MEDPAC Medicare Payment Advisory Commission

TESTIMONY

The Balanced Budget Act of 1997: a current look at its impact on patients and providers

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Statement of
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Good morning Chairman Bilirakis, Congressman Brown, members of the Subcommittee. I am Gail Wilensky, chair of the Medicare Payment Advisory Commission (MedPAC). I am pleased to participate in this hearing on the Balanced Budget Act (BBA) of 1997 and its impact on patients and providers.

When MedPAC last appeared before this subcommittee in September 1999, we testified that although there was no evidence in support of wholesale changes to the BBA, there were several areas in which specific steps could be taken to preserve access to high-quality care for Medicare beneficiaries. The Congress addressed—or began to address—some of the issues we raised when it enacted the Balanced Budget Refinement Act (BBRA) of 1999. Other issues remain unresolved and may warrant action. My testimony today discusses these unresolved issues and possible courses of action. However, changes as sweeping as those enacted in the BBA (and subsequently modified by the BBRA) necessarily take time to digest and, in considering alternatives, the Congress should take care not to oversolve problems.

Introduction

The BBA was enacted to control the growth of Medicare spending and to provide Medicare beneficiaries with additional choices for care through private health plans. To control spending on services already paid prospectively, such as the services provided by hospital inpatient departments, the Act reduced payment updates in relation to what they would have been. To control spending on services that had been reimbursed largely on the basis of costs or charges,

such as those provided by hospital outpatient departments, skilled nursing facilities, and home health agencies, the Act established new prospective payment systems. To control spending and to expand beneficiaries' choices of private health plans, the law also created the Medicare+Choice program, which allows new types of plans to participate, and established new payment rules that raised payments to plans in some areas, lowered them in others, and capped the growth in payments at less than the growth in fee-for-service spending.

Since enactment of the BBA in 1997, Medicare outlays have increased at a rate well below what was projected at the time. After flat or declining spending in fiscal years 1998 and 1999, outlays for Medicare are now growing slowly. Through the first eight months of fiscal 2000, spending has increased at only 3.5 percent, well below the 5.5 percent rate projected when the BBA was enacted. This continued slow growth in Medicare spending has raised concerns about whether the BBA may have compromised beneficiaries' access to high-quality care. Much of this concern has come from health care providers and plans. Over the past two years, providers have asserted that the impact of the BBA has been harsher than was intended by Congress, that the law's intended effects have imposed undue burdens on them, and that there have been specific problems with the Health Care Financing Administration's (HCFA) implementation of the law.

Measuring beneficiaries' access to care in traditional Medicare is a difficult exercise in the best of times. Where possible, we employ measures of providers' ability and willingness to provide services or beneficiaries' perceived ability to obtain care. However, we cannot always observe access to some services on a timely basis, because of timing of payment changes, delays in

obtaining data, or lack of consensus on appropriate use of services. Therefore, we also analyze trends in spending for specific services and in providers' financial performance. We also make analytical judgments to help us determine where problems are likely to arise. For example, we know payment systems that do not adequately account for variations in patients' resource needs are likely to be problematic for beneficiaries with the greatest need.

Last fall, before this subcommittee, MedPAC testified on the implications of the BBA for Medicare's fee-for-service sector. We noted then that our efforts to assess changes in access resulting from the BBA had been hampered by a paucity of data and by the difficulty of sorting out the effects of changes in Medicare payment policy from other policy changes and from developments in the broader health care market. In the case of hospital services, for example, we lacked systematic data on financial performance in the post-BBA period; the limited evidence we had did not allow us to attribute observed changes to Medicare. In the case of home health care, we knew that spending and use had fallen, but we had no way to disentangle the effects of payment changes enacted in the BBA from concurrent policy changes intended to reduce fraud and abuse.

We also indicated in our testimony areas in which we had reason to believe that technical aspects of Medicare's payment systems could lead to problems. For example, we noted that the absence of an adjustment for case mix in the interim payment system (IPS) for home health services could raise problems for patients with high resource needs. We noted a similar concern with respect to the newly implemented prospective payment system for skilled nursing facilities,

which did not appear to account adequately for the needs of high-acuity patients. Finally, we noted technical difficulties with the sustainable growth rate (SGR) system used to update payments to physicians.

A number of developments affecting fee-for-service Medicare have occurred since we testified last September. In some areas—such as hospitals' financial status—we now have data that allow us to make a better assessment of the BBA's implications. In other areas, changes enacted by the Congress in the BBRA have addressed the issues we raised.

Gauging the success of the Medicare+Choice program is different than measuring access to specific services in traditional Medicare. Here, the appropriate measure is whether the program is meeting the Congress's goals of controlling program spending and increasing beneficiaries' choices of plan options. In our March 1999 report to the Congress, MedPAC noted specific changes in regulatory policy—such as how HCFA defines service areas and when the agency requires submission of premium data—that could encourage plans to participate without compromising the objectives of the program. The BBRA codified these policies and made other changes intended to put the Medicare+Choice program on a more solid footing.

The following sections provide more detail on what we know about the impact of the BBA and BBRA for hospital services, home health care, physicians' services and the Medicare+Choice program. They also suggest possible courses of action.

Hospital services

Hospitals have been among the most vocal providers in seeking relief from the BBA, in part because so many of their operations were affected by provisions of the law. For inpatient services covered by the prospective payment system, the BBA froze base payments in fiscal year 1998 and reduced updates in subsequent years, instituted a new policy for transfer cases, lowered the adjustment for indirect medical education (IME) to teaching hospitals, lowered the adjustment received by hospitals that treat a disproportionate share (DSH) of low-income patients, and reduced capital payment rates. For outpatient services, the BBA eliminated the so-called formula driven overpayment, extended reductions in payments for capital and services paid on a cost basis, and directed the Secretary to implement a prospective payment system for services still being paid at least partially on the basis of costs. Collectively, these provisions were intended to slow Medicare spending growth, bring inpatient payments in line with costs, and move payments for outpatient services from a cost-based system to a prospective one.

In response to hospitals' concerns that the BBA had been too harsh, the BBRA increased IME and DSH payments for inpatient services and eased the transition to the outpatient prospective payment system. The law raised the payment base for outpatient services, provided partial protection against financial loss through 2003, added an outlier policy to compensate for extremely high-cost cases, and allowed additional payments for certain drugs, biologicals, and medical devices for three years.

Hospitals' financial status deteriorated significantly in 1998 and 1999. MedPAC estimates that on hospitals' largest lines of Medicare business—acute inpatient, outpatient, skilled nursing facility, home health, and inpatient rehabilitation and psychiatric—Medicare margins dropped from 9.8 percent in 1997 to 6.5 percent in 1998. Considering acute inpatient services alone—which account for three-quarters of hospitals' payments—hospitals' Medicare margin fell from an historic high of 17.0 percent in 1997 to 14.4 percent in 1998. Excluding payments for graduate medical education, the fraction of hospitals with negative inpatient margins rose from 23 percent in 1997 to 29 percent in 1998.

To obtain more timely data, MedPAC is co-sponsoring with HCFA a new survey of hospitals. Although data from this survey cover fewer hospitals and do not allow us to break out margins on Medicare services, they are more current than the information on Medicare margins we obtain from cost reports. Based on this new survey, we estimate the aggregate total margin for hospitals covered by Medicare's inpatient prospective payment system to have been 2.7 percent in 1999, less than half its 1997 level.

The drop in total and Medicare margins provides information we did not previously have, but two issues cloud interpretation of this information. First, while reduced Medicare payments played a role, lower private payments (relative to the cost of care) accounted for about three-quarters of the decline in total margin between 1997 and 1998. Second, changes in margins do not translate directly into changes in access or quality; instead, they indicate the pressure that hospitals face.

In assessing hospital inpatient payments, MedPAC relies on margin data for context, but we base our recommendations on updates to payments on a framework that examines factors influencing providers' costs or payments. Using this framework last year, we concluded that the update set in law for fiscal year 2000 was appropriate. This year, however, we recommended an update of 3.5 to 4.0 percent (0.6 to 1.1 percentage points above market basket). Three factors guided our reasoning. First, in view of the financial stress that hospitals are experiencing, we elected to delay the phase-in of a downward adjustment for unbundling of services—shifting the latter days of inpatient stays to a post-acute setting—that we have previously recommended until we can revisit the issue next year. Second, a first-ever drop in the case-mix index—possibly reflecting more cautious coding by hospitals in response to federal antifraud efforts—led us to recommend an upward adjustment to offset the decline. And third, we recommended an increase for the costs of scientific and technological advances, primarily in response to the impact of new drugs.

With respect to outpatient services, some transitional problems are inevitable as Medicare moves from cost-based reimbursement to prospective payment; hospitals that cannot control costs adequately will face financial risk. Changes in payment rates are probably not warranted because the protections enacted in the BBRA make it unlikely that payment amounts will be too low. Nonetheless, we recommend monitoring implementation of the outpatient prospective payment system to ensure that it does not have unintended, adverse consequences on beneficiaries' access to care and that the quality of care delivered is not compromised.

Another important issue with respect to outpatient services is the coinsurance paid by beneficiaries, which now averages almost 50 percent. Although coinsurance amounts will remain fixed at their current dollar level until they are reduced to 20 percent of Medicare-approved payment amounts, the process will take decades. By comparison, the most gradual phase-in Medicare has used to date for any payment system change is 10 years. MedPAC has twice recommended that the Congress enact legislation to accelerate the reduction to achieve a 20 percent coinsurance rate in a more reasonable time frame.

Home health care

In response to extraordinarily rapid growth in spending for home care during the early to mid-1990s, the Congress enacted major changes in the BBA as to how home care agencies are paid. Prior to the BBA, agencies were paid on the basis of their costs, subject to agency-specific limits based on per visit costs. The BBA imposed new agency-specific limits based on average payments per beneficiary and average payments per visit. This interim payment system was intended to achieve savings until a prospective payment system could be put in place. The prospective payment system is now scheduled for implementation in October.

Changes in home care have been the most pronounced of any sector of Medicare. Even with the increase in payment limits that was enacted in 1998, Medicare spending for home health services fell 45 percent between 1997 and 1999 and the number of agencies has dropped from more than 10,500 to fewer than 8,000. By 1998, the number of home health users per fee-for-service

beneficiary had returned to its 1994 level, and the average number of visits per user was below the 1994 level.

Although these changes are dramatic, they cannot be completely attributed to the payment changes enacted in the BBA. Concurrent policy changes, including antifraud initiatives targeting home care agencies, eliminating venipuncture as a qualifying service for home health eligibility, and imposing sequential billing (since discontinued) have all been important. Moreover, dramatic as the changes in spending and use have been, interpreting what they mean for Medicare beneficiaries is not easy. Without clear coverage and eligibility guidelines that reflect the clinical characteristics of beneficiaries—which MedPAC has previously recommended be developed—it is difficult to know how much of the change reflects reductions in inappropriate care and how much reflects declines in appropriate care.

In MedPAC's March report, we indicated our support of the prospective payment system for home health care that HCFA intends to put in place in October. Although the proposed system will need refinement over the longer run, it represents a substantial improvement over the IPS because it takes into account variation in resource needs among home care patients. The proposed system will also incorporate an outlier policy for beneficiaries with extraordinary costs.

With a new payment system pending, MedPAC did not make formal recommendations in our reports to the Congress earlier this year with respect to payment rates for home health services. However, given the dramatic changes in use that have already occurred, and the changes yet to

come with introduction of the PPS, the general sense of the Commission is that reducing payment rates by an additional 15 percent next year, as currently scheduled in law, would not be prudent without additional evidence to justify such a reduction.

Physicians' services

For physicians' services, the BBA required a phase-in of resource-based payments for physicians' practice expenses. The law also created a sustainable growth rate system for annually updating payments to physicians.

The transition to new payments for practice expenses started in 1999 and will continue through 2002, as required by the BBA. During this transition, payments for some high-volume surgical services will fall sharply. For example, the payment rate for single coronary artery bypass graft will drop 19 percent and the payment rate for total knee replacement will fall 23 percent. Questions have been raised about the data and methods HCFA has used to determine changes in practice expense payments. The agency is working through these issues during a refinement process that includes contractor support and the involvement of the physician community.

With respect to the SGR system, one issue that MedPAC identified last year—the potential for oscillation in updates—was resolved by the BBRA. The BBRA also directed the Secretary to correct estimates in SGRs after 2000 to avoid locking estimation errors into future spending

targets. This happened in 1998 and in 1999, when underestimates of fee-for-service enrollment led to lower target levels of spending.

MedPAC also recommended in March 1999 that the sustainable growth rate be revised to include measures of change in the composition of fee-for-service enrollment—much like demographic adjusters for payments to Medicare+Choice plans—and to include an allowance for cost increases due to improvements in medical capabilities and advances in scientific technology. The BBRA required the Secretary to study these issues and their effects on the use of physician services, and the Agency for Healthcare Research and Quality has begun this work.

We have no evidence that beneficiaries are experiencing problems with access to physicians' services. As we testified last year, a survey undertaken in early 1999 by Project HOPE for MedPAC showed that among physicians accepting all or some new patients, more than 95 percent were accepting new Medicare fee-for-service patients both in 1997 before the BBA payment changes were introduced and in early 1999. Given that updates to the conversion factor were equal to or greater than increases in input costs in 1999 and in 2000, we would not expect to find different results today.

Medicare+Choice

A key component of the BBA was the creation of the Medicare+Choice program, which the Congress intended to provide Medicare beneficiaries with choices of plan options and to help

control the growth of Medicare spending. Some policymakers saw Medicare+Choice as a vehicle to provide Medicare beneficiaries with richer benefits—lower cost sharing and prescription drug coverage—than those available in the traditional fee-for-service program. And some policymakers wanted to see rapid growth in the Medicare+Choice program to help set the stage for future changes in the structure of Medicare.

Progress toward these goals has been minimal. On the one hand, spending per enrollee in private plans has been controlled, primarily because of the slow growth in fee-for-service spending which is used to determine updates. (Compared with the previous payment rules, however, the Medicare+Choice program has probably increased spending, because the new rules have prevented the effects of the slow growth in fee-for-service spending from being passed through fully.) On the other hand, the goals of increasing choice and expanding access to plans with richer benefits remain elusive. The range of plan options has not increased, most beneficiaries in rural areas still cannot enroll in Medicare+Choice plans, benefit packages have become less generous, and enrollment growth has been stagnant.

Perhaps the most visible indicator of how the Medicare+Choice program is faring has been announcements by health plans of contract terminations and service area cutbacks. In January 1999, more than 400,000 enrollees were affected by such changes; 50,000 lived in counties where no other plan was available. In January 2000, about 330,000 enrollees' plans withdrew; 80,000 had no other plan available. Plan withdrawals are likely to have an even greater impact in January 2001. In the past several weeks, plans have announced contract terminations and

service area cutbacks indicating that nearly one million Medicare+Choice enrollees will be unable to remain in their current plans, and more than 150,000 enrollees will have no Medicare+Choice HMO alternative in their county. About 70 percent of Medicare beneficiaries lived in counties that had a Medicare+Choice plan in 1999 and 2000. That fraction is unlikely to change next year, with fewer beneficiaries having access to health maintenance organizations (HMOs), and some beneficiaries newly having access to a private fee-for-service plan.

Data on the availability of richer benefits tell the same story. The share of Medicare beneficiaries with access to a Medicare+Choice plan that did not charge a premium fell from 61 percent in 1999 to 53 percent in 2000. The share of Medicare beneficiaries with access to a Medicare+Choice plan that offered prescription drug coverage and did not charge a premium fell from 54 percent in 1999 to 45 percent in 2000. These declines occurred in both urban and rural counties, but were most pronounced in counties where the base payment was between $400 and $550 per month.

A final issues is the lack of new products. The BBA expanded Medicare's risk contracting program, which previously had been open only to HMOs, to allow participation by preferred provider organizations (PPOs), provider-sponsored organizations (PSOs), private fee-for-service plans, and high-deductible plans offered in conjunction with a medical savings account (MSA). To date, no PPOs, no MSAs, and only one private FFS plan have joined. The one PSO plan that joined is withdrawing.

Three reasons help explain why the Medicare+Choice program is not meeting expectations. First, the Congress's goals for the program are partially at odds with one another. For example, there is a basic conflict between controlling Medicare spending and providing richer benefits. The Congress wants to take advantage of the efficiencies associated with managed care, but it is still wrestling with how to do so in a way that both attracts beneficiaries to plans and allows Medicare to share the savings.

Second, both regulatory and market barriers may have made plans reluctant to participate. An example of the former is the lack of participation by PPOs, which are a popular option for people with employer-sponsored insurance. Plans offering PPOs in the commercial market argued that collecting the data and implementing the quality improvement programs required by HCFA would be prohibitively costly given their loose networks. The BBRA addressed this issue by exempting PPOs from certain quality improvement requirements. An example of market barriers may be the case of rural areas, which are often characterized by low population density and few or monopoly providers. Under such conditions, plans find it difficult to establish networks.

Finally, uncertainty about future payment streams may have made plans reluctant to participate. Under the old risk contracting program, plans could count on regular increases in premiums because updates were based on fee-for-service spending, which grew rapidly from the late 1980s through the mid-1990s. Under the new rules, updates are dependent on a spending changes in a sector that has been undergoing significant changes. The new rules have also held down updates to plans in high-payment areas to fund higher payments in the so-called floor and blend counties.

Finally, plans have had to face the prospect of lower payment growth as a new system of risk adjustment is phased in, with another new system scheduled to be implemented in 2004.

The BBRA contained a number of provisions intended to push the Medicare+Choice program forward. It increased payment rates directly by further backloading the phase-in of risk adjustment, and indirectly by the pass-through effect of higher payments to fee-for-service providers. It provided for bonus payments—5 percent the first year and 3 percent the second year—to plans entering areas with no existing Medicare+Choice plans. The law also changed requirements regarding the definition of service areas and the timing of premium submissions, which should make participation in the program more attractive.

In our March 2000 report, we supported the BBRA provisions intended to provide Medicare beneficiaries with more coverage choices. Although the Commission made no specific recommendations, we continue to be concerned about the stability of the M+C program. For MedPAC to provide useful guidance on what to do next, Congress must make its priorities for the program clear. Maintaining access to richer benefit packages will likely entail increasing spending. Expanding access to rural areas may entail considering alternatives to requiring plans to assume full risk, such as some form of split capitation.