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UNITED STATES GENERAL ACCOUNTING OFFICE

WASHINGTON, D.C. 20548

For Release on Delivery
Expected
Tuesday, June 15, 1982

STATEMENT OF

GREGORY J. AHART, DIRECTOR

HUMAN RESOURCES DIVISION

BEFORE THE

SUBCOMMITTEE ON HEALTH

HOUSE COMMITTEE ON WAYS AND MEANS

ON

1983 BUDGET PROPOSALS

RELATING TO THE MEDICARE PROGRAM

Mr. Chairman and members of the Subcommittee, we are pleased to be here today to discuss some of the implications of the 1983 Budget Proposals relating to the Medicare Program. Medicare which became effective for persons aged 65 and over on July 1, 1966, is a nationwide health insurance program for 26 million aged and 3 million disabled persons. The eligibility requirements and benefit structure are essentially uniform throughout the country.

In recent years, the cost of Medicare in terms of outlays has increased by between about 16 and 20 percent annually since 1976. The Administration's 1983 Budget, assuming no changes in law or regulations, is more or less consistent with this historical trend. That is, the actual 1981 outlays were about $42.5 billion and the estimated 1982 outlays are about $49.9 billion--an increase of 17 percent. The 1983 estimate, assuming no program changes, is $57.9 billion or an increase from 1982 of about 16 percent. The Administration's 1983 budget, however, includes a number of regulatory and proposed legislative cost-saving initiatives estimated to total about $2.5 billion, which would bring the 1983 proposed outlays down to $55.4 billion or an 11-percent increase over 1982.

The Senate's 1983 Budget Resolution calls for Medicare reductions of $4.1 billion which equates to an increase in outlays from 1982 to 1983 of about 8 percent. The proposal adopted by the House, as we understand it, calls for reductions of about $3.2 billion or an increase of about 9 percent.

We believe that the basic questions facing the Subcommittee and the Congress are--where are these reductions going to come

from and whether and when they will materialize? For an entitlement program such as Medicare, a budget is essentially an estimate or projection based on a series of assumptions concerning events that will occur in the future. To a large extent, these events--while perhaps reasonably predictable--are not totally controllable. This is especially true in a program like Medicare, where total costs depend to a large extent on the health status of 29 million individual people and the decisions made by hundreds of thousands of health services providers.

Today we will be discussing (1) some significant cost saving legislative initiatives related to the 1980 and 1981 budget reconciliation acts which have not been implemented, (2) our views on selected Medicare cost savings proposals associated with the 1983 budget, and (3) some opportunities for savings through more effective administration of the program.

UNIMPLEMENTED COST-SAVING AMENDMENTS

The Medicare provisions of the Omnibus Reconciliation Act of 1980 (Public Law 96-499 approved December 5, 1980) included three relatively large cost-saving provisions. 1/ Two of the three have not been implemented. The provision involving the largest savings--over $200 million in both 1982 and 1983--has been implemented. Section 946 of the Act provided that Medicare's reasonable charges for physicians' services were to be determined based on the reasonable charges in effect on the date the medical service was rendered

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1/This refers to amendments where the estimated savings for 1982 and/or 1983 exceeded $50 million a year.

rather than the date the Medicare claim was processed. The amendment was effective July 1, 1981, and implementing regulations were issued in December of that year.

Another significant cost-saving amendment was section 902 of the Act which involved savings of about $70 to $80 million a year. This amendment provided that under certain circumstances Medicare would pay hospitals on the basis of the State's Medicaid skilled nursing home rate for those Medicare beneficiaries who no longer require acute hospital services but must remain in the hospital because no skilled nursing bed is available in the community. The amendment was to become effective on the date on which final implementing regulations are issued, which was to be no later than June 1, 1981. Section 2102 of the Omnibus Budget Reconciliation Act of 1981 (Public Law 97-35, approved August 13, 1981) modified this provision with an additional estimated savings in 1982 and 1983 of $60 and $70 million, respectively. The statute provided for an effective date of September 1, 1981. As of May 28, 1982, HHS had not even issued the proposed implementing regulations.

The third significant savings provision in the 1980 Reconciliation Act was section 953 which made Medicare the secondary payor in any case where medical care could be paid by any liability insurance policy (including an automobile insurance policy) or under a no-fault insurance plan. The effective date of this amendment was December 5, 1980, with assumed savings in 1982 of $32 million and in 1983 of $75 million. The proposed regulation to implement the provision was issued on May 17, 1982, and is pending the receipt of public comments and preparation of a final rule.

Although a number of significant cost-saving amendments in the 1981 budget reconciliation act related to increased beneficiary deductibles have been implemented, two significant cost-saving amendments pertaining to the end-stage renal disease program have not been. Section 2145 of the Act provided for the development of cost-based incentive reimbursement rates for in-facility and home kidney dialysis services. The effective date of this amendment was October 1, 1981, and implementing regulations were required no later than that date. The estimated savings were $105 million for 1982 and $130 million for 1983. Proposed regulations were published on February 12, 1982, and comments are being analyzed. The final regulations are expected to be sent to the Office of the Secretary in August 1982.

Section 2146 of the 1981 Act provided for Medicare to become the secondary payor for the first 12 months after an individual had been determined to be eligible for end-stage renal payments if the beneficiary has private insurance coverage through an employer group health plan. The effective date of this amendment was October 1, 1981, and the estimated savings were about $95 million for 1982 and $165 million for 1983. Proposed regulations were issued on May 17, 1982, and are now pending the receipt and analysis of public comments and preparation of a final rule.

In summary, the 1980 and 1981 reconciliation acts included five major cost-saving amendments representing estimated 1982 Medicare savings of about $370 million which will not materialize because the amendments have not been implemented.

COMPLEXITY OF CURRENT PROPOSALS

We believe, as many others do, that it is essential to reform Medicare reimbursement methods, especially those for hospitals, to provide them with incentives to hold down their cost increases. This is especially true for hospital ancilliary services, which represent a major and growing portion of total hospital costs, and where, in the main, Medicare has very few operating mechanisms for holding down costs. However, we do not believe any of the proposals to control hospital costs that we are aware of would result in short-term savings because of the complexity of implementing them. Nor do we have any proposals to offer for major short-term savings in hospital reimbursements. Nevertheless, this should not dissuade the Congress from seeking longer term solutions.

If substantial sums are to be saved from the Medicare program, for example, the $4.1 billion reduction included in the Senate passed version of the first concurrent budget resolution, such savings must be realized primarily from one or a combination of three sources--(1) payments to hospitals which represent about 75 percent of Medicare payments, (2) increased beneficiary cost sharing, and (3) transfer of costs to other insurers. The options for Medicare savings being discussed include all three sources. For example

--the proposal to establish reimbursement limits on the maximum amount payable for hospital ancilliary services according to one estimate would lower payments to hospitals by $660 million in fiscal year 1983.

--the proposal to reduce from 100% to 80% Medicare's portion of allowable inpatient hospital Radiologist/Pathologist charges is estimated to save Medicare $145 million. Most of the Medicare savings would be borne by the beneficiaries through out-of-pocket payments for these services and increased Medi-gap insurance policy premiums.

--the proposal to make Medicare secondary to other insurance for the working aged is estimated to save $610 million and would result in increased costs to private insurers and presumably increased premiums for private insurance.

As discussed previously, the track record has not been good for implementing the Medicare cost savings provisions of the 1980 and 1981 reconciliation acts when the source of the savings was decreased payments to providers or transferring costs to other insurers. On the other hand, provisions resulting in increased beneficiary cost sharing have been implemented rather expeditiously. We suspect that this pattern will continue with any cost-savings proposals legislated this year.

We believe that the primary reasons for the difference in the time taken to implement legislative changes is the complexity of the subject matter and the degree of administrative discretion permitted in implementation. Normally, changes affecting beneficiary cost sharing increases have been relatively simple while those affecting providers and other insurers have been much more complex and gave the administrative agency wider latitude in implementation.

For example, when the Congress increased the part B deductible from $60 to $75 effective January 1, 1982, essentially all that HHS had to do to implement the change was to change $60 to $75 wherever it appeared in Medicare regulations and manuals and tell the computers not to pay anything until a beneficiary had incurred $75 in covered expenses in a year rather than the previous $60. HHS did not really have to be concerned with comments from the public on proposed regulations because it was doing precisely what the law called for. Implementation of this provision was estimated to save $120 million in fiscal year 1982.

On the other hand, when the Congress directed HHS in 1981 to revise the reimbursement system for the end stage renal disease program, implementation required HHS to make numerous decisions and judgments. We understand that, before the provision was enacted, HHS had in mind a methodology to implement it. In spite of this, HHS had to gather additional data on renal dialysis costs, fully develop a complex methodology for establishing payment rates, develop the regulations necessary for implementation, and publish the proposed regulations and methodology for public comment.

The law was approved on August 13, 1981, and the provision had an effective date of October 1, 1981, but proposed regulations were not published for comment until February 12, 1982. We understand that voluminous comments were received raising questions about the decisions and judgments HHS made in preparing the proposal. Also, several hearings have been held related to the proposal at which numerous issues arose. We understand that the comments

are currently being analyzed and that the regulations, with any revisions deemed necessary, and an analysis of the comments is planned to be submitted to the Office of the Secretary of HHS in August 1982. Thus, the implementation of the renal disease amendment will probably not occur until a year after its effective date. The estimated savings for fiscal year 1982 at the time of enactment were about $100 million.

I would like to point out that we would support a number of the proposals that have been raised to control Medicare costs. For example, the proposal to control payments for hospital ancillary services and the proposal to limit the use of percentage contracts by providers which we recommended in 1978. Our concern is not so much with the concept of many of the proposals but rather, because of the complexity of implementing the proposals, whether savings will materialize in the short term.

PROGRAM ADMINISTRATION

I would like to turn now to an area where we believe some short-term savings could be realized. It seems to us to be much easier to achieve short-term savings by thoroughly enforcing current program requirements than by trying to implement complex new requirements. In this connection, we note that over the last several years the administrative budget for Medicare has remained relatively static. The Administration's budget for fiscal year 1983 proposed to maintain Medicare's administrative budget at its current level. Considering inflation, the administrative budget in real dollars has probably decreased since 1980. We question

the wisdom of attempting to limit administrative costs at the same time that numerous legislative requirements are supposed to be implemented. We note that the Congress attempted to include in the continuing resolution for fiscal year 1982 more funds than requested by the Administration for the carriers and intermediaries which control Medicare payments. Also, in May 1981 testimony before a Senate Committee, we questioned the wisdom of large proposed reductions (67 percent less) in the amount allocated to intermediaries to audit provider cost reports. We did not see how reducing a cost-effective administrative function which was producing $7 in savings for every $1 spent would result in net savings to Medicare. Although audit funds were not cut as drastically as originally contemplated, they were cut significantly. We believe an increase in provider audits would result in short-term savings, assuming the intermediaries can hire experienced auditors.

The Administration's 1983 Budget includes a reduction of $330 million for a cost-saving regulatory initiative aimed at giving the Medicare contractors greater responsibility for identifying overutilization of services. However, there is no increase for 1983 in the contractors' 1982 funding level ($704 million) to implement this utilization review initiative. Although we do not know the basis for the $330 million estimate, our ongoing review at nine Medicare carriers shows that automated prepayment utilization review of Medicare claims for physician services has been quite cost effective in identifying, and preventing payment for, medically unnecessary services.

Overall, the carriers we visited had experienced a cost benefit ratio of over $7 saved for each dollar spent in the pre-payment utilization review activity. However, the range of carrier performance in terms of the cost benefit ratios, the amount of denials based on workloads, and the number and type of automated edits used by the carriers varied widely. This suggests to us that expanding this activity at those carriers with comparatively poor performance indicators and minimal utilization review effort should result in significant additional savings.

Ironically, as part of implementing the 1982 budget restraints, HCFA reduced the funding for this cost effective activity by 50 percent.

That concludes my statement. We will be happy to answer any questions you may have.

SUMMARY OF GAO TESTIMONY BEFORE
THE SUBCOMMITTEE ON HEALTH
HOUSE COMMITTEE ON WAYS AND MEANS
ON 1983 BUDGET PROPOSALS
RELATING TO THE MEDICARE PROGRAM

GAO believes the basic questions about Medicare savings facing the Subcommittee and the Congress are--where are the savings going to come from and whether and when they will materialize?

The Department of Health and Human Services has not been very successful in implementing the Medicare cost-savings provisions included in the 1980 and 1981 reconciliations acts, particularly provisions which would decrease payments to providers or transfer costs to other insurers. Five major provisions have not been implemented and, therefore, estimated savings of about $370 million for 1982 did not materialize.

GAO believes that the primary reasons for the difference in the time taken to implement legislative changes is the complexity of the subject matter and the degree of administrative discretion permitted in implementation. Normally, changes affecting beneficiary cost-sharing increases have been relatively simple and have been implemented, while those affecting providers and other insurers have been more complex, have given the administrative agency wider latitude in implementation, and have not been implemented. GAO suspects that this pattern will continue with any cost-savings proposals enacted this year.

GAO believes there are some opportunities to reduce Medicare costs by increasing administrative budgets for cost-effective functions, such as audits of provider cost reports and prepayment utilization review.