



**CONGRESSIONAL BUDGET OFFICE
PAY-AS-YOU-GO ESTIMATE**

September 20, 2001

**H.R. 5661
Medicare, Medicaid, and SCHIP
Benefits Improvement and Protection Act of 2000
(Incorporated in H.R. 4577, the Consolidated Appropriations Act)**

*As cleared by the Congress on December 15, 2000 and
signed by the President on December 21, 2000*

SUMMARY

The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) was enacted at the end of the 106th Congress as part of the Consolidated Appropriations Act (Public Law 106-554.)

BIPA modifies Medicare's payment rates for many services and adds coverage of certain preventive and therapeutic services. It also makes changes to both Medicaid and the State Children's Health Insurance Program (SCHIP). The act requires the Administration to issue regulations to reduce the growth of a mechanism used by states to obtain federal matching payments from Medicaid without an actual matching expenditure of state or local funds. BIPA also increases the allotments to states of funds distributed through the Medicaid disproportionate share (DSH) program, and postpones the expiration of funds appropriated for SCHIP in 1998 and 1999. Finally, BIPA makes mandatory appropriations for the Ricky Ray Hemophilia Relief Fund and for several diabetes programs.

CBO estimates that BIPA will increase federal direct spending by \$3.9 billion in fiscal year 2001, by \$17 billion over the 2001-2005 period, and by a total of \$15 billion over the 2001-2010 period. During the 2001-2010 period, the act will increase Medicare payments to providers by about \$94 billion and increase spending by \$1 billion in SCHIP and other programs. Those increases will be largely offset by a \$13 billion increase in Medicare premiums paid by beneficiaries and a \$68 billion reduction in federal Medicaid spending.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated annual impact of BIPA on direct spending is shown in the following table. The costs of this legislation fall within budget functions 550 (health) and 570 (Medicare).

CBO estimates that, over the 2001-2010 period, the act will add about \$62 billion in payments to Medicare providers in the fee-for-service sector and will make specific changes that will add another \$12 billion in payments to organizations in the Medicare+Choice program. Furthermore, payment rates for Medicare+Choice plans are based on spending in the fee-for-service sector, so provisions of the act that increase fee-for-service spending will lead to higher payments to Medicare+Choice plans. The estimated increase in fee-for-service spending in 2001 was not large enough to trigger an increase in Medicare+Choice payment rates for 2001, because other provisions in prior and current law raised those rates above the amounts that would have resulted based on spending in the fee-for-service sector¹. There will be an impact in subsequent years, however. CBO estimates that the increase in spending attributable to the interaction between fee-for-service spending and Medicare+Choice payment rates will total \$6 billion during the 2002-2005 period and \$20 billion over the 2001-2010 period.

Increased spending for Medicare Part B will be partially offset by higher Part B premiums. The premium for 2001 is \$50.00 per month and was not changed by this act. In subsequent years, however, about 25 percent of new Part B outlays will be covered by additional premiums paid by beneficiaries. CBO estimates that those premium payments will increase by \$4 billion from 2001 through 2005 and by almost \$13 billion during the 2001-2010 period.

CBO estimates that, over the 2001-2010 period, the act will reduce Medicaid spending by about \$68 billion. The requirement that the Administration issue regulations to constrain states' use of a mechanism to obtain federal matching payments from Medicaid without an actual matching expenditure of state or local funds will reduce spending by about \$77 billion. Almost \$10 billion of that reduction will be offset by other provisions, including increases in the allotments to states of funds distributed through the Medicaid disproportionate share program, higher payments to federally qualified health centers and rural health clinics, and several programs to increase the enrollment of eligible individuals in Medicaid.

¹ However, payment rates for Medicare+Choice plans were increased beginning March 1, 2001, as a result of several BIPA provisions that directly modified the payment rules for Medicare+Choice plans.

ESTIMATED BUDGETARY EFFECTS OF THE MEDICARE, MEDICAID, AND SCHIP BENEFITS IMPROVEMENT AND PROTECTION ACT OF 2000 (H.R. 5661)

	Outlays, By Fiscal Year, in Billions of Dollars										2001-	2001-
	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2005	2010
CHANGES IN DIRECT SPENDING												
Medicare												
Title I: Medicare Beneficiary Improvements												
Subtitle A—Improved Preventive Benefits	0.1	0.3	0.4	0.5	0.5	0.5	0.5	0.5	0.5	0.5	1.6	4.1
Subtitle B—Other Beneficiary Improvements	0.4	0.6	0.7	0.9	1.2	1.7	1.8	1.8	1.8	1.9	3.8	12.8
Subtitle C—Demonstration Projects	0	0	*	*	*	*	*	*	*	*	*	0.1
Title II: Rural Health Care Improvements												
Subtitle A—Critical Access Hospitals	*	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.7
Subtitle B—Other Rural Hospitals	0.1	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.3	1.0	2.3
Subtitle C—Other Rural Provisions	*	*	*	0.1	0.1	0.2	0.3	0.4	0.4	0.5	0.3	2.1
Title III: Provisions Relating to Part A												
Subtitle A—Hospital Inpatient Services	1.0	1.8	0.8	0.8	0.8	0.8	0.8	0.9	0.9	1.0	5.2	9.6
Subtitle B—Skilled Nursing Facilities	0.2	0.8	0.3	0.1	0.1	0.1	0.1	0.1	0.1	0.1	1.5	2.1
Subtitle C—Hospice Care	*	0.1	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.6	1.4
Subtitle D—Waive Penalty for Late Enrollment	a	a	a	a	a	a	a	a	a	a	a	a
Title IV: Provisions Relating to Part B												
Subtitle A—Hospital Outpatient Services	0.5	1.2	1.3	1.3	1.4	1.5	1.6	1.7	1.8	1.9	5.7	14.2
Subtitle B—Physicians' Services	0	*	*	*	*	*	*	*	*	*	*	*
Subtitle C—Other Services	0.1	0.4	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.3	1.2	2.7
Title V: Provisions Relating to Parts A and B												
Subtitle A—Home Health Services	0.7	0.4	0.2	0.2	0.3	0.3	0.4	0.4	0.5	0.5	1.8	3.8
Subtitle B—Direct Graduate Medical Education	*	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.4	0.8
Subtitle C—Coverage and Appeals Process	*	*	0.1	0.1	0.2	0.2	0.3	0.3	0.4	0.4	0.4	2.0
Subtitle D—Access to New Technologies	*	*	*	*	*	*	*	*	*	*	0.1	0.1
Subtitle E—Other Provisions	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.3	0.3	1.2	2.7
Title VI: Medicare Managed Care	0.6	0.9	1.0	1.2	1.3	1.0	1.4	1.5	1.7	1.9	4.9	12.4
Title VII: Medicaid (Effect on Medicare)	0	*	*	*	*	*	*	*	*	*	0.1	0.3
Title IX: Other Provisions												
Subtitle A—PACE Waivers	0	0	*	0	0	0	0	0	0	0	*	*
Medicare+Choice Interaction	<u>0</u>	<u>1.6</u>	<u>1.4</u>	<u>1.5</u>	<u>1.8</u>	<u>1.9</u>	<u>2.4</u>	<u>2.7</u>	<u>3.1</u>	<u>3.6</u>	<u>6.3</u>	<u>20.1</u>
Subtotal, Gross Medicare Outlays	<u>3.9</u>	<u>8.7</u>	<u>7.3</u>	<u>7.7</u>	<u>8.7</u>	<u>9.3</u>	<u>10.7</u>	<u>11.6</u>	<u>12.6</u>	<u>13.7</u>	<u>36.3</u>	<u>94.3</u>
Premium Receipts	<u>-*</u>	<u>-0.7</u>	<u>-1.0</u>	<u>-1.1</u>	<u>-1.3</u>	<u>-1.4</u>	<u>-1.6</u>	<u>-1.7</u>	<u>-1.9</u>	<u>-2.0</u>	<u>-4.1</u>	<u>-12.8</u>
Subtotal, Net Medicare Outlays	<u>3.9</u>	<u>8.0</u>	<u>6.3</u>	<u>6.6</u>	<u>7.4</u>	<u>7.9</u>	<u>9.1</u>	<u>9.9</u>	<u>10.7</u>	<u>11.7</u>	<u>32.3</u>	<u>81.5</u>
Medicaid, SCHIP and Other												
Title VII: Medicaid (Effect on Medicaid and SCHIP)	-0.1	-1.3	-3.5	-5.2	-6.3	-8.2	-9.2	-10.3	-11.6	-12.6	-16.3	-68.2
Medicaid Spending for Medicare Enrollees	-0.1	0.1	-0.1	*	0.1	0.1	0.1	0.1	0.1	0.1	*	0.6
Title VIII: SCHIP	*	*	0	0	0	*	*	*	*	*	*	0.1
Title IX: Other Provisions												
Subtitle D—Mandatory Appropriations	0.1	0.4	0.2	0.1	*	*	*	*	*	*	0.9	1.0
Subtotal, Medicaid, SCHIP and Other	*	-0.8	-3.3	-5.1	-6.2	-8.1	-9.0	-10.1	-11.5	-12.4	-15.3	-66.5
Total Changes	3.9	7.2	3.0	1.6	1.2	-0.2	0.1	-0.3	-0.7	-0.7	17.0	15.1

NOTES: SCHIP is the State Children's Health Insurance Program.

* = Between -\$50 million and \$50 million.

a. Waiver of the late enrollment penalty has no effect on gross outlays. The budgetary effect (a loss of less than \$50 million in premium collections during the 2001-2010 period) is included in the premium receipts line.

BUDGETARY IMPACT OF MAJOR PROVISIONS

The following sections discuss changes in gross outlays directly attributable to provisions of the act. In addition, the estimate includes three other effects: the effect of changes in Medicare spending in the fee-for-service sector on payment rates for enrollees in Medicare+Choice plans; the effect of changes in Medicare Part B outlays on receipts from Part B premiums; and the effect on federal spending for Medicaid of changes in Medicare coverage, Part B premiums, and cost-sharing requirements.

Title I: Medicare Beneficiary Improvements

Subtitle A, Improved Preventive Benefits. The act adds coverage under Medicare of two preventive services and modifies coverage and payment rates for three currently-covered preventive services. Individuals with a high risk for glaucoma are newly eligible for coverage of an annual glaucoma screening exam, and individuals with diabetes or renal disease are newly eligible for medical-nutrition therapy and counseling services. In addition, BIPA makes all Medicare beneficiaries eligible for coverage of screening colonoscopy services; previously those services were covered only for individuals with a high risk for colon cancer. The act also increases payment rates for certain mammography services and requires Medicare to pay for screening pap smears and pelvic exams as frequently as every two years, instead of every three years. CBO estimates those provisions will increase Medicare spending in the fee-for-service sector by \$0.1 billion in 2001, \$1.6 billion during the 2001-2005 period, and \$4.1 billion through 2010.

Subtitle B, Other Beneficiary Improvements. BIPA shifts responsibility for payment of certain costs from beneficiaries to the Medicare program; broadens the set of drugs and biologicals (which are biologically-derived substances that require injection to be effective) covered under Medicare; and, for individuals under 65 who are disabled by amyotrophic lateral sclerosis (ALS, also known as Lou Gehrig's disease), waives the 24-month waiting period before they may enroll in Medicare. CBO estimates those provisions will increase Medicare spending in the fee-for-service sector by \$0.4 billion in 2001, \$3.8 billion from 2001 through 2005, and \$12.8 billion through 2010.

Cost Sharing for Hospital Outpatient Services. The Balanced Budget Act of 1997 (BBA) established a fee schedule for hospital outpatient services and a separate schedule for the cost-sharing amounts to be paid by beneficiaries for those services. Medicare pays the difference between the two amounts. The fees are adjusted each year for inflation and other

factors (such as changes in technology and in the volume of services), whereas the cost-sharing amounts were frozen until they declined to 20 percent of the amount specified in the fee schedule².

BIPA further reduces the cost-sharing amounts for certain services to the lower of the deductible for hospital inpatient services (\$792 in 2001) or a specified percentage of the standard fee-schedule amount. That percentage will be reduced from 57 percent in 2001 to 40 percent in 2006 and subsequent years³. CBO estimates that this provision will increase Medicare payments by \$0.2 billion in 2001 and by \$5.7 billion from 2001 through 2010.

Cost Sharing for Drugs Covered under Part B. After a beneficiary has met the \$100 annual deductible for Part B services, the Medicare program pays "participating" providers 80 percent of the usual fee for covered drugs (and for most other Part B services that have a cost-sharing requirement) and the beneficiary pays the other 20 percent. Under prior law, if a provider did not participate, the program paid 76 percent of the usual fee and the beneficiary paid up to about 33 percent of the usual fee⁴. (Thus, a provider who did not participate could collect about 9 percent more than the usual fee.)

BIPA limits beneficiaries' cost-sharing obligation to 19 percent of the usual fee for covered drugs furnished by nonparticipating providers. The Medicare program will continue to pay 76 percent of the usual fee, so nonparticipating physicians will receive only 95 percent of the usual fee for those drugs. CBO expects that this provision will result in a slight increase in the number of providers who participate, with the program paying those providers 80 percent of the usual fee for all of the covered services they furnish. CBO estimates that the provision will increase Medicare spending by about \$0.2 billion over the 2001-2010 period.

Standard for Coverage of Drugs and Biologicals under Part B. Under prior law, Medicare covered drugs and biologicals provided incident to a physician's service if the drug or biological could not be administered by the patient himself. BIPA changes that standard to cover drugs and biologicals provided incident to a physician's service if patients usually do not administer the product themselves. CBO estimates that this change in the definition of a covered drug will increase Medicare spending by less than \$50 million in 2001 and by \$4.8 billion over the 2001-2010 period.

² When BBA was enacted, payments by beneficiaries accounted for about half of the total fees, with beneficiaries paying far more than half of the total for some services.

³ After 2006, cost-sharing amounts for services affected by this provision will remain at 40 percent of the fee schedule amount (that is, the copayment will grow at the same rate as the amount specified for the service in the fee schedule) until the copayment increases to the amount at which it was frozen by the BBA. The copayment amount will then be frozen until it declines to 20 percent of the amount specified in the fee schedule.

⁴ Beneficiaries are billed more than the usual cost-sharing amount (generally 20 percent) on 4 percent of claims.

Immunosuppressive Drugs. Under prior law, Medicare covered immunosuppressive drugs for three to four years after a beneficiary received an organ transplant covered by Medicare. BIPA eliminates that time limit. This provision will increase Medicare expenditures by about \$0.1 billion in 2001 and by \$1.4 billion over the 2001-2010 period.

Waive Waiting Period for ALS. Individuals under 65 are entitled to enroll in Medicare 24 months after becoming entitled to disability insurance benefits under Social Security. BIPA waives that 24-month waiting period, effective July 1, 2001, for persons diagnosed with ALS. CBO estimates that this provision will increase Medicare spending by \$0.1 billion in 2001 and by \$0.7 billion during the 2001-2010 period.

Subtitle C, Demonstration Projects. The act requires Medicare to conduct demonstration projects to evaluate the budgetary and health effects of Medicare coverage of disease management services, clinical trials for cancer treatment, and a lifestyle modification project. CBO estimates that those demonstrations will not have a significant effect on Medicare spending, because the clinical trials demonstration is small, the lifestyle modification provision largely codifies a demonstration project established under prior law, and the disease management demonstration will be difficult, if not impossible, to implement.

The disease management demonstration is a three-year project to evaluate the impact of disease management services on the costs and health of Medicare Part B beneficiaries with certain medical conditions. Participants will be entitled to coverage of all their prescription drugs through the enrolling disease management organization (DMO) with only “modest cost sharing.” Offering such highly desirable drug benefits will create strong demand for disease management services among chronically ill beneficiaries.

CBO expects that DMOs will not enter into contracts with the Secretary because of the nature of the agreements that are required by the act. The act specifies that the fee paid to DMOs be negotiated in a manner that would guarantee a “net reduction in expenditures under the Medicare program” for participating beneficiaries. Given such a requirement, it is unlikely that the full cost of prescription drugs could be covered by the negotiated fee. CBO anticipates that DMOs will not assume risk for all costs associated with providing drug coverage if those costs are not reflected in the negotiated fee, especially since DMOs will not have any gatekeeper authority to control access to or reimbursement for drugs or for covered Medicare benefits. Without participation by DMOs in the demonstration project, no significant costs will be incurred.

Title II: Rural Health Care Improvements

Subtitle A, Critical Access Hospitals. The BBA established special payment rules for rural hospitals designated as critical access hospitals. BIPA eliminates the cost-sharing requirement for Medicare beneficiaries receiving outpatient laboratory services from a critical access hospital and increases payment rates for certain physician services, skilled nursing services, and ambulance services furnished in or by those hospitals. CBO estimates those provisions will increase Medicare spending by less than \$50 million in 2001, \$0.2 billion during the 2001-2005 period, and \$0.7 billion through 2010.

Subtitle B, Other Rural Hospitals. Hospitals that serve a large number of low-income patients may qualify for a "disproportionate share" adjustment to the basic payment rates for inpatient services. Under prior law, rural hospitals faced higher thresholds than urban hospitals to qualify for that adjustment, and qualifying rural hospitals generally received a much lower percentage adjustment than urban hospitals. BIPA eliminates the separate thresholds for rural hospitals, and increases the size of the adjustment for most qualifying rural hospitals. The act also allows more hospitals to receive higher payments by making it easier to qualify as a Medicare-dependent, small rural hospital, or as a sole community hospital. CBO estimates those provisions will increase Medicare spending by \$0.1 billion in 2001, \$1.0 billion from 2001 through 2005, and \$2.3 billion through 2010.

Subtitle C, Other Rural Provisions. The act provides for additional payments for miles 17 through 50 for ambulance trips in rural areas between July 1, 2001, and January 1, 2004. The act also expands reimbursement for Medicare services provided via certain telecommunications systems, which began in a limited way under the BBA. Reimbursement will be limited to specific types of providers and service sites within rural areas and within areas participating in current federally-approved telemedicine demonstrations. Unlike prior law, the referring provider will no longer be required to be present during the telemedicine service, and the referring and consulting providers will no longer be required to split the service fee. In addition, the act establishes permanent authority for a physician assistant to bill Medicare directly if he or she owned a rural health clinic that lost the ability to bill directly under the BBA. It also exempts hospitals of fewer than 50 beds that own rural health clinics from the per-visit limit. CBO estimates that these provisions will cost less than \$50 million in 2001, \$0.3 billion between 2001 and 2005, and \$2.1 billion through 2010.

Title III: Provisions Relating to Part A

Subtitle A, Hospital Inpatient Services. CBO estimates that provisions in BIPA affecting payment rates for hospital inpatient services will increase Medicare spending by \$1.0 billion in 2001, \$5.2 billion from 2001 through 2005, and \$9.6 billion through 2010.

The act permanently increases payment rates by 1.1 percent for the operating-cost component of inpatient services furnished by hospitals paid under the prospective payment system. That increase was implemented on April 1, 2001, so there will be a temporary 2.2 percent increase to payment rates for the second half of fiscal year 2001. The act also establishes an additional temporary increase of 0.55 percent in 2002. Those changes will increase Medicare spending by \$0.5 billion in 2001 and by \$8.3 billion over the 2001-2010 period.

BIPA also increases the adjustments to payment rates in 2001 and 2002 for teaching hospitals and disproportionate share hospitals; delays until 2003 the full implementation of prospective payment systems for psychiatric, rehabilitation, and long-term hospitals and hospital units; and makes it easier for hospitals to qualify for higher payments by being reclassified into a nearby urban area. CBO estimates those provisions will increase Medicare spending by \$0.4 billion in 2001 and by \$1.3 billion through 2003; they will not have a significant effect on Medicare spending after 2003.

Subtitle B, Skilled Nursing Facilities. The BBA established a prospective payment system for services furnished by skilled nursing facilities. Under that system, which is being phased in through 2003, skilled nursing facilities will be paid a prospectively determined daily rate for each patient. That payment amount will be based on the resource utilization group (RUG) to which the patient is assigned based on characteristics of the patient's condition.

BIPA permanently increases the daily payment rates by 1 percent (implemented as a temporary 2 percent increase during the second half of fiscal year 2001), with a temporary additional increase of 0.5 percent in 2001 and a separate temporary one-sixth increase in the nursing component of the federal prospective payment rate from April 2001 through September 2002. The act also permits entities other than skilled nursing facilities to bill for services covered by Part B and furnished to patients who are not in a stay covered by Part A. CBO estimates the provisions related to skilled nursing facilities will increase Medicare spending by \$0.2 billion in 2001, \$1.5 billion from 2001 through 2005, and \$2.1 billion through 2010.

Subtitle C, Hospice Care. The act permanently increases payment rates for hospice services by 5 percent, beginning April 1, 2001. Federal spending will increase by less than \$50 million in 2001, \$0.6 billion during the 2001-2005 period, and \$1.4 billion through 2010.

Subtitle D, Waive Penalty for Late Enrollment. People automatically become eligible to enroll in Medicare Part A through employment (or through a spouse's employment) if they and their employer pay Medicare payroll taxes for at least 40 quarters. Others can buy into Medicare upon turning 65 by paying a Part A premium. However, if they do not enroll when they are first eligible, a late-enrollment penalty is added to that premium.

Until 1990, some people employed by state and local governments did not pay Medicare payroll taxes and did not become eligible to enroll in Part A through their employment. In many cases, the state or local government pays the Part A premium for such retirees. BIPA waives the late enrollment penalty, beginning in 2002, for those individuals. CBO estimates that this provision will reduce premium collections by less than \$50 million during the 2001-2010 period.

Title IV: Provisions Relating to Part B

Subtitle A, Hospital Outpatient Services. The BBA established a fee schedule for hospital outpatient services to replace a system under which hospitals were reimbursed based on their costs. BIPA permanently increases payment rates under that fee schedule by 1 percent and applies to additional technologies a provision in prior law under which hospitals that adopt new technologies that increase costs are paid outside the fee schedule for using those technologies. BIPA also broadens the set of hospitals that are covered by provisions that limit the amount that their payments will decline as a result of the transition to the fee schedule. CBO estimates those provisions will increase Medicare spending by \$0.5 billion in 2001, \$5.7 billion from 2001 through 2005, and \$14.2 billion through 2010.

Paying for more cost-increasing new technologies outside the fee schedule accounts for \$12.7 billion of the 10-year total. The Balanced Budget Refinement Act of 1999 (BBRA) established the separate payment for cost-increasing new technologies. Under the BBRA provision, Medicare pays for those services based on their cost; those separate payments cannot exceed 2.5 percent of Medicare spending for hospital outpatient services. (That limit is reduced to 2.0 percent in 2004 and subsequent years.) The BBRA requires a proportional reduction in each separate payment if the Secretary estimates that the limit will be exceeded. Payments for a service may be based on cost for up to three years before it must be brought back onto the fee schedule.

CBO estimates that the cost of technologies eligible for separate payment under the rules established by BBRA and modified by BIPA will substantially exceed the limits established by BBRA. CBO's estimate is based on the assumption that the Secretary will not impose the draconian reductions in payment rates that would keep the separate payments within the 2.5 percent limit for 2001, and that those higher payments will be incorporated into the fee schedule in subsequent years.

Subtitle B, Physicians' Services. BIPA authorizes a demonstration project to evaluate the use of incentive payments to physicians' group practices to encourage coordination of care through efficient service delivery systems. CBO estimates that this demonstration project will not have a significant effect on Medicare spending.

Subtitle C, Other Services. The act permanently increases payment rates for many Part B services, temporarily increases spending for other services by postponing implementation of provisions in prior law, and modifies the eligibility criteria for providers of Part B services. CBO estimates these provisions will increase Medicare spending by \$0.1 billion in 2001, \$1.2 billion between 2001 and 2005, and \$2.7 billion through 2010.

Providers of dialysis services, durable medical equipment, prosthetics and orthotics, and ambulance services will receive higher updates to payment rates in 2001 (and in 2002 for some services), which will permanently increase the amounts paid for those services. The act temporarily increases spending for occupational and physical therapy services, ambulatory surgery, and drugs and biologicals covered under Part B, by delaying implementation of provisions in prior law that would have reduced spending for those services.

BIPA also authorizes certain tribal facilities and Indian Health Service facilities to bill Medicare directly (rather than submitting claims to the Indian Health Service) and modifies the qualifications for community mental health centers and suppliers of prosthetics and orthotics to provide services covered by Medicare.

Title V: Provisions Relating to Parts A and B

Subtitle A, Home Health Services. CBO estimates the provisions applicable to home health agencies will increase federal payments by \$0.7 billion in 2001, \$1.8 billion through 2005, and \$3.8 billion through 2010. The act delays for one year the 15 percent reduction in the home health payment rates set to occur October 1, 2001, and it increases the update for home health payment rates in 2001 by 1.1 percent. It eliminates periodic interim payments to the home health agencies, but to assist with the transition, it provides for a payment to qualifying agencies equal to four times the last full fortnightly periodic interim payment. That additional periodic interim payment will be included in the settlement of the last cost report from the interim payment system. The act also clarifies the law regarding the use of telemedicine by home health agencies, and it modifies the definition of homebound to permit beneficiaries to regularly attend certain adult day-care programs without violating the requirement that the beneficiary be confined to his or her home. The act also temporarily increases payments to rural home health agencies by 10 percent from April 1, 2001, through March 31, 2002.

Subtitle B, Direct Graduate Medical Education. BBRA established a floor for calculating Medicare payments for the cost of operating a medical education program at 70 percent of the adjusted national average cost per resident. BIPA raises that floor to 85 percent of the national average. In addition, the act changes the formula by which subsidies for nursing and allied health education programs are allocated to hospitals. CBO estimates those provisions will have a negligible effect on Medicare spending in 2001, and will increase Medicare spending by \$0.4 billion over the 2001-2005 period and by \$0.8 billion through 2010.

Subtitle C, Coverage and Appeals Process. The act modifies the Medicare coverage and appeals process in a number of ways. In general, it specifies time limits for initial determinations and instructs the Secretary to enter into contracts with independent contractors to review appealed claims. The act also establishes a process for an expedited review if a physician believes a denied claim will put a beneficiary at risk. In addition, the act clarifies the circumstances under which a beneficiary can challenge a decision at the national or local level that Medicare does not cover a service. CBO estimates the cost of the coverage and appeals provisions to be less than \$50 million in 2001, \$0.4 billion between 2001 and 2005, and \$2.0 billion through 2010.

Subtitle D, Access to New Technologies. The act modifies the process for establishing codes and payment rates for certain clinical laboratory tests and durable medical equipment. CBO estimates those provisions will increase Medicare spending by \$0.1 billion between 2001 and 2010.

BIPA also requires the Secretary to establish a mechanism for paying additional amounts to hospitals that employ cost-increasing new technologies in inpatient care. As with the provision establishing separate payments for the use of cost-increasing technology in hospital outpatient departments, this provision is intended to be budget-neutral. Unlike that provision, the budget-neutrality adjustment will be implemented by reducing the basic payment rate for all inpatient services (rather than by reducing the separate payment for the cost-increasing technologies.) CBO assumes that the budget-neutrality adjustment will be effective, and estimates that the provision will not have a significant effect on Medicare spending.

Subtitle E, Other Provisions. BIPA increases Medicare payments to hospitals for "bad debt"—the cost-sharing amounts that hospitals do not collect from Medicare beneficiaries or from Medicaid programs on behalf of certain low-income Medicare beneficiaries—from 55 percent of bad debt to 70 percent. CBO estimates that this provision will increase Medicare spending by \$0.2 billion in 2001, \$1.2 billion through 2005, and \$2.7 billion through 2010.

This provision will also affect Medicaid, which pays for cost sharing for certain low-income Medicare beneficiaries. States have the option of limiting their payments for cost sharing for

these beneficiaries to the difference between their Medicaid rates and the amount that Medicare pays. (If a state's Medicaid rate is less than the Medicare payment, the state may choose to pay nothing for cost sharing.) About two-thirds of states have chosen to pay cost sharing based on Medicaid rates.

Although hospitals are required to accept Medicaid rates as payment in full, any unpaid cost sharing is considered bad debt under Medicare rules. Under BIPA, CBO expects that more states will limit their cost sharing to Medicaid rates, since Medicare will now pay a larger share of the resulting bad debt. CBO estimates this change will lower federal Medicaid spending by \$1.2 billion over the 2001-2010 period. (Those federal Medicaid savings are included in the “Medicaid Spending for Medicare Enrollees” line in the table.)

Title VI: Medicare Managed Care

BIPA makes numerous changes to the Medicare+Choice program, which pays managed care organizations for services to enrolled Medicare beneficiaries. Prior law established a minimum monthly payment rate (\$415 in 2001, before adjusting for demographic factors and health status) and guaranteed that the monthly payment rate would increase by at least 2 percent each year. BIPA raises the minimum amount in 2001 to \$475 in most counties and to \$525 in counties in metropolitan areas with a population greater than 250,000. The act also increases the minimum update to 3 percent for 2001. BIPA also extends to 10 years the transition to the use of improved methods of adjusting payments to Medicare+Choice plans to reflect differences in expected costs related to beneficiaries' health status. The act also extends and modifies a number of managed care demonstration projects. CBO estimates those provisions will increase Medicare spending by \$0.6 billion in 2001, \$4.9 billion over the 2001-2005 period, and \$12.4 billion through 2010.

Title VII: Medicaid

CBO estimates that the provisions of title VII will reduce federal Medicaid spending by \$16.3 billion over the 2001-2005 period and \$68.2 billion over the 2001-2010 period. These savings are in addition to the effects of the act's Medicare provisions on Medicaid spending that were discussed earlier. Title VII will also increase outlays for Medicare (by \$0.1 billion and \$0.3 billion, respectively, over the same periods) and SCHIP (by less than \$50 million and by less than \$0.1 billion, respectively, over the same periods).

Increased disproportionate share hospital (DSH) payments. The act makes a number of changes to the Medicaid DSH program and provides assistance to certain public hospitals. In total, these changes will increase federal Medicaid spending by \$3.9 billion over the

2001-2005 period and \$6.1 billion over the 2001-2010 period.

Special rule for 2001 and 2002 allotments. Prior law established allotments for each state that set an upper bound on federal Medicaid DSH payments for each year from 1998 through 2002. Allotments for most states declined during this period. After 2002, state allotments were set at the 2002 amount adjusted for inflation.

Under BIPA, DSH allotments for 2001 and 2002 will be the 2000 amount adjusted for inflation. DSH allotments in later years will still be based on the 2002 amounts set under prior law. CBO estimates that these higher allotments will increase federal DSH spending by \$0.3 billion in 2001 and \$0.6 billion in 2002, with no change in subsequent years. This estimate is net of an offsetting decrease in payments for hospital services.

Higher allotments for low-DSH states. The act increases the 2001 allotments for states whose 1999 DSH spending was greater than zero and less than 1 percent of their total Medicaid spending. For these states, the 2001 allotment will be 1 percent of their total (federal and state) Medicaid spending in 2001. In later years, the DSH allotments for these states will be the 2001 amount adjusted for inflation.

CBO anticipates that this provision will affect 11 states, raising their combined DSH allotments in 2001 from \$37 million to \$115 million. However, some states will probably not be able to spend all of their additional allotments because of various restrictions on how DSH funds may be spent. Overall, CBO estimates that this provision will raise federal Medicaid spending by \$0.3 billion over the 2001-2005 period and \$0.6 billion over the 2001-2010 period.

Identification of Medicaid managed care patients. BIPA clarifies that Medicaid enrollees in managed care plans should be included in the calculation of a hospital's inpatient and low-income utilization rate, a factor used to determine which hospitals are eligible to receive DSH payments. The act also specifies that states must require that managed care organizations provide information regarding hospital services paid for by Medicaid. CBO estimates that this provision will increase federal DSH outlays by less than \$50 million over the 2001-2010 period.

Temporary increase in limit on DSH payments to individual hospitals. Under prior law, DSH payments to an individual hospital were limited to 100 percent of the hospital's costs for uncompensated care. (A special rule gave California a higher limit of 175 percent.) BIPA raises the limit on DSH payments to public hospitals in all states to 175 percent of uncompensated care for two state fiscal years, starting with the first fiscal year that begins after September 30, 2002. (For most states, this will be the fiscal year that starts on July 1, 2003.) The act also increases the expenditure limits for states with section 1115

waivers (which allow states to conduct demonstration projects and hold states to certain spending limitations) to reflect DSH payments that exceed 100 percent of the cost of uncompensated care. CBO's estimate assumes that this change will allow states with section 1115 waivers to make payments to DSH hospitals in excess of their allotments.

CBO estimates that these provisions will increase federal Medicaid outlays by \$1.9 billion over the 2001-2010 period, and that this additional spending will occur entirely in states with section 1115 waivers⁵. (Because all states are likely to spend their entire DSH allotment by fiscal year 2003, the 175 percent limit may affect the distribution of DSH spending among states that do not have section 1115 waivers, but not the total amount.)

Assistance for certain public hospitals. Starting in 2002, the act will allow states to make additional payments to public hospitals that were in operation on October 1, 2000, were not receiving DSH payments on that date, and have a low-income utilization rate of 65 percent or higher. Those payments will not be subject to annual state DSH allotments and will be limited to \$15 million in 2002, \$176 million in 2003, \$269 million in 2004, \$330 million in 2005, and \$375 million annually after that.

CBO anticipates that at least one hospital (Cook County Hospital in Illinois) will qualify for those payments and that, even if no other hospitals qualify, payments to that hospital alone will equal the amounts authorized. As a result, CBO estimates that this provision will increase federal Medicaid spending by \$0.8 billion over the 2001-2005 period and \$2.7 billion over the 2001-2010 period.

New payment system for federally qualified health centers (FQHCs) and rural health clinics (RHCs). Previously, payments for services provided by FQHCs and RHCs were based on Medicaid's share of total costs in those facilities. The Medicaid share was usually determined using the percentage of visits that were covered by Medicaid. Prior to BBA, states had to reimburse FQHCs and RHCs for 100 percent of their Medicaid-related costs. BBA (and subsequent changes made by BBRA) phased out this requirement, allowing states to reduce their payments to 95 percent of costs in 2001 and 2002, 90 percent in 2003, and 85 percent in 2004. After 2004, states would no longer have had to pay based on costs. At the end of 2000, states with over half of all FQHC enrollees had chosen to continue cost-based reimbursement.

BIPA requires states to reimburse FQHCs and RHCs using a new payment system based on a fixed payment per visit. In 2001, the amount of this payment will be based on 100 percent of the average cost per visit over the 1999-2000 period, adjusted for any change in the

⁵ After CBO prepared its estimate, the Administration indicated that, according to its interpretation of this provision, states will not be able to make payments in excess of their allotments. As a result, these provisions will not affect DSH spending.

intensity of services provided. This initial per-visit amount will then be adjusted annually for any inflation in the cost of primary care services and any change in the intensity of services provided.

CBO anticipates that FQHCs and RHCs will respond to the new payment system by increasing the number of visits used to provide services to Medicaid beneficiaries. With a fixed payment amount per visit, the additional visits will result in higher Medicaid payments to FQHCs and RHCs, even in states that had chosen to continue cost-based reimbursement under prior law. By 2005, CBO expects that Medicaid visits in FQHCs and RHCs will be 10 percent higher than they would have been under prior law. We estimate that this new payment system will increase federal Medicaid outlays by \$0.3 billion over the 2001-2005 period and \$1.0 billion over the 2001-2010 period.

Expansion of County-Operated Health Systems. California's Medicaid program includes entities known as County-Operated Health Systems (COHSs), which are managed care systems that are paid on a fully-capitated basis and offer comprehensive services to all Medicaid beneficiaries in a single county or group of counties. Payment rates for these entities are determined through confidential negotiations between the state and the COHSs.

Prior law limited total COHS enrollment to 10 percent of the state's Medicaid population. BIPA raises this limit to 14 percent. CBO anticipates that this will lead to higher spending because the state will have less leverage in negotiating rates with the newly-expanded COHSs, and because payment rates to existing COHSs are somewhat more generous than other managed care arrangements. CBO estimates that this provision will increase federal Medicaid outlays by less than \$50 million over the 2001-2005 period and \$0.1 billion over the 2001-2010 period.

Issuance of final regulation on Medicaid upper payment limits. BIPA requires the Secretary of Health and Human Services to issue a final regulation that will restrict the amount of Medicaid payments that states may make to facilities that are operated by local governments and thus curtail the use of an accounting practice that allows states to artificially inflate their reimbursable spending. This final regulation must be based on a proposed rule that was announced on October 5, 2000, with certain modifications. CBO's estimate for the provision is based on those parameters, although they may differ in certain respects from the final rule that was published in the *Federal Register* on January 12, 2001. CBO estimates that this provision will reduce federal Medicaid outlays by \$21.7 billion over the 2001-2005 period and \$77.3 billion over the 2001-2010 period.

Background. Under prior law, federal regulations limited total Medicaid payments that states could make to each class of health care facility—hospitals, nursing homes, outpatient clinics, and intermediate-care facilities for the mentally retarded (ICF/MRs)—to the amount that

would be paid for the same services using Medicare's payment principles. This amount is commonly known as the Medicare upper payment limit (UPL). The UPLs for outpatient clinics and ICF/MRs applied to all private and public facilities, while hospitals and nursing homes had two separate UPLs: one for facilities operated by state governments and one for all other facilities.

Since Medicaid rates are typically lower than Medicare rates, most states had room to increase their Medicaid payments without exceeding the UPL. This difference gave states an opportunity to use financing mechanisms to generate additional federal matching funds without increasing state Medicaid spending.

Below is a simplified description of how the UPL mechanism works:

State raises payment rates for local facilities. A state estimates the UPL (using a methodology approved by the Health Care Financing Administration, now known as the Centers for Medicare and Medicaid Services) for a particular class of facility and calculates the additional amount that it can spend without violating the UPL. The state then increases its Medicaid spending by this amount by raising payment rates, but only for facilities operated by local governments. Since local governments operate only a small fraction of all health care facilities (for example, less than 10 percent of all nursing home beds are operated by local governments), the new rates are often dramatically higher than previous rates (for example, rates might jump from \$100 per day to \$1,500 per day).

State pays local facilities based on higher rates. The state then pays local government facilities for Medicaid services using the higher rates. States may use their own funds or funds borrowed from local governments to make the additional payments. The facilities (or the local governments that run them) then repay to the state the added amount received as a result of the higher payment rates. Once these transfers are taken into account, state Medicaid payments to local government facilities are often no different than they were before the UPL mechanism was put in place.

State receives federal matching payment. The state then claims federal matching funds for the higher Medicaid payments made to local government facilities. The higher payment rates for the local government facilities allow the state to receive extra federal matching funds without, on net, having to spend any additional state funds to get them. The state can use the additional matching funds for any purpose. States with UPL mechanisms have spent their extra funds on additional Medicaid services (using the funds as the state match to draw down more federal matching funds), on health programs other than Medicaid, and on education or other programs.

The Health Care Financing Administration estimated that at least 26 states were using UPL mechanisms by the end of 2000. Although some states have been using these mechanisms for years, the number engaged in the practice grew rapidly in 2000 as more states learned about UPL financing mechanisms and hurried to enact them—and receive additional federal funds—before the federal government moved to curb the practice. CBO estimates that, without the new regulation issued pursuant to BIPA, federal Medicaid spending due to the UPL mechanism would have grown rapidly, jumping from \$6.8 billion in 2001 to \$23.2 billion in 2010. UPL-related spending would have totaled \$60 billion over the 2001-2005 period and \$160 billion over the 2001-2010 period.

Major elements of the regulation. The regulation will curb, but not eliminate, states' ability to receive additional federal matching funds using the UPL accounting practice. The regulation will create separate UPLs within each provider class for private facilities, facilities operated by local governments, and facilities operated by state governments. Under prior law, states were able to generate very high federal payments mainly because they could aggregate private and local spending for the calculation of the UPL, and direct that extra spending to local facilities only. Without the ability to aggregate private and local spending, states' ability to generate additional federal matching funds will be greatly reduced because payment rates for local government facilities will no longer be inflated to reflect the additional payments that could be made to private facilities.

The UPL will still be defined as the amount that would be paid for services under Medicare payment principles. The only exception is for hospitals operated by local governments, which will have a UPL equal to 150 percent of the Medicare amount. That provision of the regulation will dampen the overall effects of the regulation, and expand states' ability to generate federal funds for local hospitals. Ultimately, CBO anticipates that the final regulation will reduce states' ability to generate additional federal funds through UPL mechanisms by 95 percent for nursing homes and about 33 percent for hospitals.

The full reduction in states' ability to generate additional federal funds through UPL mechanisms will be realized beginning in fiscal year 2009, because the final regulation also provides three sets of transition rules for states with UPL mechanisms. Those transition rules are based on the effective dates for the amendments to the Medicaid plans that created them:

States with effective dates on or after October 1, 1999. These states will be able to continue using their current UPL mechanisms until September 30, 2002. CBO's estimate assumed that the final regulation would take effect on December 31, 2000, (the deadline specified in BIPA for issuance of the regulation) and that any states without approved state plan amendments would have to conform immediately to the new UPL rules⁶.

⁶ The regulation took effect March 5, 2001.

States with effective dates after October 1, 1992, and before October 1, 1999. These states will be permitted to phase out their existing UPL mechanisms over a three-year period beginning in the state fiscal year that starts after September 30, 2002. (For most states, this will be the fiscal year that starts on July 1, 2003.) States will have to reduce their UPL-related spending by 25 percent in the first year, 50 percent in the second year, and 75 percent in the third year.

States with effective dates on or before October 1, 1992. BIPA specifies that these states will be permitted to phase out their current UPL accounting practices over a six-year period, beginning with the first state fiscal year that starts after September 30, 2002. (For most states, this will be the fiscal year that starts on July 1, 2003.) States must reduce their UPL-related spending by 15 percent annually and be in full compliance with the new regulation by October 1, 2008. CBO anticipates that five states—California, Illinois, New Mexico, Pennsylvania, and Wisconsin—will fall in this category.

Once these transition rules are taken into account, CBO estimates that the final regulation will reduce UPL-related spending by half over the 2001-2005 period and by two-thirds over the 2001-2010 period.

Likelihood of administration action under prior law. CBO's estimate for this provision assumed that under prior law there was some probability that the administration would have acted on its own to limit states' use of UPL financing mechanisms. As a result, estimated savings do not represent the full impact of the regulation on Medicaid spending.

Subsequent developments. Several states had amendments to their Medicaid plans that would establish or expand UPL mechanisms pending with HCFA. CBO assumed that HCFA would not approve these plan amendments until they were revised to comply with the new UPL regulation. However, the Administration has approved these amendments without changes, so these states will be eligible for a two-year transition period before they have to comply with the new UPL regulation. As a result, federal Medicaid spending related to UPL mechanisms will be higher in 2001 and 2002, and the cost savings associated with BIPA will be lower, than CBO had anticipated.

Increased federal medical assistance percentage for Alaska. BIPA establishes a special formula to determine the federal medical assistance percentage (FMAP) for Alaska for the 2001-2005 period. The FMAP is the federal government's share of Medicaid spending for most services. CBO anticipates that Alaska's FMAP for 2001 will be 60.1 percent under the new formula, compared to 56.0 percent under prior law. CBO estimates that this provision will increase federal Medicaid outlays by \$0.2 billion over the 2001-2005 period.

Extension of transitional Medicaid. States are required to continue Medicaid benefits for certain welfare-related beneficiaries who would otherwise lose their coverage because of

increased earnings. Under prior law, this requirement expired at the end of 2001; the act extends it through 2002. CBO estimates that this provision will increase federal Medicaid spending by \$0.5 billion over the 2001-2005 period.

Allow additional entities to determine presumptive eligibility. The act will expand the kinds of entities that states may use to determine presumptive eligibility under Medicaid to include SCHIP eligibility workers, schools, and certain other entities. CBO estimates that this provision will raise Medicaid spending by \$0.4 billion over the 2001-2005 period and \$1.0 billion over the 2001-2010 period. States that use these new entities will also find additional children who are eligible for SCHIP, increasing outlays in that program by less than \$50 million over the 2001-2005 period and \$0.1 billion over the 2001-2010 period.

Uniform application form for QMB and SLMB benefits. The act will require the Secretary of Health and Human Services to develop a simplified application form for qualified Medicare beneficiary (QMB) and specified low-income Medicare beneficiary (SLMB) benefits. (Under the QMB program, Medicaid pays all Medicare premiums and cost sharing for Medicare beneficiaries with incomes below the poverty level. Under the SLMB program, Medicaid pays the Part B premium for Medicare beneficiaries with incomes between 100 and 120 percent of the poverty level. Both QMB and SLMB beneficiaries must also have limited assets.) States' use of the simplified form is optional. This provision will take effect one year after enactment.

CBO estimates that this provision will slightly increase QMB and SLMB enrollment, raising federal Medicaid spending by \$0.1 billion over the 2001-2005 period and \$0.2 billion over the 2001-2010 period. CBO assumes that newly-enrolled QMBs will also consume more Medicare services because they will no longer have to pay cost sharing, raising Medicare outlays by \$0.1 billion and \$0.3 billion, respectively, over the same periods.

Effects of Medicare Provisions on Medicaid Spending for Medicare Enrollees

A change in the Medicare Part B premium affects federal Medicaid spending because Medicaid covers the cost of that premium for individuals who are eligible for both Medicaid and Medicare and for other low-income Medicare beneficiaries who do not qualify for full Medicaid benefits. In addition, higher Medicare payment rates will also affect the amount of cost-sharing owed by beneficiaries; Medicaid covers those cost-sharing payments for certain low-income individuals. On the other hand, several Medicare provisions are likely to reduce Medicaid spending by substituting Medicare payments for services that previously were the responsibility of the Medicaid program. On balance, CBO estimates that those interactions will have little effect on Medicaid spending through 2005, and will increase Medicaid spending by \$0.6 billion during the 2001-2010 period.

Title VIII: State Children's Health Insurance Program

CBO estimates that Title VIII will increase SCHIP outlays by less than \$50 million over the 2001-2005 period and by \$0.1 billion over the 2001-2010 period. Due to interactions between SCHIP and Medicaid, this title will also reduce Medicaid outlays by less than \$50 million over the 2001-2010 period.

BIPA establishes special rules for the redistribution and availability of the allotments that states received in 1998 and 1999 under SCHIP. Under prior law, states had three years to spend those allotments. After three years, all unspent funds would have been made available for another year and redistributed to states that had spent their entire allotments.

Under the act, the amounts that will be redistributed in 2001 and 2002 will be less than what they would have been under prior law. States that have spent their 1998 allotment will receive a redistribution in 2001 equal to the difference between their total SCHIP spending between 1998 and 2000 and their 1998 allotment. Similarly, redistributions for 2002 will equal the difference between spending between 1999 and 2001 and the 1999 allotment. The states that have been unable to spend their allotments within three years will receive the remaining amounts. All funds from the 1998 and 1999 allotments will remain available through 2002. Finally, the act also allows states to spend additional funds from their 1998 allotments on outreach activities.

The provision effectively transfers SCHIP funds from states with developed programs that spend most or all of their allotments to states with less mature programs that are far below their allotment amounts. For this reason, CBO estimates that this provision will increase outlays by less than \$50 million over the 2001-2005 period and by \$0.1 billion over the 2001-2010 period.

Title IX: Other Provisions

PACE Waivers. The act authorizes the Secretary to extend waivers for providers to operate under the Program of All-Inclusive Care for the Elderly (PACE) for an additional year, and grants the Secretary additional flexibility in negotiating the terms of those waivers. CBO estimates that provision will increase Medicare spending by \$0.1 billion over the 2001-2005 period.

Mandatory Appropriations. BIPA appropriates \$475 million in 2001 for the Ricky Ray Hemophilia Relief Fund. The act also appropriates \$140 million in both 2001 and 2002 and \$200 million in 2003 for diabetes programs administered by the Centers for Disease Control, the Indian Health Service, and the National Institutes of Health. CBO estimates that these appropriations will increase spending by \$0.9 billion over the 2001-2005 period.

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