar from $37 billion in 1999 to $141 billion in 2009 as enrollment in those plans continues to expand. The spending increase also reflects the expected growth in expenditures per enrollee. CBO projects that risk-based plans will account for 16 percent of Medicare enrollees in 1999, 22 percent in 2004, and 31 percent in 2009, assuming that the second phase of risk adjustment is implemented on a budget-neutral basis.

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 $175 billion in 1999 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.

TABLE 2. OUTLAYS FOR MEDICARE BENEFITS, BY SECTOR (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
Total	210	212	228	243	253	277	298	328	343	378	409	443
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	1.0	7.3	6.8	4.1	9.5	7.7	10.0	4.4	10.1	8.4	8.2

SOURCE: Congressional Budget Office.

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.

Postacute Care Services. Growth in payments for skilled nursing facility (SNF) and home health services—the fastest-growing areas of fee-for-service spending in Medicare during the decade preceding passage of the Balanced Budget Act—slowed significantly in 1998. The most dramatic change was in spending for home health care, which actually fell by 14.9 percent in 1998. SNF expenditures, by contrast, continued to rise 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—a measure of the relative costliness of the cases treated in hospitals paid under the prospective payment system—fell 0.5 percent in 1998. Much of that unprecedented drop in the

index 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 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 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).

CBO's current baseline, prepared in March 1999, projects that net mandatory Medicare spending will grow from $192 billion in 1999 to $227 billion in 2002. Those figures are $18 billion and $20 billion, respectively, below the levels projected in August 1997.

TABLE 3. COMPARISON OF AUGUST 1997 AND MARCH 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
March 1999 Projection	187	190	192	206	219	227
March 1999 Projection Minus August 1997 Projection	-1	-9	-18	-15	-22	-20

SOURCE: Congressional Budget Office.

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

Why the Projections Have 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 of the annual differences between the August 1997 and March 1999 projections.

Most 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 and implementation of adjustments to payments to Medicare+Choice plans on the basis of risk in a manner that will reduce spending.

CBO has not revised its estimates of the effect of the BBA on Medicare spending. With one possible exception, CBO believes that its estimates of the Balanced Budget Act were reasonable.

Spending for Home Health Services

The one policy for which CBO may have significantly underestimated savings is the interim payment system for home health agencies. CBO's current projection of outlays for home health services is much lower than projected in August 1997. Those lower projections are largely attributable to new information about the effects of Operation Restore Trust and other antifraud initiatives and to increases in the lag between when services are furnished and when payment is made; they do not fully incorporate our revised assessment of the effects of the interim payment system.

Lower payments for home health services also explain most of the shortfall in Medicare spending so far this year. Some of the drop in home health spending stems from longer payment lags resulting from a new method of processing claims known as sequential billing, in which a claim is paid only if all prior claims have been processed. Medicare will suspend that billing process in July, which should increase spending during the last quarter of the fiscal year. In addition, 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 per-beneficiary limit 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.

CONCLUSION

CBO is currently updating its projections of Medicare spending and will release them on July 1, as called for in the budget resolution. Because the rate of Medicare spending through May of this year has been lower than CBO estimated in March (and about 2½ percent below the rate for the first eight months of last year), the July projections of Medicare spending in 1999 and 2000 will probably be several billion dollars lower than the March estimates.

Medicare will replace the interim payment system for home health services with a prospective payment system in 2001. Because that system will remove much of the uncertainty about payments that has contributed to the current apparent drop in utilization, spending for home health services could rebound in 2001 and

subsequent years. Therefore, CBO does not now anticipate significantly revising its projections of spending on home health services—or other categories of services—beyond 2000. CBO expects that total Medicare spending will resume growing at an average rate of 7 percent to 8 percent a year in the decade after 2000.