CHAPTER 1

Recent changes in the Medicare program

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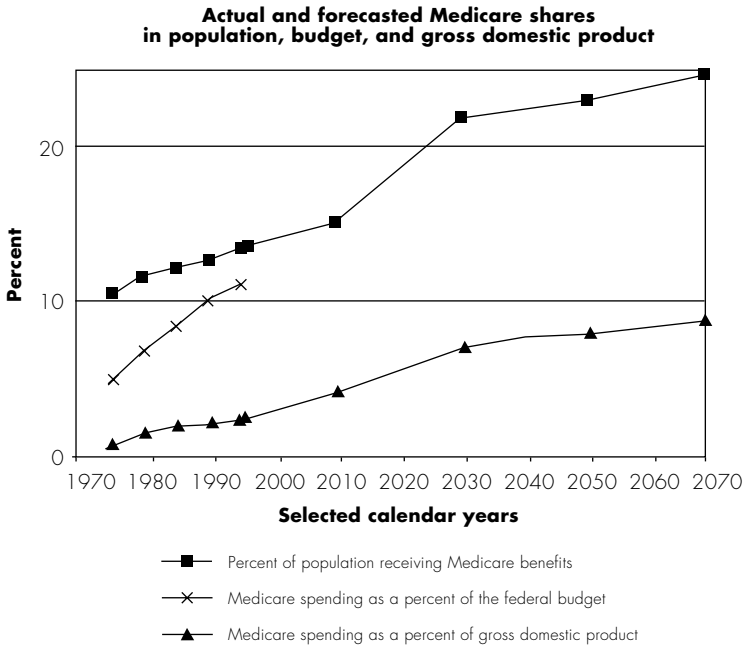
In this chapter

- Factors leading to the Medicare provisions in the Balanced Budget Act
- A summary of the Balanced Budget Act and the Balanced Budget Refinement Act
- Evaluating the impact of the recent changes

In the past three years, Medicare has undergone considerable change. First, the Balanced Budget Act of 1997 enacted the most far-reaching changes to the program since its inception. The changes included reducing annual payment updates, implementing new prospective payment systems, adding preventive care benefits, and expanding choice of managed care plans. Then, in response to concerns that Balanced Budget Act policies cut provider payments too severely, the Congress enacted the Balanced Budget Refinement Act in the fall of 1999. These changes were smaller in scope than those enacted by the Balanced Budget Act, but were clearly important to the provider groups that pressed for their passage. Lastly, in the midst of debate on the Balanced Budget Refinement Act and contrary to all projections, Medicare experienced its first decline in annual spending. Although an objective, immediate assessment of the impact of these changes is constrained by data limitations and the phase-in schedules of many policy changes, available evidence suggests that no widespread problems in beneficiary access to care have occurred. However, previous problems with vulnerable populations persist and some studies suggest that access to certain services has been compromised by the Balanced Budget Act. As a result, continued monitoring is warranted.

FIGURE 1-1

1997 view of Medicare growth



Source: Congressional Budget Office. Long-term budgetary pressures and policy options, March 1997.

This chapter summarizes the factors leading to the Medicare provisions in the Balanced Budget Act of 1997 (BBA) and the Balanced Budget Refinement Act, (BBRA) enacted in the fall of 1999, and summarizes the major provisions of each piece of legislation. To the extent possible, the chapter assesses the impact of these changes. It discusses changes in Medicare spending and identifies factors other than the BBA—such as improved compliance with payment rules, administrative delays, and broader health care market dynamics—that have contributed to changes in Medicare spending, as well as in provider participation rates and financial performance. It concludes that the Commission is concerned about how the BBA and other policies affect beneficiaries' access to care, and briefly summarizes the Commission's conclusions about access to care.

Factors leading to the Medicare provisions in the Balanced Budget Act

The Medicare provisions in the BBA were a reaction to a combination of factors, including mounting fiscal pressures (recent rapid growth in Medicare spending, disturbing projections of future growth, and the then-projected depletion of the hospital insurance trust fund in fiscal year (FY) 2001); evidence that Medicare was overpaying some providers; and a consensus for the need to introduce better incentives than available under cost reimbursement. In addition, policymakers wanted to reform the program to offer beneficiaries greater choice among managed care plans and more coverage for preventive services. The following discussion addresses each of these factors in greater detail.

Mounting fiscal pressures

In 1997, the Congress faced a Medicare program with an annual growth rate of more than 8 percent; some sectors, such as home health, had annual growth rates of more than 30 percent. The program commanded an increasing share of the federal budget and was projected to crowd out discretionary spending. Balancing the budget without increasing tax rates or reducing other spending required slowing the rate of growth in the Medicare program.

Figure 1-1 illustrates the magnitude of the problem. Medicare beneficiaries made up 13.7 percent of the population in 1996. By 2010, this percentage was projected to increase to 15.2 percent; by 2030, to 22 percent. Medicare spending was 2.7 percent of gross domestic product (GDP) in 1996, and was projected to grow to 4.4 percent by 2010 and to 7.4 percent by 2030.

However, it was the growth of Medicare as a percent of the entire federal budget that many policymakers found particularly disturbing. At 11.3 percent of the total budget in 1995, Medicare's share had more than doubled since 1975 and represented the budget's third-largest program. Some feared that the program's seemingly relentless growth would crowd out discretionary spending, even if the federal budget grew as fast as GDP.

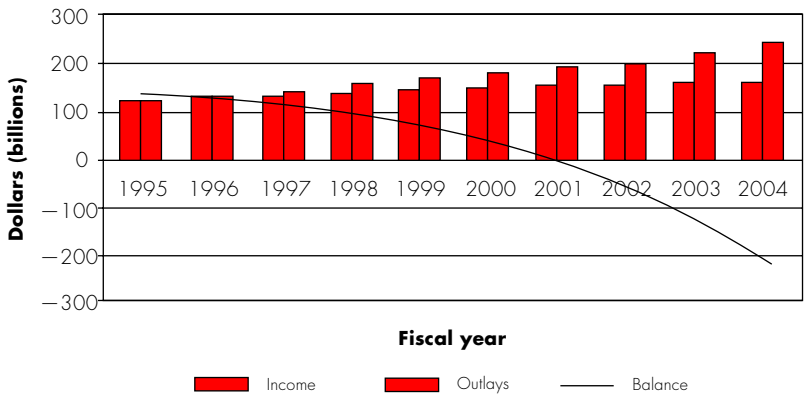
In addition to general fiscal pressures, projections showed that the Hospital Insurance Trust Fund (which funds Part A of Medicare) would be depleted in 2001, well before the retirement of the "baby-boomer" generation. As shown in Figure 1-2, income to the trust fund (chiefly payroll tax) was about equal to outlays in 1995. After that date, outlays were projected to exceed income every year.

Evidence of overpayment to providers and health plans

As fiscal pressures mounted, evidence suggested that Medicare was overpaying some providers, both as a result of payments per unit that significantly exceeded costs and because of incentives

FIGURE 1-2

Hospital Insurance Trust Fund: 1996 projections



Source: 1997 Federal Hospital Insurance Trust Fund report.

in the payment systems that rewarded using excessive services. A consensus developed on the need to correct these trends through a variety of approaches, including developing prospective payment systems (PPSs) and reducing annual payment updates.

One of the statistics most widely cited as evidence of overpayment was the hospital inpatient margin, which reflects the difference between Medicare payments and Medicare-recognized costs for hospitals receiving PPS payments. Margins had been increasing since 1991, when they were −2.4 percent, and were projected to reach 12.7 percent in 1997 (ProPac 1997). This growth was related to growth in spending for home health and skilled nursing facility (SNF) care, as hospitals transferred some patients to post-acute settings for care previously provided on an inpatient basis. Hospitals had an incentive to discharge patients earlier under a PPS, because they would receive the same diagnosis related group payment regardless of the patient's actual length of stay. Because many of the patients discharged earlier required continued care, spending for SNF and home health care increased. Hospitals also had additional incentives to transfer patients to hospital-owned SNFs or home health care services, because they would not only receive the inpatient payment, but also the cost-based payments for care delivered in the other settings.

The increase in home health and SNF spending also raised concerns about whether cost-based reimbursement was creating incentives for overutilization and, in turn, excessive spending. Home health spending nearly quintupled in six years, going from $3.5 billion (3.5 percent of Medicare spending) in 1990 to $16.9 billion (8.8 percent) in 1996. The numbers of home health agencies, beneficiaries being served, and visits per beneficiary all increased, as did evidence of management problems, fraud and abuse, and the provision of unnecessary services (Grob 1997). SNF spending also increased dramatically, from $2.5 billion in 1990 to $11.3 billion in 1996. During this period, the number of people receiving care in SNFs doubled and the cost per day tripled, largely as a result of the increased use of ancillary services, such as physical and occupational therapy. These statistics, combined with the increase in the number of hospital-based SNFs (from 1,145 in 1990 to 2,088 in 1996) and more infrequent review of bills, raised questions as to whether these spending increases were appropriate.

In addition, studies suggested that the growth in Medicare managed care enrollment—instead of producing savings, as was the experience in the private sector—was actually increasing costs. Health plans tended to enroll healthier-than-average beneficiaries, while being reimbursed for the cost of caring for beneficiaries with average health status. This mismatch was estimated to result in overpayment of between 5 and 7 percent (Riley 1996). Because enrollment in the Medicare risk health maintenance organization (HMO) plans was increasing rapidly—from 1.3 million in 1990 to 4.5 million in 1997—overpayments were becoming increasingly costly.

Consensus on the need to introduce more rational payment methods

Increasingly, policymakers recognized the limitations of the cost-based reimbursement of certain providers and of administered pricing in general. To varying degrees, policymakers sought to develop prospective payment systems for providers currently subject to cost reimbursement and to experiment with private sector innovations, such as competitive bidding for goods and services.

Prospective payment systems

The Health Care Financing Administration (HCFA) implemented a PPS for hospital inpatient services in 1983, which led to reduced spending growth and increased efforts by hospitals to control costs, as evidenced by shorter lengths of stay and increasing margins. In 1992, HCFA implemented a physician fee schedule that set payments for services in advance and limited aggregate spending growth.

In general, expected PPS benefits included a more aggregate unit of payment that would remove the incentive to add services to a particular episode and a prospectively determined rate that meant providers could keep the rewards if they cut their costs. A PPS system also provided policymakers with a tool to control spending directly, through base

payments and updates. Similar benefits were expected from extending PPS payment systems to other services, such as home health, SNF, hospital outpatient, and hospitals not already covered by the current PPS system, including rehabilitation and long-term care hospitals.

Competitive pricing of medical supplies and services

In their search for better payment methods, policymakers looked to private-sector innovations. The private sector had tested competitive bidding, asking providers and suppliers to name their best prices and basing payment or participation in the program on those prices, or "bids." Some believed this approach had advantages over the current system, in which prices often were set without information on the true costs of production.

Some policymakers were particularly interested in testing this new approach to determine payments for non-physician Part B services and payments to managed care plans. The Office of Inspector General and others had noted that the Medicare program was paying more for durable medical equipment (DME) than were other federal purchasers. Among non-physician Part B services, DME seemed like a good candidate for a competitive bidding demonstration.

Policymakers also were interested in using competitive bidding for managed care payments. Before the BBA was passed, payments were arbitrarily set at 95 percent of local fee-for-service (FFS) payments. Frustration with this approach spurred interest in testing competitive bidding for managed care to get a more accurate sense of the relative efficiency of managed care compared with FFS. Several attempts to demonstrate this approach were made in Baltimore and Denver in the mid-1990s, but opposition from plans, providers, and beneficiaries derailed the efforts. Some believed that a legislative mandate was needed to overcome opposition.[1]

Interest in expanding managed care choices for beneficiaries

Although choices available to people in the private insurance market were expanding—from indemnity and HMO plans to preferred provider organizations, HMOs with a point-of-service option, and others—most Medicare beneficiaries still were limited to either the traditional Medicare FFS plan or HMOs, and many areas of the country had no HMO alternative.

At that time, HMO alternatives were limited to a small Medicare cost HMO program and a rapidly expanding Medicare risk HMO program, in which participating plans were paid a capitated amount based on FFS spending in beneficiaries' counties of residence. This payment method led to beneficiaries in some higher-payment counties getting generous benefit packages and paying no premiums, while beneficiaries in lower-payment counties received fewer benefits and paid premiums.

To ameliorate some of these inequities and to allow more types of plans to participate in the program, the Congress included provisions in the BBA intended to create more managed care options in more counties.

Interest in more coverage of preventive services

Policymakers also were interested in adding coverage for preventive services; many believed this coverage would improve beneficiaries' health status and quality of life and produce Medicare savings in the long run. There was neither clear evidence of potential savings nor consensus in the medical community on the merit of covering certain preventive services. However, the Congress and the Administration were ready to act.

A summary of the Balanced Budget Act and Balanced Budget Refinement Act

In 1997, the Congress enacted the BBA, making the most far-reaching changes to the Medicare program since its inception. The law slowed the growth in payments to virtually all FFS providers and managed care plans and increased beneficiary premiums, for an estimated savings of $112 billion between 1998 and 2002. These savings, combined with a shift in the financing of many home health services from the Part A to the Part B trust fund, extended the projected depletion date of the Hospital Insurance Trust Fund by about six years (through early 2007). In addition, new types of managed care products were authorized and Medicare coverage was expanded for several preventive care services.

The legislation achieved reductions in provider payments through similar types of policy changes across provider groups. One recurring policy change reduced the annual update adjustment for providers paid under existing prospective payment methods. This policy was enacted for inpatient hospitals, physicians, and managed care plans. Another type of policy change created new PPSs for providers previously paid under cost-based reimbursement, which allowed Congress to adjust the new payment components under these systems to produce savings. For example, most of the SNF and home health PPS savings were achieved by linking the base payment rate under PPS to the costs in a prior year in which SNF and home health costs were significantly lower. A third mechanism reduced formulaic payment adjustments; capital, indirect medical education, bad debt, and disproportionate share adjustments were all reduced to hospitals. Other changes were unique to a provider category, such as risk adjustment for managed care. Reductions in provider

1 Even with legislative mandate, there was local and Congressional opposition to the implementation of later competitive pricing demonstrations in two new sites: Phoenix, AZ, and Kansas City, MO.

payments accounted for about $99 billion of the estimated Medicare savings.

Another $13 billion was saved through an increase in beneficiary premiums, which resulted from an increase in the percent of Part B costs paid by premiums and from the transfer of many home health services from Part A to Part B. The Congress considered, but ultimately rejected, increasing beneficiaries' contributions to the cost of their care by extending coinsurance obligations to home health services or relating Part B premiums to income.

Despite its unprecedented magnitude, the BBA did not fix the long-term financing needs of the program. Instead, it created the savings necessary to allow Congress more time to consider appropriate longer-term solutions for Medicare that would address the fundamental mismatch between spending projections and expected revenue growth.

However, within two years—before many BBA provisions had been put in place, and before the Congress was ready to address long-term Medicare reform—provider groups persuaded the Congress to revisit many BBA provisions and issues. These groups were concerned that many provisions had unintended consequences and that access to some Medicare services might be compromised. The result was the BBRA.

The BBRA increased Medicare spending by about $16 billion over five years (FY 2000–2004). However, this increase was a small fraction of the roughly $1.3 trillion expected to be spent by Medicare over the same time period.

The BBRA increased payments for hospitals, nursing homes, home health agencies, managed care plans, and other providers. The types of policy changes were relatively similar across provider categories and were largely motivated by concerns that access to care was adversely affected and providers were overly burdened. One type of change delayed implementing several BBA payment policies. For example, the legislation delayed the 15 percent reduction in home

TABLE 1-1

Inpatient hospital services

Prospective payment system hospitals	
Major Balanced Budget Act provisions	**Major Balanced Budget Refinement Act provisions**
Reduced annual hospital payment updates (FY 1999–2002): in 1998, update is zero; in 1999, MB minus 1.9 percent; in 2000, MB minus 1.8; in 2001 and 2002, MB minus 1.1.	Not addressed
Reduced DSH payments by 1 percent in 1998, 2 percent in 1999, 3 percent in 2000, 4 percent in 2001, 5 percent in 2002.	Froze the reduction in DSH formula to 3 percent in 2001, changed the reduction to 4 percent in 2002, and required the Secretary to collect hospital data on uncompensated care to assist in developing a new DSH payment system.
Reduced reimbursement for Medicare bad debts from 100 percent to 75 percent in 1998, 60 percent in 1999 and 55 percent in subsequent years.	Not addressed
Reduced capital payments 17.7 percent in FY 1998–2002.	Not addressed
Established a transfer policy for 10 high-volume DRGs, reducing payment rates when hospitals discharge patients in these DRGs to post-acute care facilities following unusually short stays.	Not addressed
Reduced IME and payment adjustment from pre-BBA level of 7.7 percent (for each 10 percent rise in teaching intensity) to 7.0 percent in 1998, 6.5 percent in 1999, 6.0 percent in 2000, and 5.5 percent in 2001 and subsequent years.	Reduced IME adjustment to 6.5 percent in 2000, 6.25 percent in 2001, and 5.5 percent in 2002 and subsequent years.
Carved IME and DME payments from HMO payments and gave them directly to teaching hospitals.	Not addressed
Established a cap on the number of residents supported by Medicare DME payments.	Established a national per-resident amount, reducing variation in DME payments by establishing a floor at 70 percent of the national average per-resident amount and imposing a temporary freeze for hospitals above 140 percent of the average.

(continued)

TABLE 1-1

Inpatient hospital services (continued)

Hospitals exempt from the prospective payment system	
Major Balanced Budget Act provisions	**Major Balanced Budget Refinement Act provisions**
Established PPS for inpatient rehabilitation hospitals and required a report on a PPS for LTC hospitals.	Requires that inpatient rehabilitation PPS be a per-discharge system using function-related groups; requires by 2002 the development and implementation of a per-discharge PPS for LTC and a per diem PPS for psychiatric hospitals.
Reduced annual payment updates; reduced capital payments for rehabilitation, LTC and psychiatric hospitals by 15 percent.	Not addressed
Capped payment to the 75th percentile of hospital-specific historic costs, adjusted for inflation (known as "target amounts").	Adjusted the labor-related portion of the 75th percentile cap to reflect geographic differences in wage-related costs.
Created numerous payment adjustments, including the opportunity for older hospitals to rebase, reducing bonus payments; targeting of relief payments, and instituting new payment criteria for certain start-up hospitals.	Increased bonus payments for eligible LTC and psychiatric hospitals until PPS implementation.
Established a rural hospital flexibility program and created a new designation: Critical Access Hospitals.	Modified the CAH program, including substituting the 96-hour LOS rule with 96-hour average LOS; allows certain for-profit hospitals or clinics to convert to CAH status.
Reinstated special payments to small, rural, Medicare-dependent hospitals.	Extended the Medicare-dependent hospital program for an additional five years.
Not addressed	Required MedPAC to conduct an assessment of all special payment provisions for rural hospitals and their impacts on access and quality.

Note: FY (fiscal year), MB (market basket), DSH (disproportionate share hospital), DRG (diagnosis related group), IME (indirect medical education), DME (direct medical education), HMO (health maintenance organization), PPS (prospective payment system), LTC (long-term care), CAH (critical access hospital), LOS (length of stay).

health PPS payments and instituted a two-year moratorium on therapy payment caps. A second change reduced the cuts for managed care, hospital disproportionate share payments and indirect medical education payments. A third type of change refined new payment methodologies, such as adding an outlier policy under the outpatient PPS and modifying the physician payment provisions to reduce oscillations in the new annual update formula. A fourth change was intended to ease the transition to new payment systems. For example, the BBRA established temporary payment floors in the outpatient PPS and temporary higher SNF payments and home health payments under the interim payment system.

The BBRA also modestly reduced certain beneficiaries' out-of-pocket liability, through increased coverage of immunosuppressive drugs and limits in outpatient department coinsurance. These savings to beneficiaries were offset by an increase in Part B premiums due to increases in Part B provider payments.

Major BBA and BBRA provisions are summarized below.

Inpatient hospital services

The BBA changed payments for inpatient hospital services in a number of ways. For PPS hospitals, the law provided for no update to operating payments in FY 1998 and limited updates from FY 1999–2002. It required phased reductions in the per-case adjustments for the indirect costs of medical education (IME) and, temporarily, for hospitals serving a disproportionate share (DSH) of low-income patients. It also reduced the payment rates when hospitals discharged patients in 10 high-volume diagnosis related groups (DRGs) to post-acute care facilities following unusually short stays. For PPS-exempt hospitals, the BBA reduced annual update adjustments and capped payment to the 75th percentile of hospital-specific historic costs, adjusted for inflation, known as target amounts. It also established a PPS for rehabilitation hospitals in FY 2001, among other changes.

The BBRA modified several BBA reductions. IME and DSH payments were increased, relative to the BBA provisions. Other changes were made to reduce geographic disparity in graduate medical education payments and to ease the transition to a PPS for certain PPS-exempt hospitals (Table 1-1).

Outpatient hospital services

The BBA enacted major changes in Medicare's payments for services provided in hospital outpatient departments. It eliminated the so-called formula-driven overpayment—under which Medicare's payments did not correctly account for beneficiaries' cost-sharing—and extended the reduction in payments for services paid on a cost-related basis. The law also directed the Secretary to establish a PPS for services paid at least partially on the basis of incurred costs.

TABLE 1-2

Outpatient services

Major Balanced Budget Act provisions	Major Balanced Budget Refinement Act provisions
Established a PPS beginning FY 1999 (later delayed until 2000) (also see Table 1-7).	Eased transition to PPS by setting payment floors effective through 2003. Added outlier policy and allowed for cost reimbursement for certain drugs and supplies for three years (permanently exempts cancer hospitals; rural hospitals with fewer than 100 beds are exempt for four years).
Eliminated formula-driven overpayment, effective 1998.	Clarified that new outpatient PPS should not impose a reduction of 5.7 percent in addition to removal of the formula-driven overpayment.
Extended payment reduction for services paid on a cost-related basis through December 1999.	Extended payment reduction for services paid on a cost-related basis until implementation of PPS. (also see Table 1-7).

Note: PPS (prospective payment system), FY (fiscal year).

TABLE 1-3

Skilled nursing services and outpatient rehabilitation services

Major Balanced Budget Act provisions	Major Balanced Budget Refinement Act provisions
Skilled nursing services	
Established a case-mix adjusted per diem PPS for SNFs, which will transition over four years beginning July 1, 1998.	Gives SNFs the option to be paid at a fully federal rate for the PPS.
Updated PPS payment rates by market basket minus one.	Not addressed
Not addressed	Increased payments for 15 categories of high-cost cases by 20 percent, effective April through September 2000.
Not addressed	Provided a temporary, across-the-board, 4 percent increase in payments in FY 2001-2002.
Outpatient rehabilitation services	
Effective January 1, 1999, established an annual per beneficiary limit of $1,500 for all outpatient physical therapy services and a separate $1,500 limit for all outpatient occupational therapy services (excluding services furnished by hospital outpatient departments).	Imposed a two-year moratorium (2000–2001) on therapy payment caps.

Note: PPS (prospective payment system), SNF (skilled nursing facility).

The BBRA eased the transition to a PPS by setting payment floors effective through 2003, adding an outlier policy to compensate for extremely high cost cases, and allowing cost reimbursement for certain drugs and supplies for three years. It also clarified how HCFA should calculate aggregate payments to hospitals in the first year of the PPS to mitigate the effect on hospitals. The legislation also limited beneficiary cost-sharing for an outpatient service to the Part A deductible after the PPS is implemented (Table 1-2).

Services in skilled nursing facilities and rehabilitation services

The BBA enacted a PPS for services provided in skilled nursing facilities (SNFs). Previously, these services were paid on the basis of costs, subject to limits on routine services. Under the new system, payments were intended to cover the routine, ancillary, and capital costs incurred in treating a SNF patient, including most items and services for which payment was previously made under Part B of Medicare. Patients in SNFs were classified under the Resource Utilization Group system, Version III (RUG-III), which groups patients by clinical characteristics for determining per diem payments.

The new payment system slows spending growth for SNF services by moving these facilities from cost-based reimbursement to federal rates based on average allowable per diem costs in FY 1995 (trended forward using the increase in the SNF market basket index, minus 1 percent). Because nursing home spending—particularly for ancillary services—grew rapidly between FY 1995 and FY 1997, using FY 1995 as the base for payment purposes reduced payments for many nursing homes. The PPS is being phased in over a four-year period that began in 1998. Payments in FY 1999 are based on a 50/50 blend of federal rates and facility-specific rates and will be based entirely on the federal rates as of FY 2001.

In response to the perception that the BBA reductions were too deep and inequitable, the BBRA included a 4 percent across-the-board increase in payments to SNFs for FY 2001 and 2002 and a 20 percent increase for 15 payment categories. These policies are temporary and will not be built into the base for PPS.

The BBA also established annual per beneficiary caps for outpatient rehabilitation services; these were suspended for two years (2000 and 2001) under BBRA (Table 1-3).

Home health services

Before the BBA, home health agencies were paid on the basis of costs, subject to limits based on costs per visit. The BBA directed the Secretary to implement a PPS effective October 1999—since delayed by the Congress to October 2000—and established an interim payment system (IPS) intended to control spending growth until the PPS was in place.

The IPS reduced limits based on costs per visit and introduced agency-specific limits on average costs per beneficiary. Home health agencies are now paid the least of their actual costs, the aggregate per-beneficiary limit, or the aggregate per-visit limit. Agencies with a 12-month cost reporting period ending in FY 1994 are subject to per-beneficiary limits based primarily on average costs per beneficiary in FY 1994, trended forward using the home health market basket index.[2] Home health spending grew rapidly in the mid-1990s, so the use of FY 1994 as a base for payment led to substantial payment cuts for some home health agencies.

The BBRA provided some relief from the BBA reductions. It delayed a BBA-mandated 15 percent payment reduction to be imposed with PPS implementation, increased payments under IPS to certain agencies, and provided additional payment for administration of an outcome and assessment survey (Table 1-4).

TABLE 1-4

Home health services

Major Balanced Budget Act provisions	Major Balanced Budget Refinement Act provisions
Established a PPS for home health services, effective October 1999 (later delayed until October 2000).	Clarified that the payment update for 2002 and 2003 will be MB − 1.1 percent.
Authorized Secretary to collect data to develop a case-mix adjusted PPS (for example, data from the Outcome and Assessment Information Set).	Mandated that home health agencies receive $10 for each new beneficiary administered the Outcome and Assessment Information Set questionnaire during cost-reporting periods beginning in FY 2000.
Established an IPS until PPS implementation. The IPS reduced limits based on costs per visit and introduced agency-specific limits on average costs per beneficiary, based on a blend of agency-specific costs and average per patient costs for agencies in the same region.	Required that per-beneficiary limits under the IPS be increased 2 percent in FY 2000 for agencies with limits below the national median.
Established a 15 percent across-the-board payment reduction, effective October 1999 (later delayed to October 2000).	Delayed 15 percent reduction until one year after implementation of the home health PPS; Secretary to report within six months of PPS implementation on the need for the 15 percent reduction.
Eliminated coverage for home health visits for the sole purpose of obtaining a blood sample.	Not addressed
Provided for the transfer of some home health spending from part A to part B.	Not addressed

Note: PPS (prospective payment system), MB (market basket), FY (fiscal year), IPS (interim payment system).

Physician services

The BBA replaced the volume performance standard system, used to update physicians' fees, with a new sustainable growth rate (SGR) system. It also introduced a single conversion factor for all physician services, which reduced payments for some services and increased them for others. Finally, the BBA clarified requirements for payments to physicians for their practice costs.

Unlike some other BBA provisions, changes to Medicare's payments to physicians occurred almost immediately. January 1, 1998, HCFA implemented the single conversion factor and took the first step toward revising practice cost payments. The effects of these changes were largest for some surgical procedures, such as cataract surgery, and for some orthopedic procedures, where payment rates fell by 13 percent or more. However, payments for office visits and some diagnostic services increased by at least 7 percent.

The BBRA made several adjustments to the BBA provisions, including modifying the SGR provisions to limit oscillations in the annual update to the conversion factor, and requiring that the SGR be calculated on a calendar-year basis. The BBRA also required the Secretary to conduct a study of the utilization of physicians' services

2 New agencies, or those without a 12-month cost reporting period ending in FY 1994, are subject to the national median of the per-beneficiary limits for existing agencies.

TABLE 1-5

Physician services

Major Balanced Budget Act provisions	Major Balanced Budget Refinement Act provisions
Introduced a single conversion factor for all physician services, effective January 1, 1998.	Required Secretary to make available each year an estimate of the conversion factor for physician services for the succeeding year.
Replaced volume performance standard with the SGR system, effective January 1, 1998.	Modified SGR provisions to reduce update oscillations and require estimate revisions; required Secretary to conduct a study on the use of physician services under the fee-for-service program. Required Secretary to correct estimates in previously issued SGRs with the best available data.
Reformed practice expense (office expenses) RVUs in the physician fee schedule; instituted a one-year delay in implementing proposed rule on practice expense reform; provided a five-year transition period for implementing a new method of calculating practice expenses; allowed a downpayment in 1998 toward implementing of new practice expense RVUs.	Required Secretary to establish a process for considering supplemental practice expense data.
Allowed beneficiaries to contract for health care services with physicians and other professionals who do not participate in the Medicare program; such contracts would not be subject to Medicare's payment limits.	Not addressed

Note: SGR (sustainable growth rate), RVUs (relative value units).

by Medicare beneficiaries, including the effects of improvement in medical capabilities, advancements in scientific technology, and other factors.[3]

Other provisions of the BBRA required the Secretary to correct estimates in previously issued SGRs with the best available data. The Secretary also must make available to MedPAC and the public each year an estimate of the SGR and the conversion factor applicable to physician payments for the succeeding year. Finally, the BBRA required the Secretary to establish a process for considering supplemental practice expense data (Table 1-5).

Medicare+Choice plans

Before Congress enacted the BBA, Medicare's payments to private health plans participating in the section 1876 risk contracting program were based on the average payments made on behalf of beneficiaries in its traditional FFS program living in the same county. The BBA severed this link by instituting a floor under county payment rates, blending local and national payment rates (subject to a so-called budget-neutrality provision), requiring a minimum update from the prior year, and removing the component of base rates attributable to spending for graduate medical education. Overall, the law limited updates to payment rates in all counties by slowing the growth rate in national FFS spending and by subtracting a specified factor from that rate. The blending policy increased updates in some counties and reduced them in others.

In addition to changes in base payment rates, the BBA required HCFA to implement a new system of risk adjustment that considers the health status of enrolled beneficiaries. The law required HCFA to start the new system by January 1, 2000. The system will raise payments to plans for certain enrollees hospitalized in the year preceding the payment year and will reduce payments for other enrollees. Payment increases will depend on principal diagnoses associated with hospital admissions. HCFA proposed to phase in the new system over a five-year period and estimated that it would ultimately reduce average payment rates by 7.6 percent.

The BBRA modified the BBA by increasing the phase-in time for risk adjustment, trimming the reductions in growth rates and improving incentives for plans to participate in the program, among other policy changes (Table 1-6). Payment rates will also increase, as greater FFS spending leads to increased updates.

Other provisions directly affecting beneficiaries

The BBA added coverage for certain preventive care services, including pelvic screening exams, prostate and colorectal cancer screening tests, diabetes self-management training, and bone mass measurement for those at high risk for osteoporosis. It also expanded coverage for screening mammography. Beneficiary Part B premiums increased, both because they were set at 25 percent of Part B costs and as a result of the shift of home health services from Part A to Part B. In addition, the BBA expanded premium assistance for beneficiaries with incomes up to 135 percent of the poverty level, and created new assistance for beneficiaries with incomes of up to 175 percent of the poverty level. The BBA reduced

3 The study is due to the Congress within three years of enactment of the BBRA. MedPAC is required to analyze and evaluate the study and report to the Congress, with any appropriate recommendations, within 180 days of report submission.

TABLE 1-6

Medicare+Choice

Major Balanced Budget Act provisions	Major Balanced Budget Refinement Act provisions
Created M+C program as Part C of Medicare, making substantial changes to the previous Medicare risk contracting program and eliminating the cost contract option in 2002.	Extended cost contract program through 2004.
Eliminated payment based on average payments made for beneficiaries in its traditional FFS program (by county) by establishing new payments as the greatest of: a blend of national and local payment amounts, minimum payment amount, or minimum update.	Not addressed
Carved out IME and GME payments from HMO payment rates over five years.	Not addressed
Required payments to be risk adjusted, effective January 1, 2000.	Created phase-in plan for risk adjustment that mitigates the Balanced Budget Act payment reductions scheduled for 2001 and 2002.
Limited updates to all counties by slowing the rate of growth in national FFS spending and by subtracting 0.5 percent from that rate.	Increased M+C capitation rates by trimming the reduction to FFS increases to 0.3 percent in 2002, adding bonus payments if a plan enters a county not previously served, and indirectly through FFS spending increases used to annually update the payment amounts for counties receiving the blend or the minimum payment amount.
Authorized PSOs, PPOs, MSAs (under demonstration authority) and private FFS plans to participate in M+C.	Exempted PPOs from the quality and information standards required of HMOs.
Provided for a five-year exclusion period if a plan withdraws from the M+C program.	Reduced the exclusion period from five to two years for organizations seeking to re-enter the M+C program after withdrawing.
Limited the enrollment and disenrollment periods for all plans (except MSAs) after 2001. Beneficiaries can enroll/disenroll once during the first six months of 2002 (or the first six months of eligibility). After 2002, the six-month time frame is reduced to three months. Special disenrollment rules apply for certain circumstances.	Not addressed
Required the Secretary to mail each beneficiary general information on Medicare and comparative information on available M+C plans. Mailing will be financed by a surcharge on plans.	Proportionally divided the cost of education program between FFS and managed care plans.
Authorized a competitive pricing demonstration project for HMOs.	Delayed competitive pricing demonstrations in Phoenix and Kansas City until at least January 1, 2002.
Not addressed	Extended Social HMO demonstration until 18 months after the Secretary submits a report for integration and transition of Social HMOs into an option under M+C.

Note: M+C (Medicare+Choice), FFS (fee-for-service), IME (indirect medical education), GME (graduate medical education), HMO (health maintenance organization), PSO (provider-sponsored organization), PPO (preferred-provider organization), MSA (Medical savings account).

TABLE 1-7 **Other provisions directly affecting beneficiaries**

Major Balanced Budget Act provisions	Major Balanced Budget Refinement Act provisions
Permanently set Part B premiums at 25 percent of program costs and expanded premium assistance for low-income beneficiaries.	Not addressed
Not addressed	Increased coverage of immunosuppressive drugs for transplant patients.
Phased in a reduction in coinsurance for hospital outpatient services to 20 percent of each service's payment rate.	Limited coinsurance for a hospital outpatient procedure to the Part A deductible.
Changed Medigap supplemental insurance by adding two standard plans that allow annual deductibles of $1,500, prohibiting pre-existing exclusions for beneficiaries enrolling during guaranteed issue periods, and requiring guaranteed issue for beneficiaries who return to traditional Medicare within one year of enrolling in Medicare+Choice plans.	Not addressed
Provided coverage for certain preventive services, screening pelvic exams, prostate and colorectal cancer screening tests, diabetes self-management training services, and bone mass measurements for certain high-risk individuals. Expanded coverage of screening mammography.	Not addressed

coinsurance for outpatient services and added more choice among insurance options. It also added two Medigap options (each with a $1,500 deductible) and required guaranteed issue for specified Medigap policies without pre-existing condition exclusions for certain continuously enrolled individuals.

The BBRA capped beneficiaries' coinsurance obligations associated with outpatient procedures to the hospital inpatient deductible, increased coverage of immunosuppressive drugs, and indirectly led to higher Part B premiums as a result of increasing Part B spending (Table 1-7).

Evaluating the impact of the recent changes

Because the BBRA has not yet been broadly implemented, its impact cannot be assessed. Preliminary data on spending and access to care are available on the impact of the BBA, but analysis is constrained by a limited amount of data; an inability to tease out "cause and effect" given multiple, simultaneous policy and market changes; and the extended phase-in schedules of several policies, some of which have yet to begin. In addition, measuring beneficiary access to care—a critical indicator of the success of the program—is an imprecise science.

Even if comprehensive data were available, defining the BBA's success would not be simple. Any evaluation must attempt to balance Medicare's multiple roles and responsibilities. For example, although Medicare has a responsibility to ensure that beneficiaries have access to quality care, it must also be a prudent purchaser—paying a fair market price for its goods and services. Medicare should not allow fraud and abuse or be expected to routinely compensate providers for lost income from other payers. Lower-than-expected spending and poor provider financial performance, in and of themselves, do not indicate that the BBA missed its mark.

Recent Medicare spending levels

As intended, the rate of growth of Medicare spending declined from pre-BBA levels (Table 1-8). Due to spending changes (including the home health shift) and growing payroll receipts, the estimated depletion date of the Part A trust fund has been revised to FY 2015 (Figure 1-3).

Spending reductions in FY 1998 and 1999 have been greater than projected; Medicare spending rose only 1.5 percent in 1998, compared with a projection of 5.7 percent by the Congressional Budget Office (CBO) when the BBA was enacted. In addition, for the first time in the history of the Medicare program, spending in 1999 actually declined, dropping by about $1.7 billion (about 1 percent) instead of increasing by $10 billion (about 5 percent) as projected.

However, HCFA's Office of the Actuary and CBO project average annual increases of 6-7 percent between 2000–2010 (Figure 1-4) and sharper spending increases after the leading edge of the "baby-boom" generation becomes eligible for Medicare in 2010. Annual per capita spending is expected to increase an average of 5-6 percent between 2000–2010.

Nevertheless, since the passage of the BBA, many advocates for provider groups have expressed concern about the impact of payment reductions in the BBA.

TABLE 1-8

Change in Medicare growth rates by provider sector: before and after the Balanced Budget Act

Service area	Percent average annual growth rate per FFS beneficiary	
	FY 1992–1997	FY 1997–1999
Inpatient hospital	5.8	−0.5
Home health (combined Parts A and B)	21.9	−26.9
Skilled nursing facility	30.9	0.4
Physician fee schedule	4.8	3.7
Outpatient hospital	6.7	−5.1
Medicare+Choice (per M+C beneficiary)	7.9	6.5
Total Medicare (per beneficiary)	8.0	−0.7

Note: FFS (fee-for-service), FY (fiscal year).

Source: Office of the Actuary, HCFA.

Advocates have cited the lower-than-expected spending, reduced numbers of certain Medicare providers (such as managed care plans and home health agencies), poor provider financial performance, and, in turn, compromised access to care as evidence that the effects of BBA were excessive and, in some cases, beyond the intent of the legislation.

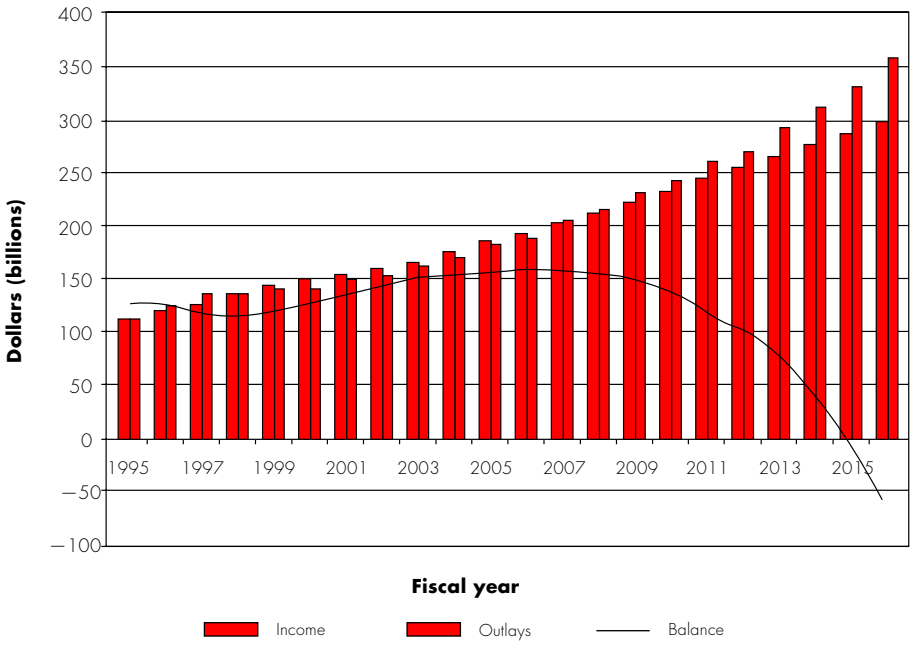
Although passage of the BBRA is expected to address some of these concerns, it is important to understand the causes behind the lower-than-expected spending, which reflect not only the inherent uncertainty of projections, but also the unanticipated improved compliance with payment rules and delays in claims processing. In addition, understanding the role of health care market dynamics helps inform policymakers of the relationships between reduced spending levels and provider participation in Medicare, and as well as providers' overall financial performance.

Improved compliance with payment rules

Rigorous enforcement of existing payment rules, in combination with fraud and abuse provisions enacted in the 1996 Health Insurance Portability and Accountability Act (HIPAA), appear to have led some providers to be far more careful in their coding practices. HIPAA provisions required stricter screening of claims by Medicare contractors and tougher enforcement of Medicare laws by the departments of Justice and of Health and Human Services. Through investigations and lawsuits, the departments have pursued a range of providers—including hospitals, physicians, home health agencies, clinical

FIGURE 1-3

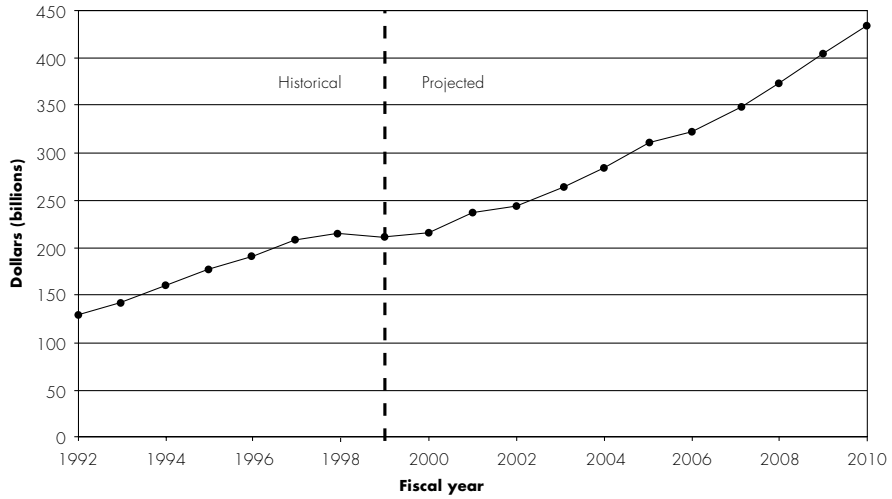
Hospital Insurance Trust Fund: 1999 projections



Source: 1999 Federal Hospital Insurance Trust Fund report.

FIGURE 1-4

Aggregate Medicare spending, fiscal years 1992–2010



Note: Includes both fee-for-service and Medicare+Choice spending.

Source: Projections from the CBO January 2000 baseline; historic data from the economic and budget outlook: fiscal years 2000–2009, January 1999, CBO.

laboratories, and durable medical equipment suppliers—as well as Medicare contractors themselves.

Part of the response to fraud and abuse policies has been less aggressive billing by health care providers. Recent testimony by CBO provided an example of the changes in hospital billing patterns and their impact (Crippen 1999).[4] The agency noted that patients with respiratory infections are usually assigned to one of two DRGs: respiratory infections—for which Medicare payments 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 fell by 43,000, while the number of cases assigned to the lower-paying DRG increased by 42,000. According to CBO, that single change in coding reduced Medicare program spending by about $100 million in 1998.

Claims processing delays

CBO also attributes some of the spending slowdown to delays in processing Medicare claims, which appear to be due to improved compliance efforts and efforts to prepare computer systems for the year 2000. As CBO notes, increasing processing time by one week reduces Medicare outlays for a fiscal year by about 2 percent. The reduction is only temporary, of course, because the delay moves outlays into the next fiscal year.

Health care market dynamics

Although Medicare is the single largest payer in the market (accounting for 20 percent of spending) and its beneficiaries the largest group of health care consumers, its policies do not operate in a vacuum. Providers' choices and performance are also influenced by market factors, such as commercial insurers' behavior, Medicaid policy, demographics, and local practice patterns.

A recent study exploring managed care growth in four markets suggested that factors such as prior managed care history, beneficiary characteristics, supplemental coverage patterns, and the form of provider organization strongly affect differences in managed care growth across the country (Brown and Gold 1999). In addition, the pattern of managed care plan withdrawals from Medicare suggests that in some markets, providers have regained leverage and do not find it in their interests to contract with managed care plans. As a result, some plans do not have sufficient networks to participate in the Medicare program, which means that some plans' decisions not to participate in Medicare are driven by factors independent of Medicare payment policy. Finally, managed care plans have not entered into rural areas, despite dramatic increases in Medicare payment rates.[5] In some cases, this reluctance is due partly to business decisions that reflect plans' inabilities to negotiate with providers and insufficient numbers of enrollees over which to spread insurance risk.

In the traditional Medicare program, providers' performances and business decisions also have been influenced by factors external to Medicare. The continued growth of managed care and preferred provider organizations in the commercial market has increased pressure on providers to accept discounted payments. In FY 1997, private payers' payments to hospitals dropped by 4 percentage points, relative to the cost of treating patients. Data for FY 1998 are not yet available, but there is every reason to believe that the downward pressure from private payers has continued as Medicare has reduced its payments. Physicians have also experienced revenue constraints. Growth in average annual net income fell from 7.2 percent for 1986–1992 to 1.7 percent for 1993–1996, partly as more physicians opted for employment with large group practices well equipped to

4 The CBO did not analyze the clinical appropriateness of these coding changes. See further discussion on coding patterns for physician services in Chapter 3.

5 See Chapter 5 for further discussion.

contract with managed care plans (Levit et al. 1998).

In considering providers' financial performances, it is also important to consider Medicare's influence relative to that of private insurance. For many providers, Medicare is the "800-pound gorilla" in the market, significantly outweighing commercial payers. For others, however, Medicare payments may be a much smaller factor.

On average, Medicare payments accounted for about 21 percent of total expenditures for physician services in 1997. Among physicians, however, certain specialists—such as geriatricians and opthamologists—rely more heavily on Medicare beneficiaries. Medicare payments accounted for about one-third of total hospital spending, but this figure varies depending on location, specialty, and market niche. Medicare's market share for post-acute care services varies by site. For example, in 1997, Medicare accounted for 40 percent of home health services but only 12 percent of spending on nursing home care (Long 1999).

Access to quality care

Ultimately, the Commission is most concerned about how BBA and other policy changes affect beneficiaries' access to quality care. Are providers willing to care for beneficiaries? Are beneficiaries receiving appropriate care? Is the health care infrastructure sufficient to meet the needs of Medicare beneficiaries? To determine whether access to care has been compromised, MedPAC has examined the results of numerous studies on providers' willingness to care for beneficiaries. Using results from the 1998 Medicare Current Beneficiary Survey, MedPAC has analyzed beneficiary access and satisfaction data. The Commission has found no increase in systemic access problems, but is concerned that previous barriers for vulnerable populations persist. In addition, the Commission is concerned that some studies suggest access to certain services has been adversely affected by BBA policies and that other BBA policies have not yet been implemented. Accordingly, it believes that continued monitoring of access to care is necessary. Chapter 2 examines these access to care issues in greater detail. ■

References

Board of trustees, Federal Hospital Insurance Trust Fund. Annual report. Washington (DC), FHITF. March 1999.

Board of trustees, Federal Hospital Insurance Trust Fund. Annual report. Washington (DC), FHITF. March 1997.

Brown RS, Gold MR. What drives Medicare managed care growth? Health Affairs. November/December 1999, Vol. 18, No. 6, p. 140–149.

Committee on Ways and Means, U.S. House of Representatives. Summary of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (H.R. 3426), Committee on Ways and Means. May 14, 1999, available at http://www.house.gov/ways_means/bbacrssu.pdf.

Committee on Ways and Means, U.S. House of Representatives. Medicare and health care chartbook. Washington (DC), Committee on Ways and Means. February 27, 1997.

Crippen D, Congressional Budget Office. The impact of the Balanced Budget Act on the Medicare fee-for-service program. Oral testimony before the Committee on Commerce, U.S. House of Representatives. September 15, 1999.

Grob GF, Office of the Inspector General, Department of Health and Human Services. Oral testimony before the Health Subcommittee, Committee on Ways and Means, U.S. House of Representatives. March 4, 1997.

Levit K. National health expenditures in 1997: more slow growth, Health Affairs. November/December 1998, Vol. 17, No. 6, p. 103–104.

Long A, Health Care Financing Administration. Fax to Anne Mutti, MedPAC. Washington (DC). December 14, 1999.

Prospective Payment Assessment Commission. Report to the Congress: Medicare and the American health care system. Washington (DC), ProPAC. June 1997.

Riley G, Tudor C, Chiang YP, et al. Health status of Medicare enrollees in HMOs and fee-for-service in 1994, Health Care Financing Review. Summer 1996, Vol.17, No. 4, p. 65–76.