FOCUS on Health Reform

THE HENRY J. KAISER FAMILY FOUNDATION

OCTOBER 2009

MEDICARE SAVINGS IN PERSPECTIVE: A COMPARISON OF 2009 HEALTH REFORM LEGISLATION AND OTHER LAWS IN THE LAST 15 YEARS

Although Medicare is not the main focus of current health reform legislation, the primary proposals under consideration in the House (H.R. 3200, America's Affordable Health Choices Act of 2009) and the Senate (Senate Finance Committee Chairman's Mark, America's Healthy Future Act of 2009) include a number of provisions that would affect Medicare program expenditures. Medicare savings provisions in H.R. 3200 are projected to reduce program expenditures by $539 billion over the 10-year period from 2010 to 2019, while other provisions would increase Medicare expenditures by $320 billion, for a net reduction of $218 billion over 10 years, according to CBO.[1] The Senate Finance Committee legislation is estimated to decrease net Medicare spending by $379 billion between 2010 and 2019, including $91 billion in additional spending and $470 billion in spending reductions.[2] This policy brief considers the proposed 10-year Medicare savings in these health reform proposals in the context of other laws enacted during the last 15 years **(Appendix A)**.

Laws affecting the Medicare program have had a range of policy objectives, including deficit reduction, trust fund solvency, benefit improvements, and payment reforms **(Appendix B)**. Achieving these objectives has involved reducing or increasing Medicare expenditures to varying degrees **(Appendix C)**. For example, when the BBA of 1997 was enacted, CBO estimated that Medicare savings provisions would reduce Medicare program expenditures by $434 billion over the 10-year period from 1998 to 2007, while other provisions would increase Medicare expenditures by $40 billion during that time period, resulting in a net reduction of $394 billion. In contrast, some provisions in the MMA of 2003, which added an outpatient prescription drug benefit to Medicare, were projected to increase Medicare expenditures by $466 billion over 10 years, while other provisions were expected to reduce expenditures by $76 billion over those years, for a net expenditure increase of $390 billion.

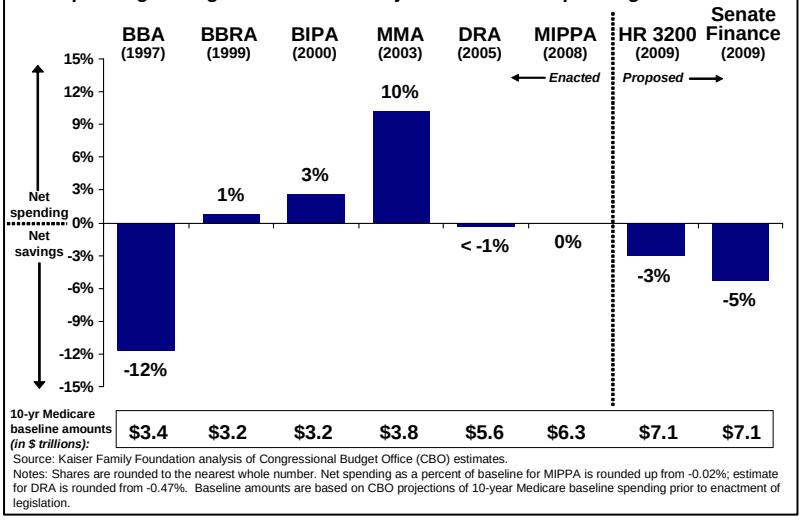
While the absolute dollar amounts convey a sense of the magnitude of the policy changes associated with each law, they are not directly comparable from one law to another. For example, they are not adjusted to account for actual increases in spending over time.[3] In addition, the assumptions used in estimating the effects of program modifications can change over time as CBO takes new information into account.

To compare the changes in Medicare expenditures from 2009 House and Senate health reform legislation with those from prior laws, we calculated net changes in 10-year projected Medicare expenditures estimated at the time each law was enacted as a share of the contemporaneous projected Medicare baseline spending. **Exhibit 1** compares the magnitude of each law's effect on Medicare expenditures as projected at the time of enactment.

Exhibit 1

Net Effect of Major Legislation on Medicare Spending

Net Spending/Savings as a Share of Projected Medicare Spending Over 10 Years



Source: Kaiser Family Foundation analysis of Congressional Budget Office (CBO) estimates.

Notes: Shares are rounded to the nearest whole number. Net spending as a percent of baseline for MIPPA is rounded up from -0.02%; estimate for DRA is rounded from -0.47%. Baseline amounts are based on CBO projections of 10-year Medicare baseline spending prior to enactment of legislation.

Using this approach, provisions in H.R. 3200 would result in $218 billion in net Medicare spending reductions over 10 years, or 3 percent of Medicare baseline spending, while the Senate Finance bill would reduce net Medicare spending by $379 billion over 10 years, or 5 percent of Medicare baseline spending. By contrast, the BBA of 1997 was projected to reduce net Medicare spending by $394 billion over 10 years, or 12 percent of Medicare baseline spending. In other words, the reduction in Medicare expenditures enacted into law as a part of the BBA, expressed as a share of baseline spending, is nearly four times the Medicare spending reduction proposed under H.R. 3200 and more than twice as great as in the Senate Finance bill. In contrast, the MMA of 2003 was projected to result in a net increase in Medicare expenditures of $390 billion, or 10 percent of projected Medicare baseline spending.

Following enactment of the BBA in 1997, Congress increased payments to Medicare Advantage plans (then called Medicare+Choice) and increased spending for certain providers in the BBRA of 1999 and again in the BIPA of 2000. Even if these subsequent increases in Medicare spending are taken into account (i.e., incorporated in the spending projections for the BBA of 1997), the net spending reductions under the BBA are substantially greater than those proposed under H.R. 3200 or the Senate Finance bill.

Under current law, Medicare payments to physicians are scheduled to be reduced by 21.5 percent in 2010, with additional reductions in future years. The Senate Finance Committee Chairman's Mark would cancel the physician payment reduction for 2010 but not in future years, at an estimated cost of $10.9 billion. H.R. 3200 would permanently change the sustainable growth rate (SGR) formula for Medicare physician payments, estimated by CBO to cost $229 billion over 10 years. There is some question as to whether this additional spending should be required to be offset by revenue increases or spending reductions.[4] If this spending is excluded from the analysis, then H.R. 3200 would increase Medicare spending by $91 billion over 10 years, resulting in a net Medicare spending reduction of $448 billion over 10 years, or 6 percent of projected Medicare spending – still considerably less than the net reduction enacted in the BBA of 1997.

Changes in Medicare expenditures – both increases and decreases – directly affect the long-term sustainability of the program and the solvency of the Medicare Trust Fund. For example, following passage of the BBA of 1997, the Medicare Hospital Insurance Trust Fund was projected to be solvent for an additional seven years, attributable to savings enacted in the BBA as well as other factors. H.R. 3200 is projected to extend the solvency of the Medicare Hospital Insurance Trust Fund by an additional five years, from 2017 to 2022, according to the Centers for Medicare & Medicaid Services Office of the Actuary. Changes in Medicare spending can also have a direct impact on hospitals, physicians, and other providers and on costs borne by beneficiaries.

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[1] Congressional Budget Office cost estimates for H.R. 3200 as introduced on July 14, 2009, available at http://www.cbo.gov/doc.cfm?index=10464. Spending increases and reductions may not sum to the net effect due to rounding. Medicare savings in H.R. 3200 include reforms to the sustainable growth rate (SGR) formula for Medicare physician payment.
[2] Congressional Budget Office letter to Chairman Max Baucus, Preliminary Analysis of the Chairman's Mark for the America's Healthy Future Act, as Amended, October 7, 2009, available at http://www.cbo.gov/doc.cfm?index=10642.
[3] Between 1997 and 2009, for example, annual spending increased by 141 percent.
[4] The 2010 budget resolution conference agreement and H.R. 2920, as passed by the House of Representatives on July 22, 2009, would establish "PAYGO" rules for the House, requiring new spending, such as tax cuts or new benefits, to be paid for with revenue increases or spending reductions in other programs, but would exempt the change in the SGR formula from these requirements.

APPENDIX A:
Major Legislation Affecting Medicare Spending in the Last 15 Years

BBA – Balanced Budget Act of 1997 (P.L. 105-33) [10-year window: 1998-2007]
- Expenditures from Congressional Budget Office (CBO), E*stimated budgetary effects of the Balanced Budget Act of 1997,* 1997.
- Baseline from CBO, *An Analysis of the President's Budgetary Proposals for Fiscal Year 1998; Table A-4: CBO Baseline Projections of Mandatory Spending, Including Deposit Insurance* (March 1997).

BBRA – Balanced Budget Refinement Act of 1999 (P.L. 106-113) [10-year window: 2000-2009]
- Expenditures from CBO, *Pay-as-you-go estimate for H.R. 3194, An act making consolidated appropriations for the fiscal year ending September 30, 2000, and for other purposes*, December 8, 1999 (as cleared by the Congress on November 19, 1999 and signed by the President on November 29, 1999).
- Baseline from CBO, *An Analysis of the President's Budgetary Proposals for Fiscal Year 2000; Table 3-2: Outlays for Medicare Benefits, by Sector* (April 1999).

BIPA – Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000; enacted as part of the Consolidated Appropriations Act (P.L. 106-554) [10-year window: 2001-2010]
- Expenditures from CBO, *Pay-as-you-go-estimate for H.R. 5661, Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000*, September 20, 2001 (as cleared by the Congress on December 15, 2000 and signed by the President on December 21, 2000).
- Baseline from CBO, *An Analysis of the President's Budgetary Proposals for Fiscal Year 2001; Table A-9: CBO's Projections of Mandatory Spending* (April 2000).

MMA – Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173)
[10-year window: 2004-2013]
- Expenditures from CBO, *Estimate of Effect on Direct Spending and Revenues of Conference Agreement on H.R. 1: Detail*, November 20, 2003
- Baseline from CBO, *The Budget and Economic Outlook: Fiscal Years 2004-2013; Table 4-5: CBO's Baseline Projections of Mandatory Spending,* January 2003; Congressional Budget Office, *An Analysis of the President's Budgetary Proposals for Fiscal Year 2004; Table 3: Changes in CBO's Baseline Projections of the Deficit or Surplus Since January 2003* (March 2003).

DRA – Deficit Reduction Act of 2005 (P.L. 109-171) [10-year window: 2006-2015]
- Expenditures from CBO, *Cost estimate for S. 1932, Deficit Reduction Act of 2005*, January 27, 2006 (Conference agreement, as amended and passed by the Senate on December 21, 2005).
- Baseline from CBO, *An Analysis of the President's Budgetary Proposals for Fiscal Year 2006; Table A-1: Comparison of CBO's March 2005 and January 2005 Baseline Projections of Medicare Mandatory Spending* (March 2005).

MIPPA – Medicare Improvements for Patients and Providers Act of 2008 (P.L. 110-275)
[11-year window: 2008-2018]
- Expenditures from CBO, *Cost estimate for H.R. 6331, Medicare Improvements for Patients and Providers Act of 2008*, July 23, 2008 (enacted as Public Law 110-275 on July 15, 2008)
- Baseline from CBO, *March 2008 Baseline: MEDICARE* (March 2008).

PROPOSED:

H.R. 3200 – America's Affordable Health Choices Act of 2009 [10-year window: 2010-2019]
- Expenditures from CBO, *Estimate of the Effects on Direct Spending and Revenues of Divisions B and C and Section 164 of H.R. 3200, the America's Affordable Health Choices Act* (as introduced on July 14, 2009).
- Baseline from CBO, *March 2009 Baseline: MEDICARE* (March 2009).

Senate Finance Committee Chairman's Mark – America's Healthy Future Act of 2009
[10-year window: 2010-2019]
- Expenditures from CBO, *Preliminary Analysis of Specifications for the Chairman's Mark of the America's Healthy Future Act, as Amended, October 7, 2009.*
- Baseline from CBO, *March 2009 Baseline: MEDICARE* (March 2009).

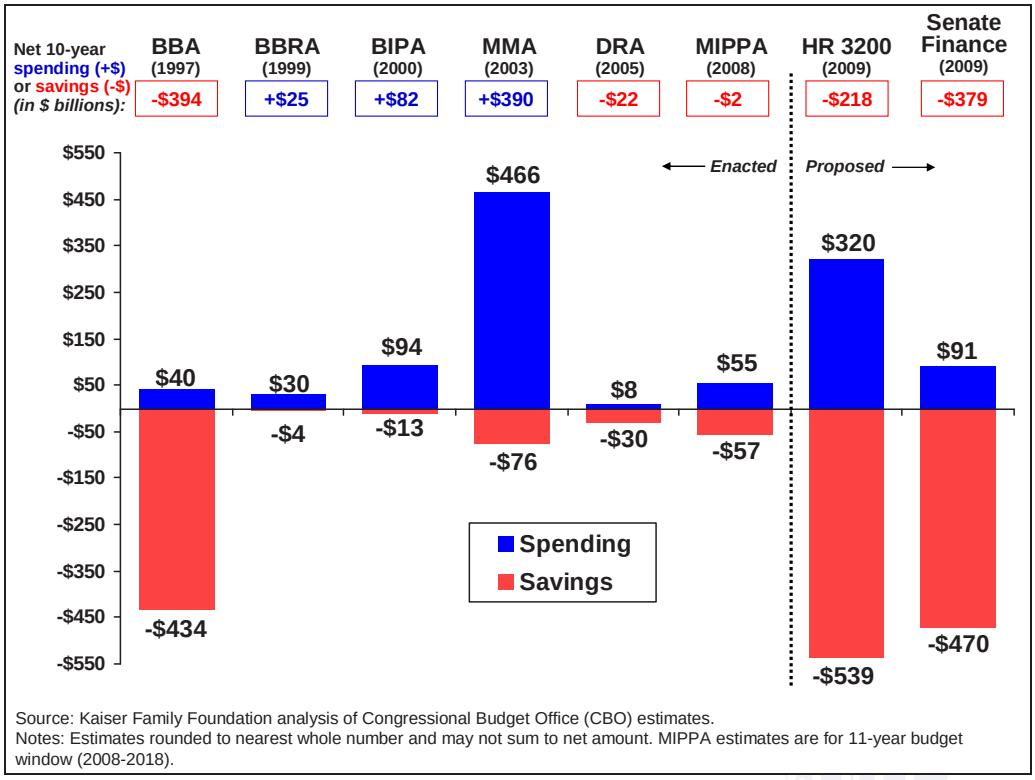
APPENDIX B: Key Medicare Expenditure Provisions in Major Legislation In the Last 15 Years

Based on CBO 10-Year Cost Estimates

	Major Medicare Provisions of Legislation		Change in 10-year Medicare spending (in $ billions)		Net 10-year effect (in $ billions)	Net as % of baseline
	Spending Increases	Spending Decreases	Increase	Savings		
Laws						
BBA (1997)	• Increased payments to hospitals for Medicare+Choice enrollees • Increased coverage of screening tests and preventive measures • Created the Welcome to Medicare exam	• Decreased payments to several providers • Decreased Medicare+Choice payments • Increased Part B premiums	+$40	-$434	-$394	-12%
BBRA (1999)	• Increased payments to several providers • Increased Medicare+Choice payments	• Increased Part B premiums as an indirect effect of changes in Part B spending	+30	-4	+25	-1%
BIPA (2000)	• Increased payments for hospital services • Broadened Part B drug coverage • Waived the waiting period for enrollment by those disabled by ALS • Increased Medicare+Choice payments	• Increased Part B premiums as an indirect effect of changes in Part B spending	+94	-13	+82	+3%
MMA (2003)	• Established prescription drug benefit • Increased Medicare Advantage payments (formerly Medicare+Choice)	• Income-related Part B premiums • Increased Part B deductible	+466	-76	+390	+10%
DRA[1] (2005)	• Increased payment rates for dialysis services • Covered screening for abdominal aortic aneurysms	• Decreased payments to several providers • Changed risk adjustment methodology for Medicare Advantage plans • Accelerated the phase-in of income-related Part B premiums • Net effect of changes in payments to physicians	+8	-30	-22	< -1%
MIPPA[1] (2008)	• Increased payments to physicians • Increased coverage of preventive and mental health services • Expanded eligibility for low-income benefits	• Decreased Medicare Advantage payments	+55	-57	-2	0%
Proposed Legislation[2]						
H.R. 3200 (2009)	• Increases payments to physicians • Expands eligibility for low-income benefits • Phases out the Part D coverage gap	• Decreases payments to several providers • Decreases Medicare Advantage payments	+320	-539	-218	-3%
Senate Finance (2009)	• One-year physician payment increase • Provides a 50% discount on brand-name drugs in the Part D coverage gap	• Decreases payments to several providers • Decreases Medicare Advantage payments	+91	-470	-379	-5%

Source: Kaiser Family Foundation analysis of Congressional Budget Office estimates.
Notes: Net spending may not add up to spending and savings due to rounding; estimates rounded to the nearest whole number. [1] MIPPA cost estimate based on 11-year budget window; Net spending as a percent of baseline for MIPPA is rounded up from -0.02%; estimate for DRA is rounded from -0.47%. [2] For a detailed description of Medicare provisions in House and Senate health reform legislation, see Kaiser Family Foundation, "Side-by-Side Comparison of Key Medicare Provisions in 2009 Health Reform Legislation," http://www.kff.org/healthreform/7948.cfm. Medicare savings in H.R. 3200 include reforms to the sustainable growth rate (SGR) formula for Medicare physician payment.

APPENDIX C:
Medicare Expenditure Changes Under Major Legislation in the Last 15 Years
Based on CBO 10-Year Cost Estimates



Source: Kaiser Family Foundation analysis of Congressional Budget Office (CBO) estimates.
Notes: Estimates rounded to nearest whole number and may not sum to net amount. MIPPA estimates are for 11-year budget window (2008-2018).

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