



CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

April 15, 1998

H.R. 2912 **Medicare Venipuncture Fairness Act of 1997**

As introduced on November 7, 1997

SUMMARY

The Medicare Venipuncture Fairness Act would amend the Balanced Budget Act of 1997 (BBA) by reinstating payment under Medicare for home health services where venipuncture is performed solely for the purpose of obtaining a blood sample. CBO estimates that enactment of H.R. 2912 would increase direct spending by \$130 million in 1999, \$1 billion over the 1999-2003 period, and \$2.5 billion through fiscal year 2008. Because the bill would affect direct spending, pay-as-you-go procedures would apply.

The bill would also require the Secretary of Health and Human Services to study potential fraud and abuse with respect to the provision of venipuncture under Medicare's home health benefit. CBO estimates that this study would increase discretionary spending by less than \$500,000.

H.R. 2912 does not contain any intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act of 1995.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated impact of H.R. 2912 on direct spending is shown in the following table. Spending on home health services in Medicare's fee-for-service program would increase by \$140 million in 1999 and \$850 million over the 1999-2003 period. The \$140 million amount for 1999 is less than 1 percent of projected spending for home health services under CBO's January 1998 baseline. Because payment rates for Medicare risk plans are related to spending in the fee-for-service program, increased spending on home health services will lead to higher payments to risk plans beginning in fiscal year 2000. CBO estimates these payments will grow by \$230 million over the 1999-2003 period. Home health services are covered under both Part A and Part B of the Medicare program. About 25 percent of new Part B outlays will be covered by premium payments by beneficiaries. Finally, CBO

estimates that discretionary spending for the study on fraud and abuse would be less than \$500,000.

	By Fiscal Year, in Millions of Dollars					
	1998	1999	2000	2001	2002	2003
CHANGES IN DIRECT SPENDING						
Fee-for-service home health services	0	140	150	170	190	200
Payments to Medicare Risk Plans	0	0	40	50	60	80
Part B premium interaction	0	-10	-10	-20	-30	-40
Net change in direct spending	0	130	180	200	220	240

The costs of this legislation fall within budget function 570 (Medicare).

BASIS OF ESTIMATE

Home health services are covered under Medicare for beneficiaries who are homebound and who need either skilled nursing care on an intermittent basis, or physical or speech therapy. For beneficiaries who receive these qualifying services, Medicare also covers visits from home health aides, medical social services, and occupational therapy. All services must be provided under a plan of care established and periodically reviewed by a physician. If a beneficiary does not receive at least one covered skilled nursing or therapy visit in a 62-day period, the plan of care is considered to be terminated.

Prior to passage of the Balanced Budget Act, if a home health agency performed venipuncture to obtain a blood sample, this service was considered a skilled nursing service that could in turn trigger coverage of the full range of home health benefits. Under BBA, venipuncture is no longer considered a skilled nursing service. Homebound beneficiaries who need blood drawn, but have no other skilled nursing or therapy need, will no longer qualify for home health benefits under Medicare¹. Beneficiaries who need skilled nursing

¹These beneficiaries can still have blood drawn at home under Medicare's laboratory benefit. If a physician determines a beneficiary is unable to travel to a laboratory or physician's office, Medicare Part B will pay for travel by a technician and collection of the sample.

or therapy in addition to venipuncture will continue to be eligible to receive the full range of home health services, including venipuncture.

CBO's estimate of costs under H.R. 2912 takes into account spending on fee-for-service benefits, payments to Medicare risk plans, and offsetting Part B premium receipts. To estimate spending on fee-for-service benefits, CBO used data on Medicare claims for home health and laboratory services for a 1-percent sample of Medicare enrollees in 1995 and 1996. Home health claims include bills for skilled nursing services, home health aide visits, therapy visits, medical social services, and other items. Home health bills do not specify whether venipuncture was the skilled nursing service provided. Therefore, CBO also examined laboratory claims during the same time period, based on the assumption that blood drawn during a skilled nursing visit would be sent to a laboratory for evaluation.

First, home health claims that included charges for therapy were excluded from the analysis because therapy services can trigger eligibility for the full range of home health benefits. In 1996, about 70 percent of spending for home health services was associated with beneficiary claims that included charges for therapy.

Second, we excluded claims for home health services that were unlikely to have been provided under the same two-month plan of care as a laboratory service. We identified home health claims for beneficiaries who received laboratory services during the one-year period from November 1, 1995, through October 31, 1996. We eliminated claims with a beginning date that was more than 15 days before or 62 days after a laboratory test. Nearly all home health claims include multiple dates of service and cover a one-month period of time or less. Therefore, we pro-rated home health payments to account for claim ending dates that were more than 62 days after a selected laboratory service.

Third, based on the assumption that beneficiaries who had multiple skilled nursing visits in a episode were receiving skilled services in addition to venipuncture, we excluded all home health episodes with 2 or more skilled nursing visits. The remaining amount, about \$270 million, represents the estimated cost of skilled nursing and home health aide services for beneficiaries who received either zero or one skilled nursing service during the episode.

CBO assumes about half of the \$270 million can be attributed to skilled nursing visits where venipuncture was performed solely for the purpose of obtaining a blood sample. We adjusted this amount for changes in costs and utilization to arrive at the \$140 million estimate for the cost of fee-for-service home health benefits in fiscal year 1999 under H.R. 2912. Beginning in 2000, payments to risk plans would also increase as a result of higher fee-for-service spending. Part of the increase in Medicare outlays would be offset by an increase in Part B premium collections.

PAY-AS-YOU-GO CONSIDERATIONS:

The Balanced Budget and Emergency Deficit Control Act of 1985 establishes pay-as-you-go procedures for legislation affecting direct spending or receipts. The projected changes in direct spending under H.R. 2912 are shown in the table below for fiscal years 1999-2008. For purposes of enforcing pay-as-you-go procedures, however, only the effects in the current year, budget year, and the succeeding four years are counted.

Summary of Pay-As-You-Go Effects

	By Fiscal Year, in Millions of Dollars									
	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Change in outlays	130	180	200	220	240	250	290	290	330	350
Change in receipts	Not applicable									

ESTIMATED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

H.R. 2912 contains no intergovernmental mandates as defined in the Unfunded Mandates Reform Act of 1995. State governments may realize small savings in Medicaid costs if some recipients receive home health benefits under Medicare instead of Medicaid.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

The bill contains no private-sector mandates as defined in the Unfunded Mandates Reform Act of 1995.

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