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MEDICARE SAVINGS FOR HEALTH CARE: CAN CONGRESS STAY THE COURSE?

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With the President's commitment that health care legislation will not increase the deficit, the savings included in any bill must be durable. Because large amounts of the savings proposed come from Medicare, it is useful to review the history of previously enacted Medicare reductions.

As it turns out, roughly one-third of the \$390 billion in savings enacted in the Balanced Budget Act of 1997 have since been reversed (see Table 1 below) – and with bipartisan support. In addition, Democratic-led Congresses have twice turned off a “trigger” mechanism, established in the Medicare prescription drug bill, that would have required savings when Medicare's financial instability crossed a defined threshold. The pattern makes clear that Congress often backs away from Medicare savings even after they have been enacted – an important recognition in the current health care debate.

The discussion below details the recent history.

RECENT MEDICARE SAVINGS AND GIVEBACKS

- **The Balanced Budget Act [BBA] of 1997.** The BBA's \$390 billion in projected savings came from slowing the rate of growth in payments to hospitals, physicians, and other providers, and from establishing prospective payment systems and other new payment methodologies for skilled nursing facilities, home health agencies, and other service providers.

In the 10 years prior to BBA, Medicare spending grew at an average annual rate of about 10 percent. After the BBA's enactment – it was signed into law on 5 August 1997 – Medicare spending slowed significantly; and in fiscal year 1999, for the first time ever, spending dropped below the prior year's level by almost 1 percent.

Nevertheless, as provider groups and health care industry representatives balked – arguing that the payment changes were too severe and threatened their ability to provide services to beneficiaries – the House and Senate considered bills to mitigate the BBA's impact, as described below.

- **The Balanced Budget Refinement Act of 1999 [BBRA].** Congress's first attempt to reverse BBA savings returned approximately \$22 billion to health care providers over 10 years. About three-fourths of the spending went to hospitals, skilled nursing facilities,

home health agencies, and Medicare’s private plans – all of which are again targeted as savings to pay for health care reform in the bills currently being considered by Congress.

Table 1: Recent Medicare Savings and Givebacks
(in billions of dollars)

Bill or Provision	10-Year Savings (-) or Costs
Savings	
Balanced Budget Act of 1997	
Title IV: Medicare, Medicaid, and Children's Health	-390
Givebacks	
Balanced Budget Refinement Act of 1999	
Titles I, II, III, IV, VI, and VII (excluding receipts)	22
Benefits Improvement and Protection Act of 2000	
Titles I, II, III, IV, V, VI, and IX (excluding receipts)	94
Sustainable Growth Rate Increases ('Doc Fixes')	5-Year Costs
2003	22
2004-05	2
2006	7
2007	3
2008	8
2009	6
2010 (estimate)	11
Total Sustainable Growth Rate Increases	60

Source: Congressional Budget Office estimates.

- **The Benefits Improvement and Protection Act of 2000 [BIPA].** Like the BBRA, the Medicare proposals included in BIPA were designed to increase payments for Medicare services that had been reduced in the BBA. Again, provider groups claimed the BBA reductions were affecting quality and access for beneficiaries (although the Medicare Payment Advisory Commission [MedPAC] testified there was no evidence to that effect at the time) and Congress was pressured to act – this time to the tune of \$94 billion in spending over 10 years.
- **Medicare Physician Payments.** The Medicare physician payment formula, in place since 1992, was designed to relate physician payments to resources used in providing services. The intent of the formula, calculated using the Sustainable Growth Rate [SGR], was to place a restraint on overall increases in Medicare spending for physician services. If expenditures exceeded the target, the payment update for future years was to be reduced. Beginning in 2002, however, as expenditures exceeded targets and reductions were scheduled to occur, Congress began passing legislation – known as the “doc fix” – to prevent this from happening.

Beginning in 2001, and most recently in 2009, Congress has passed “doc fix” legislation annually, returning \$60 billion in Medicare savings to physicians.
- **Medicare Trigger.** The Medicare Modernization Act [MMA] of 2003 (the prescription drug bill) established a requirement for the administration to submit Medicare savings proposals when two consecutive Medicare Trustees reports projected the program’s

spending from general revenues would exceed 45 percent. But instead of considering these savings proposals, Congress has acted twice to turn off the trigger – once in the 110th Congress by claiming that a spending bill met the trigger requirement, and again in the 111th by using the House rules process to turn off the trigger for the remainder of the congressional session. In both cases, the trigger was disengaged on party-line votes.

TODAY’S HEALTH CARE DEBATE

Looking at history, it is clear that while it is difficult for Congress to sustain Medicare savings, it is even harder for Congress to slow entitlement spending.

Medicare already has an unfunded liability of \$38 trillion, and its costs are soaring. The Congressional Budget Office continues to project the program will eventually consume the entire Federal budget. Nevertheless, each year Congress fails to take needed steps toward reform, making the problem worse.

The health care proposals being considered by Congress do not slow Federal health entitlement spending. In fact, they make it harder to address this growing problem because they redirect Medicare savings to Medicaid expansions and a new health entitlement for millions of Americans – at a cost that approaches \$1 trillion over 10 years.

Moreover, just as the State Children’s Health Insurance Program [SCHIP] rapidly outran its expected costs (now growing at a rate of 24 percent over the next 5 years), so too will these new entitlements – which far exceed SCHIP in size and scope. If it has been difficult to restrain SCHIP spending, it will be even more difficult for Congress constrain spending on a program intended for *all* Americans. Once the Medicare savings fall short, Congress will be forced to pay for health reform by increasing taxes or deepening the deficit – or some combination of the two.

Absent reform, the Federal Government cannot afford its existing entitlement programs, let alone create new ones; and the problem threatens both the budget and the economy. As stated by the Brookings-Heritage Fiscal Seminar – a bipartisan group of budget experts – in its April 2008 report, *Taking Back Our Fiscal Future*: “If the wedge between spending and revenue attributable to social insurance programs continues to grow, taxes would have to be raised continuously and would eventually cripple the economy.”

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