GAO
United States General Accounting Office
Washington, DC 20548

Human Resources
Division

B-199164

JUNE 12, 1980

The Honorable George M. O'Brien
House of Representatives

Dear Mr. O'Brien:

Subject: Questions About the Cost-Benefit Analyses of the Professional Standards Review Organization Program (HRD-80-93)

Your May 20, 1980, letter, asked four questions related to the cost-benefit analyses of the Professional Standards Review Organization (PSRO) program conducted by the Congressional Budget Office (CBO) and the Department of Health and Human Services (HHS). 1/ This letter provides answers to these questions. As discussed with your office, a summary of the differences between the CBO and HHS analyses is enclosed.

(1) Under the existing PSRO law (Title XI of the Social Security Act) do the PSROs have statutory authority to require health care institutions to submit to review of patients who are not covered by Medicare or Medicaid?

Under Title XI of the Social Security Act, PSROs, on their own initiative, do not have statutory authority to review medical care services provided to private (nonfederally reimbursed) patients. Third-party payers, such as private health insurers, may contract with PSROs to conduct reviews of health care services reimbursed by those organizations. The cost of such review must be fully paid by the third-party payer.

1/Until May 4, 1980, the PSRO program was administered by the former Department of Health, Education, and Welfare. Upon establishment of a separate Department of Education, the PSRO program came under the jurisdiction of HHS.

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(2) If PSROs do not have statutory authority to require health care institutions to submit to review for non-Medicare/Medicaid patients, are health care institutions free to disregard PSRO attempts to perform such review of non-Medicare/Medicaid patients?

In the absence of agreements among the third-party payer, the health care institutions, and the PSRO, the institutions are not obligated to submit to PSRO review of the health care services provided to other than Medicare/Medicaid patients.

(3) If PSROs cannot require health care institutions to submit to review of non-Medicare/Medicaid patients, in estimating PSRO's costs and savings, is it an appropriate methodology to include costs relating to patients which PSROs are not authorized to review?

In determining a benefit-to-cost ratio for the PSRO program (estimating PSRO's costs and savings), it may, as discussed below, be appropriate to include costs relating to patients which PSROs are not authorized to review.

Under Medicare reimbursement procedures most of a hospital's fixed costs--for example, building depreciation--and some variable costs are allocated between Medicare and all other payers based on the ratio of Medicare inpatient days to total inpatient days. Therefore, if the number of Medicare days is reduced by PSRO review while the number of non-Medicare days remains constant, Medicare will pay for a lower percentage of the fixed costs allocated on the ratio of days basis. However, since fixed costs are not lowered in the shortrun by decreased utilization, non-Medicare patients will pay more per day of care to cover the hospital's fixed costs. Thus, while Medicare's costs per day are lowered when the Medicare utilization rate decreases, non-Medicare costs per day are increased.

HHS looked at PSROs as a Federal program and measured savings as the reduction in Medicare expenditures. CBO looked at the impact PSROs had on total hospital expenditures (governmental and public combined) which resulted in a lower savings estimate because this view eliminates the effects

of Medicare's cost allocation procedures. 1/ Deciding which benefit-to-cost ratio appropriately measures PSRO program effectiveness depends on whether one views the PSRO program as trying to control Federal expenditures for hospital care or total expenditures for hospital care.

(4) In addition to the PSRO program, identify any other health programs administered by HHS which have been subject to cost-benefit analysis. If there are such programs, is their cost-benefit ratio better or worse than PSROs? Do the budget levels adopted for health programs bear any relationship to a cost-benefit anaylsis of the program?

We are not aware of any other health programs administered by HHS which have been subjected to an extensive cost-benefit analysis. Other programs with purposes similar to the PSRO program--i.e., controlling health costs--such as the health planning program and the health maintenance organization program, have not been thoroughly analyzed from a cost-benefit viewpoint.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 5 days from the date of the report. At that time we will send copies to interested parties and make copies available to others upon request.

I trust that this information is responsive to your needs.

Sincerely yours,

Gregory J. Ahart
Director

Enclosure

1/Neither the HHS nor CBO benefit-to-cost ratios consider savings that result from PSRO's review of Medicaid patients.

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SUMMARY OF DIFFERENCES

BETWEEN TWO COST-BENEFIT ANALYSES

OF THE PSRO PROGRAM

The most recent HHS evaluation of the PSRO program concluded that for every dollar spent by the program during calendar year 1978 for Medicare concurrent review, there is a savings of $1.27 in Medicare reimbursements. However, CBO has concluded that for every dollar spent only $0.40 in resources were saved.

The difference between these conclusions is due to differences concerning what constitutes savings, how utilization rates are measured, and how monetary values are assigned to the days of care saved.

WHAT CONSTITUTES SAVINGS-- REDUCTIONS IN FEDERAL OR NATIONAL EXPENDITURES?

The HHS cost-benefit analysis measured savings resulting from PSRO review as the amount by which Medicare expenditures for hospital services were reduced. CBO measured savings as the amount by which total expenditures (governmental and private) for hospital services were reduced. There is a significant difference between measuring savings in those two ways because Medicare's cost allocation procedures result in a lowering of the percentage of fixed costs borne by the program when its share of total hospital utilization decreases. However, since fixed costs are not lowered in the shortrun by by decreased utilization, non-Medicare patients will pay more per day of care to cover fixed costs.

HHS' method looks at PSROs as a Government program and measures the savings to the Federal Government. CBO's method looks at PSROs as a national program and measures the savings to all hospital payers. This difference in viewpoints accounts for 80 percent of the difference in the two cost-benefit ratios.

HOW ARE UTILIZATION RATES MEASURED--ON A FULLY IMPLEMENTED OR AS-IS BASIS

In making its analysis HHS studied only those areas of the country which had a PSRO actually performing hospital

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utilization review. HHS found that in the aggregate these areas had a decrease of 1.7 percent in the days of care provided to Medicare beneficiaries. CBO based its estimates on a fully implemented PSRO program. CBO assumed that, if PSROs were operational in all areas of the country, they would have the same costs and the same benefits as currently operating PSROs. Using this assumption CBO estimated the nationwide impact of a fully operational PSRO program as a reduction of 1.5 percent in Medicare utilization. The difference in methodology between HHS and CBO accounts for about 8 percent of the difference in the cost-benefit ratios.

WHAT MONETARY VALUE SHOULD BE ASSIGNED TO DAYS OF CARE?

HHS assigned a monetary value to the decrease in utilization observed in the PSRO areas studied which reflected the hospital per diem charges for those areas. CBO, using average national charges, projected possible savings for a fully implemented nationwide program.

In assigning values to days of care saved, HHS assumed that the amount of money saved on ancillary services was equal to the average daily charges billed for such services. CBO reduced the HHS assigned value because (1) the first part of a hospital stay uses more ancillary services then the later days and (2) PSROs affect utilization most by reducing lengths of stay rather than reducing admissions.

CBO reductions in the benefit-to-cost ratio to account for lower per diem costs and per diem ancillary charges, account for 9 and 3 percent of the total reduction, respectively.

The effects of the basic differences between the analyses are shown below.

DHHS benefit-to-cost ratio	1.269
Effects of CBO adjustments for:	
National vs. Federal savings	-0.699
Utilization	-0.070
Per diem reimbursement	-0.080
Ancillary care charges	-0.030
CBO benefit-to-cost ratio	0.390