MEDICARE LOOKBACK MECHANISM

Proposal: Establish annual spending targets for total Medicare expenditures, based on CBO estimates of the provisions contained in the Balanced Budget Act. The targets would be adjusted for unexpected inflation and demographic changes. If these adjusted targets are not met, Medicare spending automatically would be reduced by an amount sufficient to make up the difference.

Rationale: This proposal would ensure that Medicare spending would meet the targets envisioned by the provisions contained in the Balanced Budget Act. The "lookback mechanism" would provide a form of "insurance" that government expenditures on Medicare do not increases at an excessive rate (but would not generate scorable budget savings).

Construction of the Mechanism:

- The spending target for each fiscal year 1996-2002 would be CBO's estimated aggregate Medicare expenditures under the provisions contained in the Balanced Budget Act.

- Each year's aggregate expenditure target would be adjusted for: (1) unexpected inflation; (2) unexpected demographic changes (e.g., more Medicare beneficiaries than predicted).

- To account for possible year-to-year spending fluctuations, beginning in 1998 aggregate targets for the prior two consecutive years would be added together and compared to actual expenditures for those years (e.g., actual expenditures for 1996 and 1997). Similar comparisons would then be made every subsequent year.

- An "error band" would be placed around the aggregate two-year spending targets so that no action is required if the target is missed by a *de minimis* amount. This "band" could be set at X percent of the target amount (e.g., 1 or 2 percent) or Y billion dollars.

- The HHS Secretary is responsible for reporting to Congress within 90 days after the fiscal year end (by January 1) the following: (1) total Medicare expenditures; (2) adjusted target Medicare expenditures; (3) amount by which actual expenditures exceed the adjusted target amounts plus the "error band" (called "excess Medicare spending"); and (4) recommended actions to cut Medicare expenditures over the next two fiscal years by an amount equal to "excess Medicare spending".

- HCFA actuaries will be responsible for estimating savings to be achieved through the Secretary's recommended actions.

- Congress will have 90 days to enact provisions that save at least as much as the HHS Secretary's recommended actions or else these actions will automatically go into effect. (Alternatively, if the Secretary does not have the ability to put these cuts into place unilaterally, the default mechanism would be an across-the-board reduction in all Medicare provider payments, including managed care payments.)

MEMORANDUM

December 12, 1995

TO: Carol Rasco and Laura Tyson

FR: Chris Jennings

RE: Budget Enforcement Mechanism Issue

CC: Gene Sperling, Jennifer Klein

Attached is a background paper focusing on the budget enforcement mechanism issue as it pertains to Medicare. It was prepared by the Department of Health and Human Services and is their attempt to provide general guidelines for consideration of any "failsafe mechanism" that we may consider. As you know, the Department opposes these enforcement mechanisms but understands that this may be a necessary, if unwanted, component of any final deal.

It is worth reminding ourselves that the Democratic Coalition bill did not include a budget enforcement mechanism, rather they proposed the establishment of a Commission to make recommendations to Congress as to how to address unanticipated higher expenditures. Obviously, if we could end up with that provision, there would be few complaints from the Department.

Medicare Proposal

Introduction

Medicare spending under a balanced budget agreement should be determined by specific programmatic and policy changes designed to achieve targeted spending levels, not by an arbitrary cap on spending. An arbitrary Medicare budget cap and "look back" could potentially have several adverse effects on the Medicare program and should therefore be opposed by the Administration.

- ***Breaks link between benefits and payments*** - A cap would fundamentally change the nature of the Medicare program by breaking the link between benefits and payments.

- ***Reduces access*** - To meet a cap, over time benefits might be reduced; beneficiaries' out of pocket expenditures might be increased, affecting access to needed services; and payment rates might be reduced to a level where they are no longer sufficient to secure access to necessary health services.

- ***Makes Medicare hostage to external macro - economic forces*** - A cap that is in nominal dollars makes Medicare subject to broader economic forces such as inflation which shouldn't drive health policy.

- ***Makes Government an unreliable business partner*** - As Medicare moves to a more market-oriented approach to setting payments, arbitrary reductions imposed by the government after providers have negotiated in good faith will sour relations and threaten the market pricing process..

- ***Cost shifting*** - Caps will encourage providers to shift costs to beneficiaries and other payers or to sacrifice beneficial but costly services. As the private sector moves to control its spending, providers that care for the uninsured will be even further disadvantaged in a competitive marketplace by arbitrary reductions in Medicare payments.

- ***Scorability drives policy*** - Scorability decisions lead to features in any cap or look back that are purely budget-driven. Budget caps are a substitute for policy choices that achieve the desired level of spending. Moreover, the formulaic nature of caps can constrain the options available to policymakers in the future.

Medicare budget caps with a look back that could achieve CBO scorable savings above the level of specific savers, are especially problemmatic because they require rigid implementation with little room to correct estimation errors or make other mid-course corrections. The Medicare budget cap in the Republican conference agreement, discussed below, is an example of such a cap.

Legislative Background

Republican Conference Agreement -The budget reconciliation conference agreement contains annual Medicare spending limits. Annual spending limits for the fee-for-service (FFS) sector are derived from subtracting payments to Medicare Plus plans (which have fixed annual growth rates) from the Medicare spending limits (this is where traditional Medicare "withers on the vine"). The remainder is then apportioned to the fee-for-service sectors (e.g., hospitals, physicians). The agreement contains a prospective adjustment mechanism and a look-back provision designed to adjust fee-for-service payment rates to ensure the annual Medicare spending limits are met. Under the prospective adjustment, beginning with FY 1998, the Secretary compares projected FFS expenditures by sector for the coming year with the allotment for that sector. If the projected expenditures exceed the sector's budget allotment, the Secretary adjusts payment rates for that sector downward so that spending is within the allotment. Under the look-back provision, the Secretary can permanently reduce a sector's allotment if actual expenditures two years previously were greater than the estimated allotment.

Democratic Coalition - The Democratic Coalition bill does not contain explicit limits on Medicare spending. Rather, it sets budgetary and program goals, and establishes a Medicare Reform Commission to evaluate the extent to which the goals have been met. The Commission can recommend policy changes if Medicare spending exceeds the outlay targets. The President will then submit legislative proposals to Congress to correct the problems and Congress will consider the proposals on a fast track, similar to the Defense Base Closure process.

Approach

Although proposing substantive policies to slow the rate of growth in spending are the right approach to constraining spending, we might face criticism from those who believe that policy changes alone won't provide sufficient control on Medicare spending. The Democratic Coalition proposal of a Commission which notifies Congress when spending has exceeded projected levels would provide policymakers with an opportunity to make mid-course corrections over the life of the balanced budget agreement. Should such an approach not be accepted, an alternative which added a default spending reduction after Congressional notification could be considered - although any such movement toward a "cap" is politically and programmatically troublesome.

Given the uncertainty of estimating both baseline spending levels and savings proposals, such a budget proposal could be described as an "insurance policy" that spending is within certain targeted bands. Such a proposal should not be scored by CBO as creating additional savings, because the goal is to "ensure" that savings from already scored proposals have the desired impact. An "insurance policy" approach to Medicare spending could have the following elements:

- *Setting the Target: Total Spending and Real Dollars* - The target should be set using real dollars and should apply to all Medicare spending. Apportioning spending reductions to specific fee-for-service sectors as in the Republican plan is too rigid (e.g., if clinicians substitute less expensive outpatient services for more expensive inpatient services they would see their outpatient fees reduced)

- *Adjusting Targets* - The targets should be updated annually to reflect enrollment changes and estimating errors. The longer the projection period, the greater the room for error. Annually updating targets allows for the use of the most accurate information and minimizes disruption in the Medicare program. The Republican plan sets annual Medicare spending targets in statute for the 7 year budget window with no subsequent adjustments.

- *Accommodating "noise"* - In addition to updating targets, there should be a corridor or band around the target to permit reasonable fluctuations from the estimate without imposing payment reductions. Only if spending significantly deviates from the target should payments be reduced. To the extent practicable under such a proposal, Medicare should be a good business partner.

- *Report to Congress* - Before taking any action to reduce spending above targeted levels, the Secretary should notify Congress of the reasons for "excess" spending and give them time to act before implementing payment reductions. Among the factors the Secretary would consider in her Report would be the rate of growth in private sector health spending, changes in the characteristics of Medicare beneficiaries, and changes in medical practice including new technology.

Medicare Vs. Private Sector Health Spending

Charts

The attached charts compare growth in private sector health spending to growth in Medicare spending and show that Medicare and private spending patterns have followed similar trends.

- Expenditures per enrollee. The first three charts show historical growth in expenditures per enrollee and projected growth through 2000. It is important to look at spending on a per enrollee basis because Medicare enrollment has been growing at about 2 percent per year, while the number of enrollees in private insurance plans has been declining over the past 5 years. (However, it should be noted that this comparison might be affected by changes in the characteristics of the population covered in the private sector (e.g. employers dropping retiree benefits) and by changes in coverage.)

- Hospital and physician expenditures. The last two charts show historical growth in hospital and physician expenditures per enrollee and projected growth through 2000. This comparison is important because beyond hospital and physician services, Medicare and private insurance benefits packages are often very different. For example, two of the fastest growing benefits in the Medicare program are skilled nursing and home health care services, which are not extensively covered by private insurance nor are they as important to younger working populations. In addition, private insurance often includes prescription drug and dental coverage, but these services are not part of the Medicare benefits package.

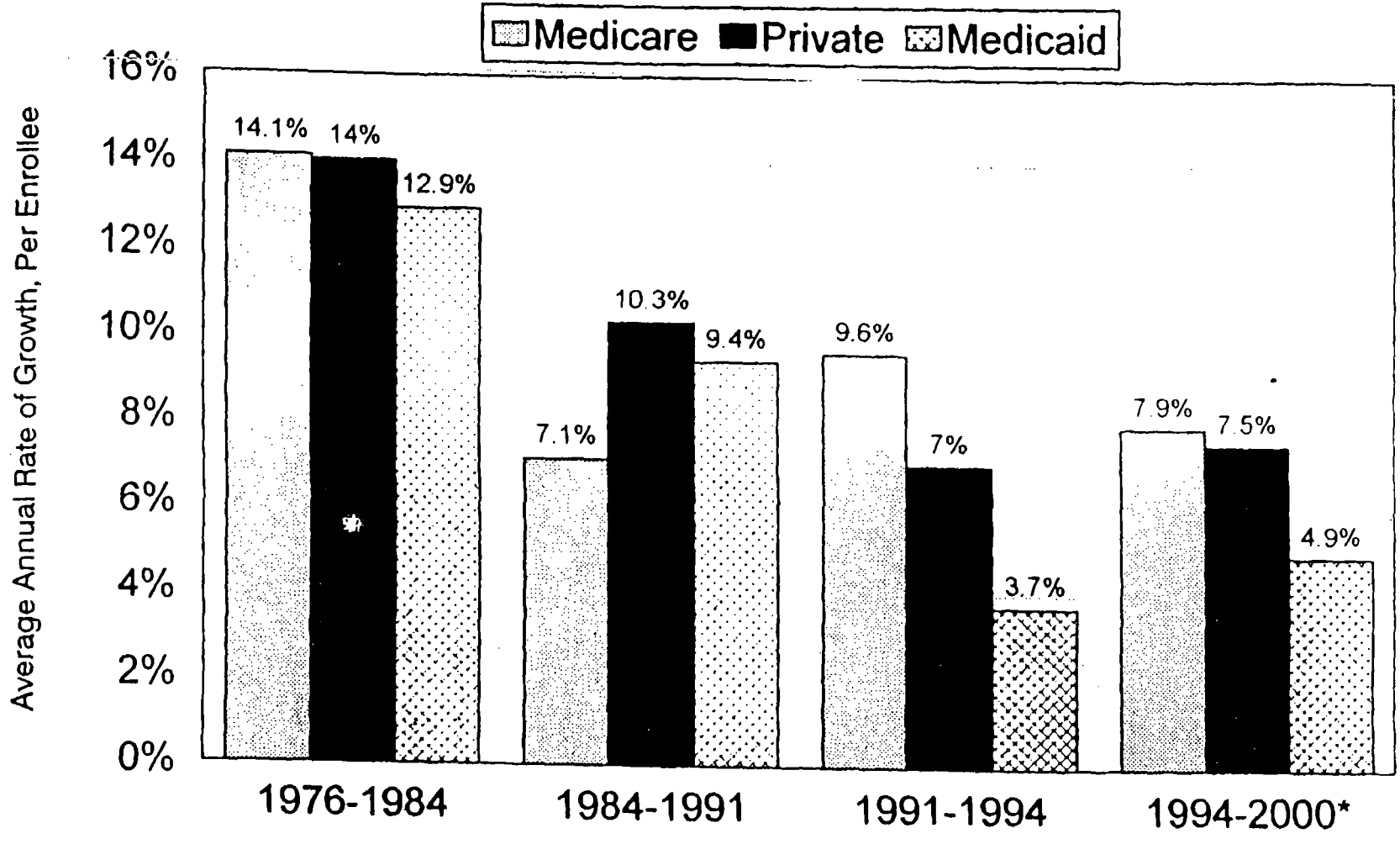
Data Issues

Comparisons of Medicare to private sector health spending should be used with caution because there is no one consistent, timely national source for private insurance expenditure data that is comprehensive and precise enough to estimate national spending. The National Health Accounts derive estimates of private health insurance spending from a number of sources, including providers, employers and consumers. As a result, estimating rates of change over time is problematic because the underlying annual estimates may not be comparable. For example, employers may make annual changes in covered populations and benefit packages, which could affect the private sector growth rates. Multiple data sources for private spending also make projecting future rates of growth problematic. Because of the flexibility inherent in the private sector, historical data may not accurately predict changes in this dynamic environment.

The Secretary's Report to Congress under the Medicare proposal would consider, among other things, the rate of growth in private sector health spending. To make this comparison more meaningful, we will continue our efforts to improve our analytic capability to measure changes in private sector spending.

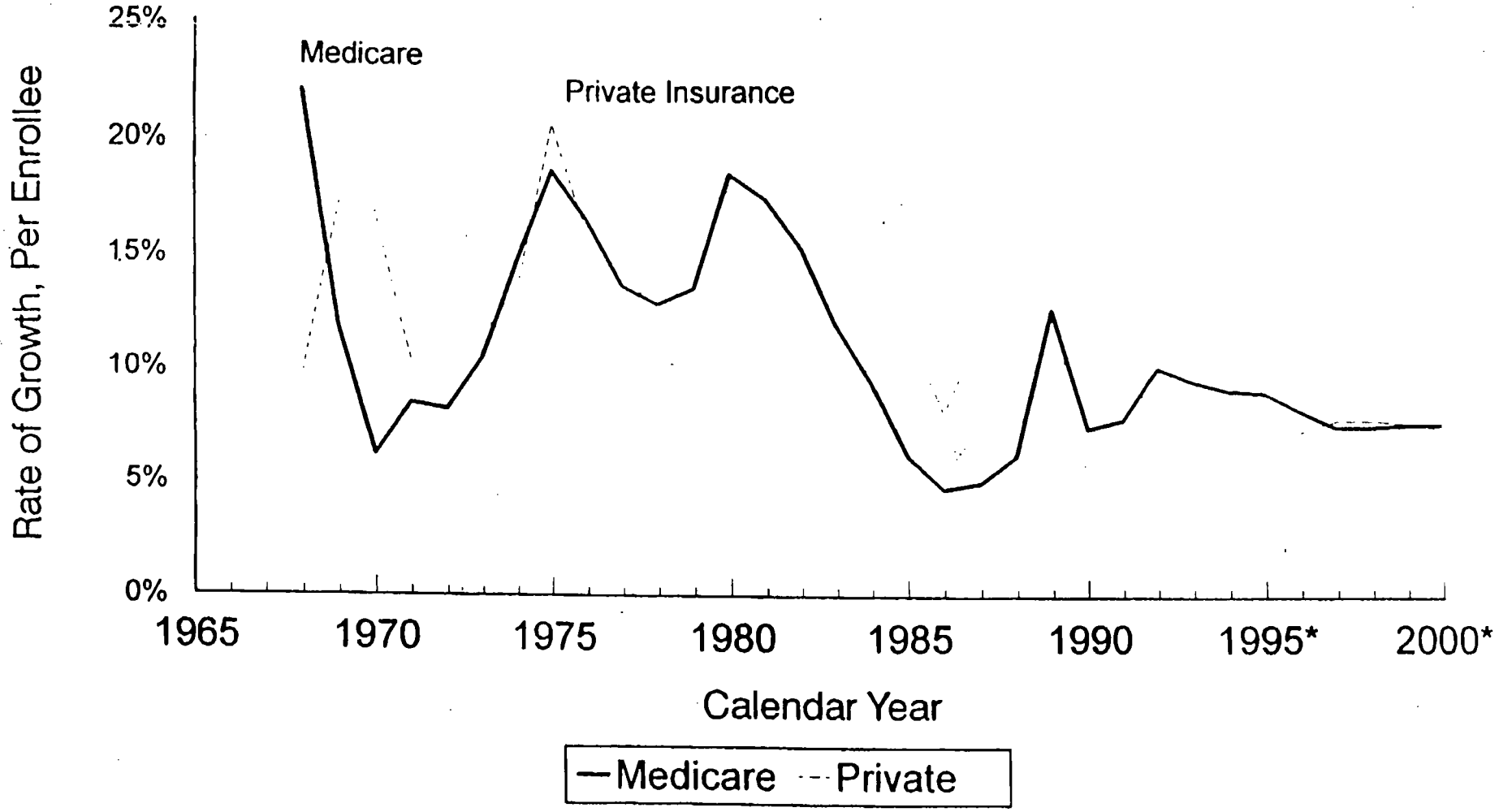
12/6/95

Growth in Expenditures, Per Enrollee
Medicare, Private, & Medicaid



*Projections
Source: HCFA/Office of the Actuary

Growth in Expenditures, Per Enrollee
Medicare vs. Private



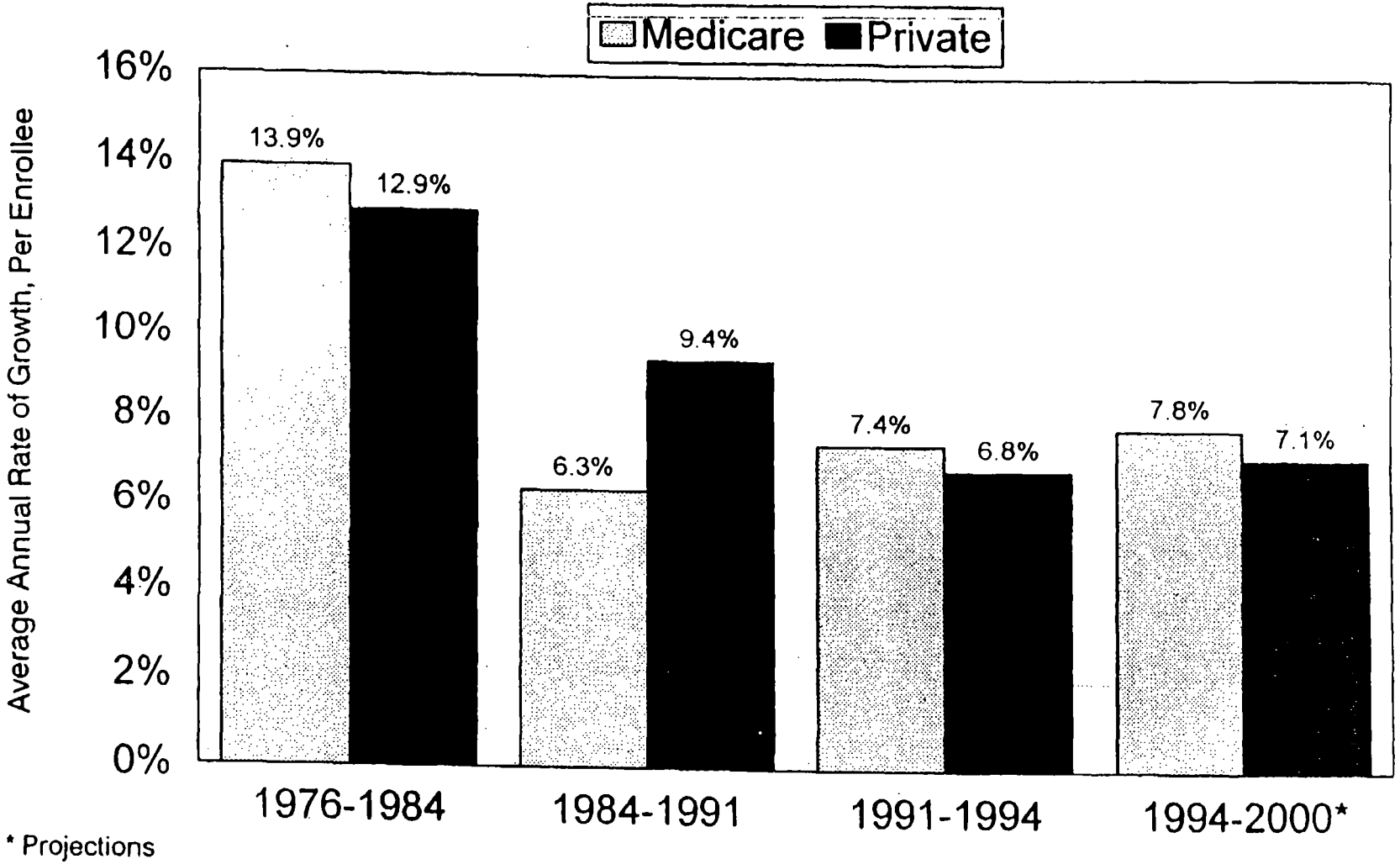
*Projections

Source: Health Care Financing Administration: Office of the Actuary, 1995

Growth in Expenditures, Per Enrollee -- Medicare vs. Private

Year	Medicare (% Change)	Private (% Change)
1965		
1966		
1967		
1968	22.1	9.8
1969	11.9	17.3
1970	6.2	16.9
1971	8.5	10.4
1972	8.2	9.9
1973	10.5	11.5
1974	14.8	13.6
1975	18.7	20 7
1976	16.5	15 8
1977	13.7	12 3
1978	12.9	14 5
1979	13.6	17
1980	18.6	17.9
1981	17.5	16.3
1982	15.4	14.1
1983	12	10.1
1984	9.4	10
1985	6.2	11.9
1986	4.7	8.1
1987	5	11.7
1988	6.2	10.9
1989	12.7	10.7
1990	7.4	9.7
1991	7.8	9.2
1992	10.1	8.6
1993	9.5	7.1
1994	9.1	5.4

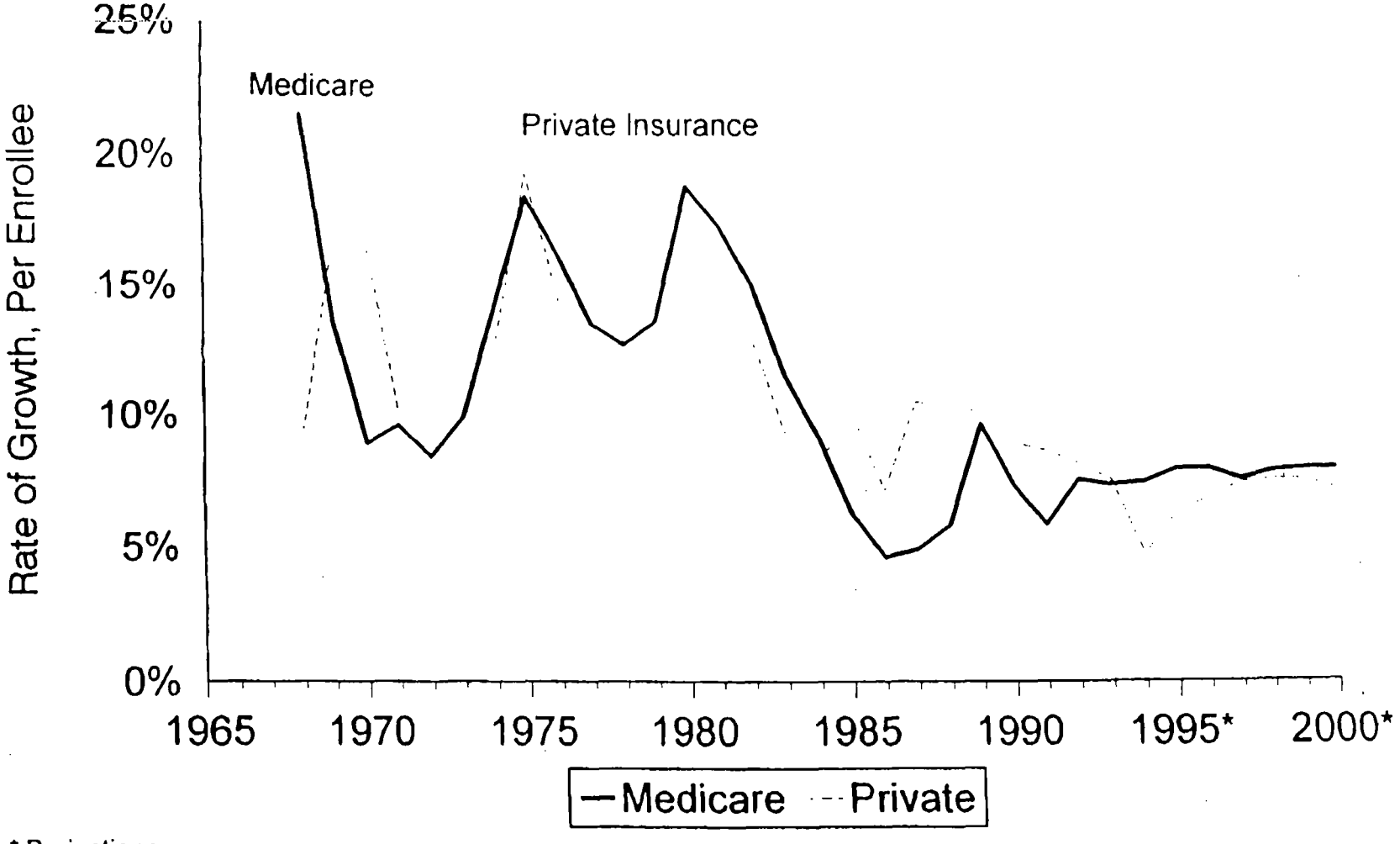
Growth in **Physician & Hospital Expenditures**, Per Enrollee
Medicare vs. Private



* Projections

Source: HCFA/ Office of the Actuary, 1995

Growth in **Hospital & Physician Expenditures,** Per Enrollee
Medicare vs. Private



* Projections
Source: HCFA/ Office of the Actuary, 1995