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GAO

Report to the Chairman, Select Committee on Aging, House of Representatives

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MEDICARE AND MEDICAID

Updated Effects of Recent Legislation on Program and Beneficiary Costs

GAO/HRD-88-85

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

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July 26, 1988

The Honorable Edward R. Roybal
Chairman, Select Committee on Aging
House of Representatives

Dear Mr. Chairman:

This report is in response to your May 1, 1987, request. The report discusses the effects of legislation since 1980 on Medicare and Medicaid program costs and on beneficiary out-of-pocket costs.

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

Sincerely yours,

Lawrence H. Thompson
Assistant Comptroller General

Executive Summary

Purpose

During the 1970's, Medicare and Medicaid program costs grew rapidly—Medicare costs rose from about $6.9 billion in fiscal year 1970 to about $28.2 billion in fiscal year 1979, while Medicaid expenditures rose from about $4.6 billion to about $20.5 billion. In the following 8 years, 1980 through 1987, the Congress made major legislative changes that were expected to affect significantly the trend in cost growth of these two health insurance programs.

In an April 8, 1987, report, Medicare and Medicaid: Effects of Recent Legislation on Program and Beneficiary Costs (GAO/HRD-87-53), GAO discussed the effects of the major legislation enacted from 1980 through 1985 on the programs' cost growth rates and on beneficiary out-of-pocket costs. The Chairman, House Select Committee on Aging, asked GAO to update that report to include legislation enacted in 1986 and 1987.

Background

Medicare is a federal program that assists most of the elderly and some disabled people in paying for their health care. The program provides two basic forms of protection. Part A, Hospital Insurance, covers inpatient hospital services, posthospital care in skilled nursing facilities, hospice care, and care in patients' homes. In fiscal year 1986, Medicare part A covered about 31.2 million enrollees, and benefits amounted to about $49 billion.

Part B, Supplementary Medical Insurance, covers physician services and a variety of other health care services, such as laboratory and outpatient hospital services. In fiscal year 1986, Medicare part B covered about 30.6 million enrollees, and benefits totaled about $25.9 billion.

Medicaid is a grant-in-aid program under which the federal government pays from 50 to 80 percent of state costs for medical services provided to low-income people who are unable to pay for their medical care. Medicaid is administered by each state within broad federal guidelines. In fiscal year 1986, about 22.5 million persons received Medicaid assistance, totaling about $41 billion.

During the period 1980 through 1987, the Congress enacted more than 30 laws that affected the Medicare and Medicaid programs. Those having the most significant effects were the Omnibus Reconciliation Act of 1980, the Omnibus Budget Reconciliation Act of 1981, the Tax Equity and Fiscal Responsibility Act of 1982, the Deficit Reduction Act of 1984,

the Consolidated Omnibus Budget Reconciliation Act of 1985, and the Omnibus Budget Reconciliation Act of 1986.

Results in Brief

GAO estimates that, had prior cost growth trends continued, actual inflation-adjusted Medicare costs may have been about $17.3 billion more during the period 1981 through 1986 than they actually were. GAO believes that the major legislative changes played an important role in this slowdown in Medicare cost growth.

The six major laws were expected to have a mixed effect on Medicaid program costs—two of the laws passed early in the period were expected to result in savings; the others were expected to increase program costs. The actual Medicaid cost experience for fiscal years 1981 through 1986 shows that program cost growth generally was affected as projected—a sharp decline in the rate of growth in fiscal year 1982 (from 16.8 percent the previous year to about 8.1 percent), followed by increases later in the period, which were still lower than the historical trend.

The average inflation-adjusted out-of-pocket cost per Medicare enrollee for Medicare-covered services increased between 1980 and 1986 by about 73 percent for part A services and about 36 percent for part B services. GAO believes that much of the increase in beneficiary costs can be attributed to the major legislation enacted during the period.

Varying state cost-sharing requirements and the nonavailability of state data precluded an analysis of the change in Medicaid recipients' out-of-pocket costs. However, 28 states have increased cost-sharing requirements for Medicaid recipients as a result of the Tax Equity and Fiscal Responsibility Act of 1982.

GAO's Analysis

Medicare Costs

Because of the numerous interrelated factors affecting Medicare costs, such as the inflation rate and utilization of inpatient hospital services, GAO did not attempt to quantify the change in Medicare costs specifically attributable to the major legislative changes. Rather, GAO compared cost growth trends before and after the legislation for inpatient hospital care

under part A and for part B services. The costs of these services represented about 96 percent of total Medicare costs in fiscal year 1986.

For part A inpatient hospital costs, GAO analyzed the 1970 through 1980 inflation-adjusted cost data and used the results to predict what the yearly costs would have been for the period 1981 through 1986 if the pre-1980 cost growth trend had continued. GAO compared the predicted costs with the actual costs for the period and estimated that total Medicare inpatient hospital costs of about $251 billion would have been about $17.3 billion more (in constant 1986 dollars) than they actually were. (See pp. 22-23.)

GAO used this same methodology to analyze the part B costs and determined that the cost growth rate during fiscal years 1981 through 1986 was virtually the same as for the prior 10-year period. Thus, these results suggest that there was no reduction in part B costs during the period fiscal years 1981 through 1986.

Medicaid Costs

Although five of the six major laws were expected to reduce Medicare outlays, this was not the case with Medicaid. Laws enacted earlier in the period, primarily the Omnibus Budget Reconciliation Act of 1981, encouraged states to control program costs. In part because of this law, fiscal year 1982 Medicaid costs increased only about 8 percent over the previous year. This was a sharp decline from the cost growth rate that averaged about 15 percent from 1973 through 1981. In contrast, the trend among states from 1983 to 1986 was to expand program eligibility and services, thus contributing to a moderate increase in Medicaid costs. Legislation enacted later in the period, primarily the Deficit Reduction Act of 1984 and the Consolidated Omnibus Budget Reconciliation Act of 1985, contributed to this trend. (See p. 32.)

Beneficiary Costs

Under Medicare part A, beneficiaries pay a deductible for inpatient hospital services and coinsurance for extended hospital and skilled nursing facility stays. Laws enacted during the period increased the part A deductible and coinsurance amounts, thus helping to increase average out-of-pocket costs per enrollee for part A services from $86 (in constant 1986 dollars) in 1980 to $149 in 1986, an increase of about 73 percent.

Under Medicare part B, beneficiaries pay monthly premiums, an annual deductible, and coinsurance. Again, the major legislation increased the

amounts paid for each of these items, thus contributing to the increase in average out-of-pocket costs for part B services from $404 (in constant 1986 dollars) in 1980 to $549 in 1986, an increase of about 36 percent.

Beneficiaries are also liable for services and health needs not covered by Medicare, such as long-term care, dental care, outpatient prescription drugs, and hearing aids. GAO did not analyze the change in beneficiary out-of-pocket costs for noncovered services.

The Tax Equity and Fiscal Responsibility Act of 1982 expanded Medicaid cost-sharing options available to the states, and many states expanded their cost-sharing requirements for Medicaid recipients. During the period September 1982 to December 1986, 26 states took 37 policy actions to adopt or expand a program under which Medicaid recipients pay nominal amounts (generally from $.50 to $3) for health services. As of December 1986, 28 states and the District of Columbia had copayment programs, while 22 states did not.

Recommendations

This report provides GAO's updated analysis of the effect of recent legislation on Medicare and Medicaid program costs and on the out-of-pocket costs to the programs' beneficiaries; it includes no recommendations.

Contents

Tables

Abbreviations

CBO	Congressional Budget Office
COBRA	Consolidated Omnibus Budget Reconciliation Act of 1985
DEFRA	Deficit Reduction Act of 1984
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHA	home health agency
HHS	Department of Health and Human Services
OBRA-81	Omnibus Budget Reconciliation Act of 1981
OBRA-86	Omnibus Budget Reconciliation Act of 1986
OBRA-87	Omnibus Budget Reconciliation Act of 1987
ORA	Omnibus Reconciliation Act of 1980
PPS	prospective payment system
SNF	skilled nursing facility
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982

Introduction

In our April 8, 1987, report, Medicare and Medicaid: Effects of Recent Legislation on Program and Beneficiary Costs (GAO/HRD-87-53), we discussed the effects of major legislation enacted from fiscal years 1980 through 1985 on Medicare and Medicaid program costs and on beneficiary out-of-pocket costs. The Chairman, House Select Committee on Aging, requested that we update that report to include legislation enacted in 1986 and, to the extent possible, 1987. The Chairman also requested that we compare legislative proposals made by the administration with the actual legislation passed by the Congress and signed by the President.

The Medicare Program

Medicare is a federal program, authorized by title XVIII of the Social Security Act, that assists most of the elderly and some disabled people in paying for their health care. The program provides two basic forms of protection:

- Part A, Hospital Insurance, which is financed primarily by Social Security payroll taxes, covers inpatient hospital services, posthospital care in skilled nursing facilities (SNFs), hospice care, and care provided in patients' homes. In fiscal year 1986, Medicare part A covered 31.2 million enrollees, and benefits amounted to about $49 billion. About $45.6 billion (93 percent) of part A expenditures were for inpatient hospital services.
- Part B, Supplementary Medical Insurance, which is a voluntary program financed by enrollee premiums (25 percent of total costs) and federal general revenues, covers physician services and a variety of other health care services, such as laboratory and outpatient hospital services. In fiscal year 1986, Medicare part B covered 30.6 million enrollees, and benefits totaled about $25.9 billion.

Although the scope and coverage of medical services under Medicare is quite broad, there are considerable beneficiary cost-sharing provisions, and there is no catastrophic limit on medical expenses paid by the beneficiary.[1] Under part A, the beneficiary is required to pay a deductible for inpatient hospital stays, $540 during 1988. In addition, for extended hospital and nursing home stays, beneficiaries pay a per-day amount called coinsurance. (The deductible and coinsurance amounts for the years 1980 through 1988 are shown in table 4.2 on p. 36.)

[1]The Congress recently passed a Medicare Catastrophic Coverage Act, which is to become effective on January 1, 1989. This act provides the largest expansion of Medicare benefits since the inception of the program in 1965.

Under part B, the beneficiary is required to pay a monthly premium to establish eligibility. Beginning in 1967, the premium was recalculated each odd-numbered year to produce an amount equal to one-half the projected average monthly cost per enrollee of the part B program. The Social Security Amendments of 1972 (Public Law 92-603) provided that the part B premium could not increase by more than the percentage increase in Social Security retirement benefits. Under this provision, the enrollees' portion of total part B costs steadily decreased until it was less than 25 percent in 1982. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (Public Law 97-248) changed the calculation for two 1-year periods beginning in July 1983 and required that the premium be set to produce an amount equal to 25 percent of the projected average monthly cost of the part B program. The Deficit Reduction Act of 1984 (DEFRA) (Public Law 98-369) extended this requirement through 1987; the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (Public Law 99-272) extended it through 1988; and the Omnibus Budget Reconciliation Act of 1987 (OBRA-87) (Public Law 100-203) extended it through 1989. DEFRA also provided that the increase in the part B premium be limited to the dollar amount of the Social Security cost-of-living adjustment. During 1988, beneficiaries pay a monthly premium of $24.80, a 38.5-percent increase over 1987. In addition, users of part B services also pay an annual deductible of $75. Before 1982 the annual deductible was $60.

Medicare part B pays for covered services by reimbursing the physician or supplier directly (assigned claims) or reimbursing the beneficiary (unassigned claims). When physicians or suppliers accept assignment, they agree to accept the Medicare determination of reasonable charges as payment in full, and the beneficiary is responsible for paying 20 percent of the reasonable charge (plus any unmet deductible for the year). On unassigned claims, the beneficiary is also responsible for the difference between Medicare's reasonable charge and the physician's or supplier's charge.

Under Medicare, the reasonable charge for a service is normally the lowest of

- the actual charge for the service;
- the customary charge, which is the amount the physician or supplier usually charges for the service; or
- the prevailing charge, which is an amount high enough to cover 75 percent of all the charges for the service in a specific geographic area.

Reasonable charges are normally updated annually to reflect changes in charges. Through fiscal year 1983 these updates occurred on July 1 of each year. Reasonable charges were frozen by DEFRA at the levels in effect on June 30, 1984, for the period July 1, 1984, through September 30, 1985. During the freeze, participating physicians[2] were allowed normal increases in actual charges to Medicare patients, but nonparticipating physicians were not permitted to increase their charges. This freeze was extended several times; the last extension was to December 31, 1986, by COBRA. The Omnibus Budget Reconciliation Act of 1986 (OBRA-86) (Public Law 99-509) continued the distinction in reasonable charges between the two physician groups. For services provided by nonparticipating physicians on or after January 1, 1987, prevailing charges are limited to 96 percent of the prevailing charges established for participating physicians.

The Health Care Financing Administration (HCFA), within the Department of Health and Human Services (HHS), is responsible for administering Medicare, establishing policy, and developing operating guidelines. HCFA operates the program with assistance from insurance companies, called intermediaries under part A and carriers under part B. The insurance companies process and pay claims for covered services.

The Medicaid Program

Title XIX of the Social Security Act authorizes the Medicaid program, which began on January 1, 1966. Medicaid is a grant-in-aid program under which the federal government pays from 50 to 80 percent of state costs for medical services provided to low-income people unable to pay for their medical care. Currently, all 50 states,[3] the District of Columbia, American Samoa, Guam, Puerto Rico, the Northern Mariana Islands, and the Virgin Islands have Medicaid programs.

Two groups of people can be covered by Medicaid. The first group, known as the categorically needy, receives or is eligible to receive public assistance under one of the cash assistance programs (Aid to Families with Dependent Children and Supplemental Security Income). A state can also elect Medicaid coverage for the second group, the medically needy. These are people who meet all of the requirements of a cash assistance program except that their income exceeds the cash assistance level by not more than one-third, after deducting medical expenses. As

[2]Physicians who agree to accept assignment on all Medicare claims.

[3]Arizona was the last state to adopt a Medicaid program. The Arizona program is operated under a waiver of certain federal requirements.

of October 1987, 36 states and four jurisdictions had medically needy programs. In fiscal year 1986, about 22.5 million persons received Medicaid assistance totaling about $41 billion.

The states are responsible for initiating and administering their Medicaid programs within broad federal guidelines. The nature and scope of a state's Medicaid program are contained in a state plan which, after approval by HHS, provides the basis for federal funds to the state. Some states administer the entire program through their state agencies; others contract with private organizations to help administer their programs. The contractors, called fiscal agents, have responsibilities that vary depending on the contractual arrangements established by the states.

Under the Medicaid program, participating states are required to provide those eligible with the following services: inpatient and outpatient hospital, laboratory and X-ray, SNF, physician, home health care, family planning, nurse-midwife, and early and periodic screening for children. Additional services, such as dental care and prescribed drugs, may be included under a Medicaid program if a state so chooses.

Out-of-pocket costs to Medicaid recipients can include coinsurance, deductibles, enrollment fees, copayments, and premiums; states can require recipients to pay any of these. Before 1982, cost-sharing was generally limited to optional services. TEFRA, however, permitted the states to require cost-sharing for nearly all services (mandated as well as optional) offered under a state plan. TEFRA provided that the cost-sharing amounts must be nominal (see p. 40) and that no more than one type of charge could be imposed on any service. By the end of 1986, 26 states took 37 policy actions to adopt or expand cost-sharing requirements, while 14 states had eliminated or relaxed such requirements.

Legislative Changes to the Medicare and Medicaid Programs

During 1980 through 1987, the Congress enacted several laws that affected the Medicare and Medicaid programs (see app. I). The six laws that the Congressional Budget Office (CBO) and HCFA estimated to have the greatest effects on the cost of the two programs through fiscal year 1987 are shown below. HCFA savings estimates, by provision, for each of the six laws are shown in appendix II.

- Omnibus Reconciliation Act of 1980 (ORA) (Public Law 96-499), enacted Dec. 5, 1980;
- Omnibus Budget Reconciliation Act of 1981 (OBRA-81) (Public Law 97-35), enacted Aug. 13, 1981;

- Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) (Public Law 97-248), enacted Sept. 3, 1982;
- Deficit Reduction Act of 1984 (DEFRA) (Public Law 98-369), enacted July 18, 1984;
- Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (Public Law 99-272), enacted Apr. 7, 1986; and
- Omnibus Budget Reconciliation Act of 1986 (OBRA-86) (Public Law 99-509), enacted Oct. 21, 1986.

The Social Security Amendments of 1983 (Public Law 98-21) also affected the Medicare program by changing the method of paying hospitals. This legislation established the Medicare hospital prospective payment system (PPS). PPS replaced the Medicare cost reimbursement system for most hospitals and established predetermined payment rates for each of 468 diagnosis related groups. In addition, PPS required payments to hospitals to be budget neutral—neither increasing nor decreasing Medicare costs—and both CBO and HCFA projected that this would be the result. It appears, however, that PPS has helped slow the rate of growth in Medicare costs (see p. 23).

The Omnibus Budget Reconciliation Act of 1987 (OBRA-87) (Public Law 100-203), enacted Dec. 22, 1987, will also affect the Medicare and Medicaid programs beginning in fiscal year 1988. CBO estimated that this law would save Medicare $9.8 billion through fiscal year 1990, and would increase Medicaid costs by $588 million.

Objectives, Scope, and Methodology

The Chairman's May 1, 1987, letter asked us to update the information in our April 8, 1987, report. His request for the previous report asked us to provide

- information on all significant changes in Medicare and Medicaid law from 1980 onward, including the originally estimated effect on program and beneficiary costs and, to the extent possible, the actual effects of each change; and
- an estimate of the cumulative effects of these laws on program costs and on beneficiary out-of-pocket costs.

The Chairman's May 1, 1987, request also asked us to compare the legislative proposals made by the administration with legislation passed by the Congress and signed by the President.

We agreed with the Committee's office to limit our detailed analysis to six major laws (see p. 13) that CBO and HCFA estimated would have the greatest effect on the Medicare and Medicaid programs through fiscal year 1987.[4] We also agreed to limit our analysis to major legislative proposals made in fiscal years 1981 through 1988. (See app. III.)

HCFA supplied us its estimates of the effects of the major laws and data on Medicare and Medicaid costs, enrollment, and utilization. We did not verify the HCFA data, but we did discuss this information with HCFA program and actuarial officials. In addition, we obtained legislative proposals and estimates from HHS's Office of the Secretary.

We also obtained, and discussed with CBO officials, CBO estimates of the effect, through fiscal year 1987, of the six laws on the Medicare and Medicaid programs.

To determine the potential effect of the legislative changes on Medicare part A program costs, we analyzed inpatient hospital cost data for fiscal years 1970 through 1980 (adjusted for inflation). We used this analysis as a basis for estimating what the cost per enrollee would have been for fiscal years 1981 through 1986 if costs had continued to grow at the same rate as during fiscal years 1970 through 1980. We then compared these estimates with the actual cost per enrollee during 1981 through 1986. We used the same methodology to determine the potential effect of the legislative changes on Medicare part B costs.[5]

Because complete data were not available for fiscal year 1987, our analysis of the actual growth in parts A and B benefit costs is through fiscal year 1986. Because OBRA-86 was not enacted until fiscal year 1987, our analysis of this growth includes only five of the six major laws. More details about our analyses are presented in chapter 2.

As requested by the Committee's office, we did not obtain official agency comments on this report. We conducted this review during the period October 1987 to February 1988, and our work was done in accordance with generally accepted government auditing standards.

[4]The Social Security Amendments of 1983 (Public Law 98-21), which established PPS, were not part of our detailed analysis because CBO and HCFA projected them to be budget neutral. We believe, however, that law helped slow the rate of Medicare cost growth; it is discussed briefly on pp. 17 and 24.

[5]Our analyses did not include the possible effect of the legislative changes on the price indexes used to adjust Medicare cost data for inflation.

Effects of Six Major Laws on Medicare Costs

CBO estimated that the six major laws enacted during 1980 through 1987 would cumulatively reduce Medicare cost outlays during fiscal years 1981-87 by about $35.9 billion; HCFA estimated $28.9 billion. Neither CBO nor HCFA has analyzed the actual effects of the six laws on Medicare costs.

Our analysis shows that there was a slowdown in Medicare part A cost growth during fiscal years 1981 through 1986 as compared with fiscal years 1970 through 1980. Lower utilization of inpatient hospital services and the major legislative changes contributed to the slowdown. Because of the interrelationship of these and other factors affecting part A costs, we did not attempt to quantify the amount attributable solely to the legislative changes.

Our analysis shows that Medicare part B costs grew at virtually the same rate during fiscal years 1981 through 1986 as for the prior 10-year period. Thus, it appears that any savings from the legislative changes affecting part B during the period were offset by higher utilization of part B services.

Estimated Effects of Six Major Laws on Medicare

Five of the six major laws enacted during 1980 through 1987 were expected to result in Medicare savings; the other, OBRA-86, was expected to increase program costs. ORA was the first of the major laws enacted, and CBO estimated that its Medicare provisions would reduce program costs by about $2.3 billion during fiscal years 1981 through 1985.

A major saving provision of this act required that the determination of Medicare reasonable charges for physician services be based on the date the service was rendered rather than the date the claim was processed. This provision was expected to reduce Medicare outlays in cases where the services were provided before the annual reasonable charge update (see p. 12), but the claims were not processed until after the update, when the higher updated reasonable charges were in effect. The law also made Medicare the secondary payer for people whose medical expenses were covered by an automobile or liability insurance plan. CBO did not estimate savings for the individual provisions of this law.

CBO estimated that the provisions of OBRA-81, the second major law, would reduce Medicare costs by $3.2 billion during fiscal years 1981 through 1984. One of the act's major provisions reduced the routine

nursing salary cost differential[1] paid to hospitals from 8.5 percent to a maximum of 5 percent. In addition, this law increased the part B deductible from $60 to $75 beginning in calendar year 1982.

Of the six major laws, TEFRA was estimated to have the greatest effect on Medicare costs. CBO estimated that the provisions of this law would reduce program costs by $23.1 billion during fiscal years 1983 through 1987. Among other changes, TEFRA established a target rate reimbursement system for hospital services; this system limited the rate of increase in Medicare payments per case for a 3-year period beginning October 1, 1982. CBO estimated that this provision would save Medicare about $7.9 billion in fiscal years 1983 through 1985. PPS was structured to be budget-neutral because it continued the limits set under TEFRA provisions; therefore, the TEFRA savings were estimated to still be in effect.

TEFRA also required employers to offer their employees (and their spouses) who are 65 through 69 years of age the same group health plans that are offered to younger workers. TEFRA made Medicare the secondary payer for these older employees who elect the plan. CBO estimated this provision would save the Medicare program about $2.3 billion through fiscal year 1987. Other major provisions of TEFRA that were expected to achieve significant savings included the following: reimbursing for radiologist and pathologist services provided to hospital inpatients at 80 percent of the reasonable charge rather than at 100 percent ($1.2 billion), temporarily suspending the provision that limited the annual increase in part B premiums to the same percentage as the increase in Social Security retirement benefits ($2.1 billion), and eliminating the routine nursing salary differential[2] paid to hospitals and SNFs ($640 million).

DEFRA also had a number of provisions that were expected to significantly affect Medicare costs. In total, CBO estimated that the provisions of this law would save the program $6.1 billion during fiscal years 1984 through 1987. Among other changes, DEFRA established a reimbursement fee schedule for outpatient laboratory services. DEFRA also froze physician fees for a 15-month period beginning July 1, 1984. CBO estimated

[1]Medicare's inpatient hospital cost reimbursement methodology had assumed that elderly patients used more routine nursing services than other patients and, therefore, paid hospitals more for these services. There were questions about the accuracy of this assumption. See Do Aged Medicare Patients Receive More Costly Routine Nursing Services? Evidence Inconclusive (GAO/HRD-82-32, Jan. 20, 1982).

[2]See footnote 1.

that the physician fee freeze would save Medicare about $2.6 billion through fiscal year 1987.

In addition, DEFRA required employer-sponsored group health plans to cover employees' spouses who are 65 through 69 years of age (even though the employee is under the age of 65). Because Medicare would be the secondary payer for such spouses, CBO estimated that Medicare outlays would be reduced by about $1.1 billion in fiscal years 1985 through 1987.

CBO estimated that the provisions of COBRA would reduce program costs by $2 billion in fiscal years 1986 and 1987. COBRA reduced the amount Medicare reimburses hospitals for the indirect costs of medical education. COBRA also limited the increase in the PPS payment rates to 1 percent for the remainder of fiscal year 1986; for fiscal years 1987 and 1988, the increase was limited to the increase in the hospital market basket index (a measure of price change in goods and services purchased by hospitals). COBRA further expanded the coverage requirement for employer group health plans by requiring that health insurance be offered to employees and their spouses over 69 years of age, thereby removing the upper age limit. This provision was expected to reduce Medicare costs by increasing the population for whom Medicare is the secondary payer for health services. COBRA added to program costs by increasing payment amounts for hospitals serving a disproportionate share of low-income patients. CBO cost estimates for individual COBRA provisions were not available.

The provisions of OBRA-86 were expected to increase program costs. CBO estimated that this law would increase Medicare costs by about $1 billion in fiscal year 1987. OBRA-86 extended part B coverage of occupational therapy to include such services provided in SNFs (when part A coverage is exhausted), clinics, or various other facilities. This provision was expected to increase costs because it would increase the use of this type of service. The law also made Medicare the secondary payer for disabled beneficiaries who are employed by a large employer and who elect to be covered by employment-based health insurance plans. This provision is expected to reduce program costs by increasing the number of people for whom Medicare is the secondary payer for health care. CBO did not estimate savings for individual provisions of this law.

CBO's and HCFA's estimated cumulative savings for each of these six public laws for fiscal years 1981 through 1987 are shown in table 2.1.

Table 2.1: CBO and HCFA Estimated Medicare Savings From Six Major Laws

Dollars in billions

Law	Date enacted	Cumulative savings, fiscal years 1981-87[a] CBO	HCFA
ORA	Dec. 5, 1980	$2.3	$0.7
OBRA-81	Aug. 13, 1981	3.2	4.0
TEFRA	Sept. 3, 1982	23.1	20.3
DEFRA	July 18, 1984	6.1	4.2
COBRA	Apr. 7, 1986	2.0	1.4
OBRA-86	Oct. 21, 1986	−1.0	−1.7
Total		**$35.9**	**$28.9**

[a]These multiyear savings estimates, made as each of the six laws was enacted, were based on the economic assumptions in use at the time of enactment. Over time, these assumptions have been revised, and the savings estimates would probably change if the effect of the laws had been re-estimated on the revised assumptions. However, re-estimates of all of the laws covered here have not been made; therefore, the figures given are those contained in the original estimates. In addition, savings estimates were made for 3- to 5-year periods, and the figures listed here for the earlier laws do not include any savings that would accrue beyond the estimating periods.

Actual Effects of Six Major Laws Not Measured

We were unable to obtain the data necessary to estimate the actual effect of legislative changes on Medicare costs. Instead, we compared the trend in Medicare cost growth in the years before the laws became effective with the trend in the years since. Based on this analysis, we estimated that actual inflation-adjusted Medicare costs were about $17.3 billion less (measured in 1986 dollars) in the years after the laws became effective than they would have been had the prior cost growth trend continued. For a variety of reasons, this estimate is not comparable with the CBO and HCFA projections noted previously. Those projections were made when the six major laws were enacted and cover the period fiscal years 1981 through 1987. Because actual cost data for fiscal year 1987 were unavailable, our estimate is for 1981 through 1986; it thus covers only five of the six laws because, as mentioned earlier, OBRA-86 was not enacted until fiscal year 1987. In addition, our estimate was calculated in constant 1986 dollars, whereas the CBO and HCFA estimates are in current dollars, based on inflation projections these agencies were using at the time the estimates were prepared. Finally, our estimate includes the effect of all factors that affected the growth rate of Medicare costs; it is not an estimate of the independent effect of the legislative changes.

Decrease in Rate of Cost Increase for Medicare

Total Medicare benefits increased about 116 percent during fiscal years 1980 through 1986. Part A benefit costs increased from $24.1 billion in fiscal year 1980 to $48.9 billion in fiscal year 1986, and part B benefit costs increased from $10.5 billion to $25.9 billion. During the same period, enrollees under part A increased 11 percent, and enrollees under part B increased 11.7 percent. The total benefit cost, the number of enrollees, and the change in cost per enrollee in the Medicare program during fiscal years 1980 through 1986 are shown in table 2.2.

Table 2.2: Medicare Experience, Fiscal Years 1980 Through 1986

Fiscal year	Total benefit cost (millions)	Number of enrollees (millions)	Cost per enrollee	Growth rate in cost per enrollee (in percent)
Part A:				
1980	$24,107	28.1	$859	•
1981[a]	28,955	28.6	1,012	18.0
1982	34,536	29.1	1,188	17.2
1983[a]	39,372	29.6	1,330	12.1
1984[a]	43,074	30.0	1,436	7.9
1985[a]	46,545	30.6	1,521	5.9
1986	48,933	31.2	1,568	3.1
Part B:				
1980	10,472	27.4	382	•
1981	12,544	27.9	449	17.5
1982	14,731	28.4	518	15.5
1983	17,542	29.0	605	16.8
1984	19,769	29.4	672	11.0
1985[a]	21,847	30.0	728	8.3
1986	25,852	30.6	845	16.1

[a]Changed from our 1987 report because of updated cost information.
Source: HCFA data; benefit payments on an incurred basis.

We analyzed changes in (1) the cost of providing inpatient hospital care under part A and (2) the cost of all part B services. The cost of these services represented about 96 percent of total Medicare costs in fiscal year 1986. We also analyzed the cost of home health care under parts A and B, which accounted for an additional 2 percent of total Medicare costs.

Increase in Inpatient Care Cost for Medicare

The cost of providing inpatient general hospital care for Medicare beneficiaries increased from about $23.1 billion in fiscal year 1980 to about

$45.6 billion in fiscal year 1986 (about 97 percent). The cost of providing inpatient hospital care, the number of days of care provided, the cost per day of care, and the growth rate in this cost for fiscal years 1981 through 1986 are shown in table 2.3, indicating that the total cost and cost per day both increased during the period.

Table 2.3: Cost of Inpatient Hospital Care Under Medicare Part A, Fiscal Years 1980 Through 1986

Fiscal year	Total benefit cost (millions)	Total covered days (millions)	Cost per covered day	Growth rate in cost per day (in percent)
1980	$23,129	110	$211	•
1981[a]	27,706	112	247	17.6
1982	32,786	115	286	15.2
1983[a]	37,198	116	321	12.5
1984[b]	40,555	103	394	22.8
1985[b]	43,628	90	485	23.1
1986	45,645	88	519	7.0

[a]Changed from our 1987 report because of updated cost information.

[b]Changed from our 1987 report because of updated cost and utilization information.

Source: HCFA data; benefit payments on an incurred basis. Total covered days and cost per day for fiscal years 1985 and 1986 are current as of November 1987, but are still considered incomplete by HCFA.

The sharp increase in the cost per day of inpatient hospital care in fiscal years 1984 and 1985 is misleading since it was caused in part by the decreased number of days. We believe it is preferable to look at the cost of inpatient hospital care in terms of the cost per Medicare enrollee because this method takes into account the effect of decreased days of care as well as the increase in enrollees over time.

The total benefit cost of inpatient hospital care converted to 1986 dollars (using the consumer price index for hospital rooms), the number of enrollees, the cost per enrollee in 1986 dollars, and the growth rate in cost per enrollee in 1986 dollars for fiscal years 1970 through 1980 and 1981 through 1986 are shown in table 2.4.

Table 2.4: Cost of Inpatient Hospital Care Per Medicare Enrollee, Fiscal Years 1970 Through 1986 (In 1986 Dollars)

Fiscal year	Total benefit cost: 1986 dollars (millions)	Enrollees (millions)	Actual cost per enrollee: 1986 dollars	Growth rate in cost per enrollee (in percent)
1970	$24,152	20.4	$1,186	•
1971	24,726	20.7	1,192	0.5
1972[a]	25,711	21.1	1,218	2.1
1973[a]	26,935	21.6	1,249	2.5
1974[a]	29,571	23.9	1,236	−1.0
1975	31,563	24.6	1,281	3.6
1976	32,931	25.3	1,301	1.6
1977	36,282	26.1	1,390	6.9
1978	37,879	26.8	1,415	1.7
1979	38,999	27.5	1,420	0.4
1980	41,581	28.1	1,481	4.3
Average				**2.3**
1981	43,370	28.6	1,518	2.4
1982	44,353	29.1	1,526	0.5
1983	45,205	29.6	1,528	0.1
1984	45,524	30.0	1,518	−0.7
1985	46,244	30.6	1,512	−0.4
1986	45,645	31.2	1,462	−3.3
Average				**−0.2**

[a]Mandatory price controls in effect.

Source: Based on total benefit cost data provided by HCFA's Office of the Actuary; costs are on an incurred basis. Adjusted to 1986 dollars using the consumer price index for hospital rooms.

As can be seen from table 2.4, the average inflation-adjusted growth rate in cost per enrollee for 1981 through 1986 (about -0.2 percent) was considerably lower than the average growth rate for fiscal years 1970 through 1980 (about 2.3 percent).[3] Had the average annual growth rate in cost per enrollee for fiscal years 1970 through 1980 continued through 1986, Medicare hospital costs would have been about $17.3 billion[4] more in constant 1986 dollars than they actually were.

Part of the reason for the slowdown in hospital benefit cost growth was the lower utilization of inpatient hospital services. The average Medicare beneficiary used about 28 percent fewer inpatient hospital days in

[3]The difference in average growth rates for the two periods was statistically significant at the 95-percent confidence level.

[4]Had we used the medical component of the consumer price index as the deflator instead of the hospital room component, the estimated savings would have been about $15 billion.

fiscal year 1986 than he or she did in fiscal year 1980. The number of hospital admissions, the admissions per 1,000 enrollees per year, the average covered days per admission, and the covered days of care per 1,000 enrollees per year for fiscal years 1980 through 1986 are shown in table 2.5.

Table 2.5: Inpatient Hospital Utilization Under Medicare, Fiscal Years 1980 Through 1986

Fiscal year	Admissions (millions)	Admissions per 1,000 enrollees	Average covered days per admission	Covered days of care per 1,000 enrollee/ year
1980	10.2	365	10.7	3,908
1981	10.7	374	10.5	3,926
1982	11.4	391	10.1	3,943
1983	11.8	400	9.8	3,926
1984	11.8	392	8.7	3,415
1985	11.2	365	7.9	2,875
1986	10.8	346	8.1	2,817

Source: HCFA's Bureau of Data Management and Strategy; data for fiscal years 1985 and 1986 are current through November 1987, but are still considered incomplete by HCFA.

As shown in table 2.5, the number of admissions in fiscal year 1986 increased about 6 percent over fiscal year 1980, but the number of admissions per 1,000 enrollees decreased about 5 percent. The average length of stay in fiscal year 1986 increased slightly over fiscal year 1985, but is still 24 percent lower than in fiscal year 1980. Consequently, the covered days of care per 1,000 enrollees is about 28 percent lower in fiscal year 1986 than it was in fiscal year 1980. Thus, overall, Medicare enrollees used fewer hospital days in fiscal year 1986 than in fiscal year 1980.

We believe that legislative changes during the period played a key role in holding down the increase in hospital costs. For example, TEFRA established cost-per-case limits and a ceiling on the rate of increase in reimbursement to most hospitals. Under PPS, Medicare payments to hospitals were limited to amounts projected under the TEFRA provisions. Both the TEFRA limits and PPS gave hospitals incentives to reduce length of stay; we believe these changes in law have been responsible for a significant portion of the decrease in length of stay.

In addition, ORA provided that Medicare be the secondary payer in cases where the beneficiary has coverage under automobile, no-fault, or liability insurance. The five subsequent laws (see pp. 10-13) expanded this program making Medicare the secondary payer, as explained earlier.

HCFA estimates that the Medicare secondary payer program saved Medicare about $725 million in fiscal year 1986.

Cost of Providing Medicare Part B Services

The total benefit costs for part B services increased about 147 percent from fiscal year 1980 through fiscal year 1986, from about $10.5 billion to about $25.9 billion; the cost per Medicare enrollee increased about 121 percent, from $382 to $845. The total benefit cost of providing part B services during fiscal years 1980 through 1986 is shown in table 2.6.

Table 2.6: Total Medicare Part B Benefit Costs, Fiscal Years 1980 Through 1986

Fiscal year	Total benefit cost (millions)	Enrollees (millions)	Cost per enrollee	Growth rate in cost per enrollee (in percent)
1980	$10,472	27.4	$382	•
1981	12,544	27.9	449	17.5
1982	14,731	28.4	518	15.5
1983	17,542	29.0	605	16.8
1984	19,769	29.4	672	11.0
1985[a]	21,847	30.0	728	8.3
1986	25,852	30.6	845	16.1

[a]Changed from our 1987 report because of updated cost information.

Source: Based on total benefit cost data provided by HCFA's Office of the Actuary; costs are on an incurred basis.

As can be seen from table 2.6, the cost per enrollee increased at a relatively uniform rate from 1981 through 1983, declined in 1984 and 1985, and increased again in 1986.[5]

We converted the total benefit cost of Medicare part B services to 1986 dollars (using the consumer price index for all medical services) and compared the growth rate in cost per enrollee for fiscal years 1970 through 1980 and 1981 through 1986. The results are shown in table 2.7.

[5]A large increase is expected in 1987.

Table 2.7: Historical Cost Growth for Medicare Part B Services, Fiscal Years 1970 Through 1986

Fiscal year	Total benefit cost: 1986 dollars (millions)	Enrollees (millions)	Cost per enrollee	Growth rate in cost per enrollee (in percent)
1970	$7,278	19.6	$372	•
1971	7,347	20.0	368	−1.0
1972	7,761	20.4	381	3.7
1973	8,115	20.9	388	1.7
1974	9,278	23.2	400	3.2
1975	10,283	23.9	430	7.4
1976	11,464	24.6	466	8.3
1977	13,271	25.4	523	12.3
1978	14,444	26.1	554	5.9
1979	15,627	26.8	584	5.4
1980	17,074	27.4	623	6.7
Average				**5.4**
1981	18,473	27.9	661	6.1
1982	19,390	28.4	682	3.2
1983	21,241	29.0	733	7.4
1984	22,578	29.4	768	4.7
1985	23,529	30.0	785	2.2
1986	25,852	30.6	845	7.7
Average				**5.2**

Source: Based on total benefit cost data provided by HCFA's Office of the Actuary; costs are on an incurred basis.

As can be seen from table 2.7, the inflation-adjusted average growth rate in part B cost per enrollee was about 5.4 percent for 1970 through 1980 and dropped slightly to 5.2 percent for 1981 through 1986. The difference in average growth rates for the two periods, however, is not statistically significant.

These results suggest no significant reduction in the rate of growth of part B costs in fiscal years 1981 through 1986. It appears, therefore, that the cost-cutting effects of the major legislative changes, such as the physician fee freeze provision of DEFRA, have been offset by increased utilization of part B services. For example, for outpatient hospital services, persons served per 1,000 enrollees were about 40 percent higher in 1986 than in 1980. Likewise, for physician and other part B services, persons served per 1,000 enrollees were about 15 percent higher in 1986 than in 1980. A "person served" represents a beneficiary for whom Medicare paid for at least one service during the year. HCFA does not measure the number of part B services provided to each beneficiary.

The total persons served, persons served per 1,000 enrollees, and percent change in persons served per 1,000 enrollees for outpatient hospital and physician/other part B services for calendar years 1980 through 1986 are shown in table 2.8.

Table 2.8: Medicare Part B Utilization, Calendar Years 1980 Through 1986

Calendar year	Total persons served (millions)	Persons served per 1,000 enrollees	Change in persons served per 1,000 enrollees (in percent)
Outpatient hospital:			
1980	7.5	275	•
1981	8.1	288	4.9
1982	8.4	297	3.1
1983	9.1	314	5.5
1984	9.8	332	5.9
1985	10.9	364	9.5
1986	11.8	384	5.5
Physician/other:			
1980	17.3	630	•
1981	18.1	648	2.8
1982	18.0	634	−2.1
1983	18.9	653	3.0
1984	19.8	675	3.3
1985	21.3	709	5.1
1986	22.2	725	2.3

Source: HCFA's Bureau of Data Management and Strategy. Data for 1986 were not available; figures shown are GAO projections based on average increase in use for previous 5 years.

Cost of Home Health Care

Unlike the legislative changes for hospital and physician care, changes for home health care services were generally designed to expand benefits rather than to control the costs of these services. For example, section 930 of ORA expanded home health benefits under Medicare by providing for the coverage of an unlimited number of visits. Before this law, there was a limit of 100 visits during a benefit period. Section 930 also eliminated the requirement that a beneficiary be hospitalized 3 days before receiving home health services under part A.

The cost of providing home health care, the number of visits, the cost per visit, and the number of visits per 1,000 Medicare enrollees for fiscal

years 1980 through 1986 (in constant 1986 dollars) are shown in table 2.9.

Table 2.9: Cost of Home Health Care, Fiscal Years 1980 Through 1986 (1986 Dollars)

Fiscal year	Total cost (millions)	Total visits (millions)	Cost per visit	Visits per 1,000 enrollees
1980	$1,034	22.0	$47	772
1981	1,171	24.8	47	855
1982	1,381	29.8	46	1,009
1983	1,642	36.2	45	1,205
1984	1,871	40.5[a]	46	1,330
1985	1,918	40.5[a]	47	1,303
1986	1,808	39.0	46	1,229

[a]Changed from our prior report because of updated information.

Source: HCFA's Bureau of Data Management and Strategy; data for fiscal year 1986 are current through November 1987, but are still considered incomplete by HCFA. Adjusted to 1986 dollars using the consumer price index for all medical services.

Based on calculations from figures in table 2.9, we found the total cost of providing home health care increased about 75 percent (excluding inflation) from fiscal year 1980 through fiscal year 1986. The number of visits per 1,000 enrollees increased about 59.2 percent and reflects the increase in utilization of the home health benefit by Medicare enrollees. It is generally believed that the increase in the use of home health benefits is at least in part related to the shorter lengths of inpatient hospital stays (caused in part by PPS). The increased utilization, rather than higher costs per visit, accounted for most of the $774 million increase (in constant 1986 dollars) in total home health costs from fiscal year 1980 through fiscal year 1986.

Although the cost and utilization data for fiscal year 1986 are considered incomplete by HCFA, it appears that the number of home health visits per 1,000 enrollees may have peaked in 1984, and has declined in 1985 and 1986.

Cost Reductions Under Gramm-Rudman-Hollings

There were no across-the-board reductions under Gramm-Rudman-Hollings for fiscal year 1987. The revised Gramm-Rudman-Hollings law (Public Law 100-119) temporarily froze Medicare payment rates from October 1 to November 20, 1987, at the level in effect at the end of fiscal year 1987. Across-the-board reductions in Medicare payments of 2.3 percent became effective on November 21, 1987, and ended on March

31, 1988. HCFA records show that total reductions will be about $0.5 billion during fiscal year 1988. Medicaid was exempted from reductions under this legislation.

Summary

Based on projections at the time of enactment, CBO and HCFA estimated that six major laws passed during 1980 through 1987 would significantly reduce Medicare outlays through fiscal year 1987. Our analysis of the cost of providing inpatient hospital care under part A shows that there was a slowdown in part A cost growth during fiscal years 1981 through 1986 as compared with fiscal years 1970 through 1980. We believe that these laws played a major role in this slowdown. The part B cost growth rate during fiscal years 1981 through 1986 was virtually the same as for the prior 10-year period, suggesting that the cost-cutting effects of the legislative changes may have been offset by increased utilization of part B services.

Effects of Six Major Laws on Medicaid Costs

The major Medicaid provisions in six major laws enacted from 1980 through 1987 had different purposes and, thus, were expected to have a mixed effect on Medicaid program costs. The laws enacted earlier in the period—primarily OBRA-81—encouraged states to cut Medicaid costs and, therefore, were expected to reduce total Medicaid outlays. Conversely, the laws enacted later in the period—primarily DEFRA and OBRA-86—generally expanded eligibility for Medicaid services and were expected to increase total Medicaid outlays. Overall, CBO estimated that the net effect of the major laws enacted during 1980 through 1987 would be a reduction in Medicaid costs of $3.6 billion; HCFA estimated a reduction of $1.7 billion.

Neither CBO nor HCFA has retrospectively analyzed the actual effects of these laws on Medicaid costs, and we did not attempt such an analysis because of the lack of comparable data from year to year. It appears, nevertheless, from total Medicaid cost experience that program cost growth generally was affected as CBO and HCFA projected—a sharp decline in the rate of cost growth in fiscal year 1982 with moderate increases in 1985 and 1986.

Estimated Effects of Six Major Laws on Medicaid

Although five of the six major laws were expected to reduce Medicare cost outlays (see ch. 2), this was not the case with Medicaid. CBO and HCFA estimated that only two of the six major laws passed during 1980 through 1987 would result in Medicaid savings; the other four would increase program costs. The estimated cost effect, based on CBO and HCFA projections, of each of the six laws is shown in table 3.1.

Table 3.1: Estimated Cost Effects of Six Major Laws on Medicaid Costs, Fiscal Years 1981 Through 1987

Dollars in millions

Law	Date passed	Cumulative effect on cost: fiscal years 1981-87 CBO	HCFA
ORA	Dec. 5, 1980	$8	$3
OBRA-81	Aug. 13, 1981	−2,885	−1,166
TEFRA	Sept. 3, 1982	−1,141	−1,428
DEFRA	July 18, 1984	159	648
COBRA	Apr. 7, 1986	91	62
OBRA-86	Oct. 21, 1986	170	175
Total		**$−3,598**	**$−1,706**

As can be seen from table 3.1, CBO estimated that, overall, the six laws would reduce Medicaid costs through fiscal year 1987 by $3.6 billion; HCFA estimated $1.7 billion.

A large portion of the savings was expected to come from OBRA-81. The major savings provision of this law specified that federal matching funds to each state would be reduced by 3 percent in fiscal year 1982, 4 percent in 1983, and 4.5 percent in 1984. A state could, however, lower the amount of the reduction by operating a qualified hospital cost review program, having an unemployment rate higher than the national average, or recovering a specified amount of unauthorized expenditures from providers. In addition, a state was entitled to a dollar-for-dollar offset in its reduction if total federal Medicaid expenditures in a year fell below a specified target amount. Thus, OBRA-81 encouraged states to increase the efficiency of their program administration and to reduce the rate of growth in Medicaid costs. CBO did not estimate the effects of individual provisions on Medicaid costs.

The other law expected to produce large Medicaid savings, TEFRA, contained several major cost-saving provisions. One expanded state options for imposing cost sharing on Medicaid beneficiaries (see pp. 40-41 for details). A second provision eliminated federal matching funds for erroneous expenditures exceeding 3 percent. Another provision expanded state opportunities to recover Medicaid expenditures from the estates of deceased beneficiaries.

Actual Effects of Six Major Laws Not Measured

Again, neither CBO nor HCFA analyzed the actual effects of the legislative changes on the cost of providing Medicaid services. The actual Medicaid cost data show that the rate of Medicaid cost growth decreased sharply in fiscal year 1982, but began to increase moderately in 1985 and 1986. The Medicaid cost growth rate was generally consistent with the projected effects of the six major laws during 1981 through 1987.

We did not attempt to determine what the cost of the Medicaid program would have been during fiscal years 1981 through 1986 if there had been no legislative changes because we did not believe that data from 1970 through 1980 would provide a good basis for a meaningful analysis. Specifically, the data from fiscal years 1970 through 1980 were not comparable from year to year because of changes in

- the number of states having a Medicaid program,
- the groups covered by Medicaid, and

- the types of health services paid for by the programs in the various states.

Increase in Medicaid Payment Cost

During fiscal year 1973 through fiscal year 1986, the total Medicaid payment cost (federal and state) grew about 375 percent, from $8.6 billion to $41 billion. The total Medicaid program payment cost from fiscal year 1973 through fiscal year 1986 in actual dollars, in constant 1986 dollars, and the annual growth rate for both are shown in table 3.2.

Table 3.2: Total Medicaid Payment Cost, Fiscal Years 1973 Through 1986

Fiscal year	Total payment cost: actual dollars (millions)	Growth rate (in percent)	Total payment cost: 1986 dollars (millions)	Growth rate (in percent)
1973	$8,640	•	$28,058	•
1974	9,983	15.5	29,403	4.8
1975	12,292	23.1	32,161	9.4
1976	14,135	15.0	33,606	4.5
1977	16,277	15.2	35,198	4.7
1978	17,966	10.4	35,764	1.6
1979	20,474	14.0	37,143	3.9
1980	23,301	13.8	37,992	2.3
1981	27,204	16.8	40,062	5.4
1982	29,399	8.1	38,698	−3.4
1983	32,391	10.2	39,221	1.4
1984	33,891	4.6	38,707	−1.3
1985	37,522	10.7	40,411	4.4
1986	41,027	9.3	41,027	1.5

Source: Medicare and Medicaid Data Book, 1983; and HCFA's Office of the Actuary. We converted the actual total payment cost to constant 1986 dollars using the consumer price index for all medical services.

Total Medicaid payment costs (actual dollars) grew at an average annual rate of about 15 percent from fiscal year 1973 through fiscal year 1981. In fiscal year 1982, however, the cost growth rate—in both actual and constant dollars—dropped sharply. The 1982 decline in Medicaid cost growth was the result of state cost-cutting actions undertaken in part to reverse the adverse effects of the double-digit cost growth on their state budgets. In addition, OBRA-81 gave states an incentive to hold down their program costs as a way of minimizing the reductions in federal matching funds mandated by this law.

As part of an effort to control program costs, states reduced or limited benefits, eligibility, and provider reimbursement. For example, according to a 50-state survey by the Intergovernmental Health Policy Project and State Medicaid Information Center, in 1982,

- 11 states limited the use of hospital inpatient services;
- 13 states reduced the amount, scope, and duration of covered services or restricted coverage of services (primarily for prescription drugs);
- 14 states imposed or increased copayments on optional services, primarily prescription drugs;
- 19 states adopted proposals to limit or decrease hospital reimbursement; and
- 16 states limited or decreased physician reimbursement.

In total, 30 states took some action to reduce or limit benefits, eligibility, or provider reimbursement in 1981, and the same number did so in 1982.

In contrast to the 1981 and 1982 period of contraction, the trend among states from 1983 through 1986 was to expand somewhat program eligibility and services. Fifteen states adopted expansions in 1983, and 19 states did so in 1984. In addition, DEFRA required states to provide Medicaid coverage to certain pregnant women and children meeting the income and resource criteria for the Aid to Families with Dependent Children program. In 1985, 28 states adopted policies that expanded program eligibility—12 of them to comply with expanded coverage requirements of DEFRA. COBRA added a variety of benefits and eligibility groups, particularly for services relating to maternity care for low-income women and long-term care to individuals at risk of being institutionalized. During 1986, at least 18 states took one or more actions to add new benefits under their Medicaid program.

Summary

CBO and HCFA projected that the six major laws enacted from 1980 through 1987 would have a mixed effect on Medicaid costs—two of the six laws were expected to result in savings; the other four were expected to increase program costs. The actual program cost experience has generally been consistent with these projections.

Beneficiary Out-of-Pocket Costs Have Increased

Beneficiaries share in the cost of their health care expenses under Medicare and, to a lesser extent, under Medicaid. Our analysis shows that the average out-of-pocket cost per enrollee for Medicare part A services, in constant 1986 dollars, increased about 73 percent from $86 in 1980 to $149 in 1986. The average out-of-pocket cost per part B enrollee in 1986 dollars increased about 36 percent during the same period, from $404 to $549. We believe that much of the increase in inflation-adjusted beneficiary costs can be attributed to the six major laws enacted during the period.

TEFRA generally expanded Medicaid cost-sharing options available to the states and, as of December 1986, 26 states took 37 policy actions to either adopt or expand a program under which Medicaid recipients share in the cost of their health services. However, the varying state cost-sharing requirements and nonavailability of state data precluded an analysis, on a national basis, of the change in out-of-pocket costs of Medicaid recipients.

Beneficiary Costs Under Medicare

Under Medicare, beneficiaries pay a deductible for inpatient hospital services which, until 1987, was based on the average cost of 1 day of hospitalization. Currently, the deductible is computed by multiplying the prior year's deductible by the percentage increase in PPS payment rates. A deductible is paid for each benefit period, which begins with a hospitalization and ends when the beneficiary has not been in a hospital or SNF for 60 consecutive days. In 1980, the deductible was $180, but in 1988 it had increased to $540. For extended hospital stays, beneficiaries are required to pay a coinsurance amount equal to one-fourth of the deductible per day ($135 per day in 1988) for the 61st through the 90th day. For stays greater than 90 days, beneficiaries have 60 lifetime reserve days during which they pay a coinsurance amount equal to one-half of the deductible per day ($270 per day in 1988). Beneficiaries who have exhausted their lifetime reserve days are liable for the entire cost of hospital services provided beyond the 90th day.

Medicare pays the full cost of the first 20 days of SNF care after beneficiaries are discharged from a hospital. Beneficiaries pay a coinsurance amount equal to one-eighth of the hospital deductible ($67.50 in 1988) for the 21st through the 100th day, and are responsible for the entire cost of SNF care provided after the 100th day. In addition, aged persons who are not eligible for Social Security and thus not eligible for part A coverage under Medicare can enroll voluntarily by paying a monthly

premium. In fiscal year 1986, about 15,576 people enrolled and paid a monthly premium of $214 each. The monthly premium is $234 for 1988.

Although coverage under part B of Medicare is voluntary, nearly everyone participating in part A also elects to participate in part B. Some people are enrolled only in part B. Enrollees under part B are required to pay a monthly premium ($24.80 in 1988), which establishes coverage. Users of part B services must pay an annual deductible of $75 ($60 before 1982). Under part B, the beneficiary is responsible for paying 20 percent of the Medicare-determined reasonable charge on claims where the physician or supplier has accepted assignment. For unassigned claims, the beneficiary is also liable for the difference between what the physician or supplier charges and what Medicare allows as the reasonable charge.

We estimated average out-of-pocket costs per enrollee under Medicare parts A and B for 1980 and 1986. The results of our analysis are shown in table 4.1.

Table 4.1: 1980 and 1986 Beneficiary Out-of-Pocket Costs

Dollars in millions (except averages)

	1980 cost	1980 cost in 1986 dollars	1986 cost
Part A:			
Deductible	$1,395	$1,860	$3,765
Coinsurance (hospital)	312	416	591
Coinsurance (SNF)	100	133	297
Total	**$1,807**	**$2,409**	**$4,653**
Average cost per enrollee	**$64[a]**	**$86[a]**	**$149[b]**
Part B:			
Deductible	$1,208	$1,611	$1,915
Coinsurance	2,535	3,380	6,259
Premiums	3,011	4,015	5,722
Reasonable charge reductions, unassigned claims	1,538	2,051	2,889
Total	**$8,292**	**$11,057**	**$16,785**
Average cost per enrollee	**$303[c]**	**$404[c]**	**$549[d]**

[a]For 28.1 million enrollees.

[b]For 31.2 million enrollees.

[c]For 27.4 million enrollees.

[d]For 30.6 million enrollees.

Source: HCFA data; costs are for calendar years. We converted the 1980 costs to 1986 dollars using the consumer price index.

As can be seen from table 4.1, the unadjusted average cost per part A enrollee increased from $64 in fiscal year 1980 to $149 in fiscal year 1986—an increase of 132 percent. The unadjusted average cost per part B enrollee increased from $303 to $549—an increase of 81 percent. During the same period, the average monthly Social Security worker's benefit increased from $356 to $488, or about 37 percent.[1]

With the effects of inflation removed, there was an increase in the total amount beneficiaries paid for coinsurance for inpatient hospital stays, SNF care, and inpatient hospital deductibles. This caused the 1986 constant dollar average cost per Medicare part A enrollee to increase from $86 in 1980 to $149 in 1986, an increase of about 73 percent.

The changes in the total part A deductible and coinsurance amounts paid by Medicare beneficiaries were caused in part by legislative changes. Section 1813(b)(2) of the Social Security Act requires the Secretary of HHS to determine, each year, the amount of the hospital deductible. The deductible is derived through a mathematical formula, and the coinsurance amounts for inpatient hospital and SNF care are specified fractions of the inpatient hospital deductible amount. Through 1986, the formula called for a base amount to be multiplied by the ratio of the prior year's average Medicare cost per inpatient day to that cost in 1966. OBRA-81 increased the base amount by 12.5 percent beginning in calendar year 1982. Thus, for that year and each subsequent year, the deductible was 12.5 percent higher than it otherwise would have been.

The decrease in the average length of inpatient hospital stay, which is partly attributed to the enactment of PPS, also contributed to the rapid rise in the deductible. PPS rates were based on average costs per discharge and, as length of stay decreased, average cost per day (used in the formula for the deductible) increased. This in turn increased the deductible.[2] From 1980 through 1986, the average length of stay decreased about 24 percent.

OBRA-86 set the deductible at $520 for 1987 and changed the formula for 1988 and later years to provide that the deductible for a given year

[1]Monthly Social Security benefit payments shown are an average of those paid to retired and disabled workers. Benefits for dependents are not included.

[2]For example, if in a given year the average cost per discharge were $5,000 and the average length of stay were 10 days, average cost per day would be $500. However, if the average length of stay were 8 days, the average cost per day would be $625.

would be equal to the prior year's deductible increased by the percentage increase in the PPS rates. This limit appears to be holding down costs to beneficiaries in 1988 since the increase in the deductible amount between 1987 and 1988 is the lowest for the period.

The deductible and coinsurance amounts for 1980 through 1988 are shown in table 4.2.

Table 4.2: Deductible and Coinsurance Amounts Under Medicare Part A, 1980 Through 1988

	Inpatient hospital			Nursing home
Benefit period	Deductible	Daily coinsurance: 61st through 90th day	Daily coinsurance: 60 lifetime reserve days	Daily coinsurance: 21st through 100th day
1980	$180	$ 45	$ 90	$22.50
1981	204	51	102	25.50
1982	260	65	130	32.50
1983	304	76	152	38.00
1984	356	89	178	44.50
1985	400	100	200	50.00
1986	492	123	246	61.50
1987	520	130	260	65.00
1988	540	135	270	67.50

Source: HCFA's Office of Beneficiary Services.

Thus, increases in the annual inpatient hospital deductible amount during the period were primarily responsible for the after-inflation increase in the total amount paid for part A deductibles (from $1.9 billion in 1980 to $3.8 billion in 1986). Because coinsurance rates are set at percentages of the inpatient hospital deductible, the increases in the deductible also helped increase the total amount paid for inpatient hospital coinsurance from $416 million in 1980 (adjusted for inflation) to $591 million in 1986 and coinsurance for SNF care from $133 million to $297 million. Much of the increase in the deductible over this period was due to the two legislative changes affecting it discussed above.

In addition, OBRA-81 changed the basis for determining the coinsurance for inpatient hospital services. This act based the coinsurance amount on the deductible for the calendar year in which services are received rather than on the deductible in effect at the time the beneficiary's illness began. While this change affects few beneficiaries, it would increase average out-of-pocket costs somewhat.

The inflation-adjusted beneficiary out-of-pocket cost per capita for part B services increased from $404 in 1980 to $549 in 1986, about 36 percent. Increases in the total amounts paid for deductibles, coinsurance, premiums, and reasonable charge reductions on unassigned claims were due in part to the legislative changes enacted during the period. ORA provided that the determination of Medicare reasonable charges for physician services be based on the date the service was rendered rather than the date on which the claim was processed. This change reduced program costs, but it increased beneficiaries' costs on unassigned claims. OBRA-81 increased the part B deductible from $60 to $75 beginning in 1982.

TEFRA changed the calculations of the part B premium for two 1-year periods beginning in July 1983. This change allowed part B premiums to increase to an amount equal to 25 percent of projected part B costs. PPS extended the period through December 1985, DEFRA extended it through 1987, COBRA extended it through 1988, and OBRA-87 extended it through 1989. Because of this change in the calculation of premiums, in 1987, beneficiaries paid about $1.5 billion more (about $48 more per beneficiary per year) than if there had been no change. The premium amounts for 1980 through 1988 are shown in table 4.3.

Table 4.3: Premium Amounts Under Medicare Part B, Calendar Years 1980 Through 1988

Benefit period	Premium amount	Increase in premiums (in percent)
1980	$9.60	•
1981	11.00	14.6
1982	12.20	10.9
1983	12.20	0.0
1984	14.60	19.7
1985	15.50	6.2
1986	15.50	0.0
1987	17.90	15.5
1988	24.80	38.5

As can be seen in the table, the premium increase between 1987 and 1988—$6.90, or 38.5 percent—was the largest for the period. DEFRA limited the increase in the part B premium, beginning in January 1986, to the dollar amount of the Social Security cost-of-living adjustment. This adjustment was 4.2 percent for 1988; thus, all Medicare enrollees who

had monthly Social Security benefits of at least $164 per month[3] in 1987 will pay the full part B premium increase in 1988 of $6.90 per month.

Total beneficiary liability for reasonable charge reductions increased from $2 billion in 1980 to about $2.9 billion in 1986 (in constant 1986 dollars). However, the amount of beneficiary liability for reasonable charge reductions decreased between 1984 and 1986 because of the increased assignment rate. In general, as more physicians accept assignment, out-of-pocket costs to beneficiaries decrease because they have no liability for reasonable charge reductions on assigned claims (see p. 11). DEFRA provided incentives to encourage physicians to accept assignment on all Medicare claims. Other factors, such as the increased supply of physicians, may also have increased the assignment rate. Medicare's national assignment rate hit a low of about 48 percent in 1976, and then began to increase. In fiscal year 1980, the assignment rate was about 52 percent; by fiscal year 1984, it was 58 percent; it increased to 69 percent in fiscal year 1986. In effect, the increase in the assignment rate between 1980 and 1986 meant that beneficiaries were liable for about $1.8 billion less in reasonable charge reductions in 1986 on unassigned claims than if the assignment rate had remained at the 1980 level.

OBRA-86 (as modified by OBRA-87) sets maximum limits on the amount a nonparticipating physician can increase his or her charges to Medicare enrollees (the "maximum allowable actual charge"). Physicians who exceed these charge levels are subject to program sanctions. These limits should help hold down beneficiary liability for reasonable charge reductions.

In summary, the legislative changes discussed above that affected the part B deductible and premium amounts increased beneficiary out-of-pocket costs. The resulting increase in out-of-pocket costs was offset to a large extent by beneficiary savings due to the increase in the assignment rate. Some portion of the higher assignment rate was due to legislative changes to encourage acceptance of assignment by physicians and other suppliers.

Our analysis shows the general change in Medicare beneficiary out-of-pocket costs between 1980 and 1986. There are a number of qualifications, however, about the figures used that should be considered. First, the costs per enrollee shown are average costs for all enrollees. The actual cost to an individual beneficiary can be much higher or much

[3]This is, $164.29 x .042=$6.90. In 1987 the average monthly Social Security benefit was $510.43.

lower than the average depending on the kind and amount of services received. For example, in 1986 only about 25 percent of part A enrollees were hospitalized. The 1986 deductible for inpatient hospital services alone was $492, and thus the out-of-pocket costs for these beneficiaries was higher than the estimated average cost of $149 shown. The other 75 percent of the part A enrollees had no out-of-pocket costs (deductibles or coinsurance) for inpatient hospital services because they were not hospitalized.

In addition, the out-of-pocket costs shown in our analysis do not reflect beneficiary payments for services and health needs generally not covered by Medicare, such as long-term care in SNFs, dental care, outpatient prescription drugs, and hearing aids. In 1980, claims totaling about $508 million were denied because they were for noncovered services. This amount rose to more than $1 billion in 1986.[4] However, most beneficiaries probably do not submit claims for services that are not covered, and we could find no data on the total amount Medicare beneficiaries spend for noncovered services.

The out-of-pocket costs for medical services for some beneficiaries (CBO estimates about 72 percent) are also affected by private health insurance—the most common form is called Medigap insurance. For those beneficiaries that have Medigap policies, out-of-pocket costs are increased by the amount of the premiums and decreased by the benefits paid, which usually cover the Medicare deductible and coinsurance amounts. In a 1986 report,[5] GAO estimated that premiums for Medigap insurance in 1984 totaled about $5 billion. Medigap policies sold to individuals must have anticipated benefits for policyholders of at least 60 percent of premiums collected; policies sold to groups must have anticipated benefits of at least 75 percent of premiums collected.

Based on the policies reviewed, GAO concluded that Medigap policies sold by (1) commercial insurers that had more than $50 million in earned premiums and (2) Blue Cross/Blue Shield plans generally met these specified benefit payouts. However, over 60 percent of the commercial insurance policies with earned premiums under $50 million in 1984 had actual benefit payments below these percentages. Medigap insurance added to beneficiary out-of-pocket expenses because, on average, premium costs were greater than benefits paid.

[4]Amounts shown do not reflect amounts later awarded as a result of a review or hearing.

[5]Medigap Insurance: Law Has Increased Protection Against Substandard and Overpriced Policies (GAO/HRD-87-8, Oct. 17, 1986).

Finally, about 11 percent of Medicare enrollees are also covered under Medicaid. The direct cost per capita to dual beneficiaries is less than the cost to the general Medicare population because Medicaid generally pays dual beneficiaries' coinsurance, deductible, and premium amounts.

Beneficiary Costs Under Medicaid

Medicaid is administered independently by each state, within broad federal guidelines. The states have the flexibility to establish income and resource eligibility levels; the scope, amount, and duration of services; methods and levels of reimbursement; and administrative structure. As a result, Medicaid varies from state to state, including the cost-sharing requirement for Medicaid recipients.

The Medicaid program was established for people who are unable to pay for health care. The original Medicaid legislation, enacted in 1965, prohibited the imposition of any cost-sharing for inpatient hospital services for all Medicaid eligibles. Cost-sharing for other services was permitted, but was based on the recipient's income and resources. This relationship to income and resources, in effect, totally exempted the categorically needy from all Medicaid cost-sharing since their eligibility for one of the cash assistance programs—and thus for Medicaid—was conditioned on their lack of income and resources.

The 1972 amendments to the Social Security Act changed the Medicaid cost-sharing requirements, allowing states to impose on the categorically needy nominal copayments for optional services. TEFRA, enacted September 3, 1982, further expanded state cost-sharing options. With certain exceptions, states can now require copayments, coinsurance, and deductibles for almost all services—mandatory as well as optional—for both the categorically and medically needy.

Under TEFRA, cost-sharing was to remain nominal. For example, deductibles cannot exceed $2 per month per family for each period of eligibility; coinsurance rates cannot exceed 5 percent of the payment the state makes for the service; and maximum copayments for noninstitutional services range from $.50 to $3, depending on the amount of the state payment for the service.

Since TEFRA, states have generally expanded their cost-sharing requirements. Surveys of state Medicaid programs by the Intergovernmental Health Policy Project and the National Governors' Association show that, during September 1982 to December 1986, at least 26 states took 37 policy actions to either adopt a copayment program or expand an

existing program, while 14 states dropped or relaxed copayment programs. As of December 1986, 28 states and the District of Columbia had copayment programs, while 22 states did not.

Among states that have cost-sharing programs, there is a wide variation in the services and procedures on which copayments are imposed. For example, Maine requires a copayment only on prescription drugs; Iowa has copayment requirements on 12 types of health services, including podiatrist, optometrist, dental, medical equipment, hearing aids, and physical therapy. Some of the more common services for which copayments are imposed include prescription drugs, hearing aids, dental care, and hospital emergency room services for nonemergency health care.

Only three states with cost-sharing programs have coinsurance provisions. Florida Medicaid recipients must pay 5 percent of the cost of dentures and hearing aids; Missouri recipients must pay for dental care 5 percent of whichever is less—allowable Medicaid reimbursement or provider's billed charges. South Dakota charges 5 percent of allowable reimbursement for prosthetic devices, medical equipment, and mental health center services.

Medicaid beneficiaries can incur substantial out-of-pocket costs when they are institutionalized in a nursing home. These beneficiaries are required to apply all of their income[6] to the cost of their care except for a personal needs allowance (for example, $25 a month in Georgia and $35 a month in Maryland). Thus, if the cost of a Georgia beneficiary's nursing home care was $1,200 per month and he or she received Social Security benefits of $500 per month, $475 would be applied to the cost of care, the beneficiary would retain $25 as a personal needs allowance, and Medicaid would pay the nursing home $725 and pay for any other covered services the beneficiary received.

However, Medicaid recipients' use of personal income to offset some of the cost of nursing home care is not strictly comparable with the out-of-pocket medical expenses for noninstitutionalized Medicaid and Medicare beneficiaries. As out-of-pocket costs for medical services increase, noninstitutionalized beneficiaries generally have less to spend on their other needs. This is not a problem, however, with Medicaid recipients living in nursing homes because their basic needs (e.g., room and board) are furnished by the nursing home.

[6]If the beneficiary has a spouse who is not institutionalized, a portion of the beneficiary's income is provided for the spouse's maintenance.

Summary

From 1980 through 1986, Medicare beneficiary average out-of-pocket costs (adjusted for inflation) have increased about 73 percent for part A services and about 36 percent for part B services. We believe that most of the increase can be attributed to major legislation enacted during the period.

We could not measure the change in Medicaid recipient out-of-pocket costs. However, many states have expanded their cost-sharing requirements for Medicaid recipients since the enactment of TEFRA.

Increase in Medicare Providers and Use of Services

The number of providers participating in Medicare increased about 36 percent from 1980 through 1986. The greatest increase was in the number of home health agencies (HHAs). The number of licensed physicians increased nationwide from 365,000 in 1980 to nearly 442,000 in 1986. HCFA does not have information on the number of physicians who actually treat Medicare beneficiaries.

The use rate of some types of Medicare services—particularly under part B—also increased during 1980 through 1986. In contrast, the number of covered days of care in hospitals under part A decreased about 28 percent.

Increase in Medicare Providers

Under Medicare, providers are defined as the following: hospitals, SNFs, HHAs, hospices, and comprehensive outpatient rehabilitation and outpatient physical therapy (including speech pathology) facilities. During 1980 through 1986, there was an increase in the number of all types of health care providers participating in the Medicare program, except for inpatient hospitals, which decreased by about 1 percent. The number and type of providers participating in Medicare in 1980 and 1986 are shown in table 5.1.

Table 5.1: Number of Providers Participating in Medicare, 1980 and 1986

Type of facility	Participating as of June 1980	Participating as of June 1986	Difference between 1980 and 1986	Growth rate (in percent)
Hospitals	6,777	6,720	−57	−0.8
SNFs	5,052	6,897	1,845	36.5
HHAs	2,924	5,978	3,054	104.4
Hospices	[a]	268	268	•
Comprehensive outpatient rehabilitation facilities	[b]	96	96	•
Outpatient physical therapy[c]	419	907	488	116.5

[a]Coverage was effective 11/83.

[b]Coverage was effective 7/81.

[c]Includes speech pathology.

Source: HCFA's Bureau of Data Management and Strategy.

Although not included in the Medicare definition of provider, we also attempted to gather data on the number of other types of facilities that furnished services under Medicare in 1980 and 1986 (see table 5.2).

Table 5.2: Other Facilities Furnishing Services Under Medicare, 1980 and 1986

Type of facility	Participating as of June 1980	Participating as of June 1986	Difference between 1980 and 1986	Growth rate (in percent)
Independent laboratories[a]	3,663	4,138	475	13.0
End stage renal disease facilities	999	1,463	464	46.4
Rural health clinics	391	432	41	10.5
Ambulatory surgical centers	[b]	574	574	•

[a]Includes portable X-ray.

[b]Coverage was effective 7/82.

Source: HCFA's Bureau of Data Management and Strategy.

Under Medicare, any licensed physician, unless specifically excluded,[1] can participate in the program and receive payment for treating beneficiaries. Nationally, there were 365,000 licensed physicians in 1980 and 441,849 in 1986. HCFA does not maintain information on the number of physicians who actually treat Medicare beneficiaries.

Since October 1, 1984, Medicare has had a "participating physician" program, under which physicians can agree on a year-to-year basis to accept assignment on all Medicare claims. Nonparticipating physicians may accept or reject assignment on a claim-by-claim basis, as all physicians treating Medicare patients did before the participating physician program was introduced. As incentives to participate, DEFRA provided for periodic publication of lists of participating physicians and electronic claims processing for them. The number of participating physicians in Medicare increased from 118,428 in fiscal year 1985 to 128,624 in December 1987.

Increase in Use of Medicare Services

In general, the use of Medicare part A services decreased during the period 1980 through 1986, while the use of part B services increased. The use of selected Medicare services in 1980 and 1986 is shown in table 5.3.

[1]Physicians convicted of Medicare-related or Medicaid-related crimes are automatically excluded. Physicians can also be excluded if HHS determines that they have (1) submitted fraudulent claims, (2) habitually overutilized or otherwise abused the Medicare program, or (3) failed to provide care of a quality meeting professionally recognized standards of health care.

Table 5.3: Beneficiary Use of Medicare Services, 1980 and 1986

	Use rate per 1,000 enrollees	
	Fiscal year	
Type of service	1980	1986[a]
Covered days of care, inpatient hospital	3,908	2,817
Covered days of care, SNF	309	261
Visits, HHA	772	1,229
	Calendar year	
	1980	1986[b]
Outpatient hospital services	275	384
Physician and other medical services	630	725

[a]Current as of November 1987, but still considered incomplete by HCFA.

[b]Data for 1986 were not available; figures shown are GAO projections based on the average increase in use for 1980 through 1985.

Source: HCFA's Bureau of Data Management and Strategy.

As can be seen from table 5.3, the use of HHA, outpatient hospital, and physician and other medical services increased during the period, while the number of inpatient hospital and SNF days decreased.

Public Laws Changing Medicare and Medicaid (Mar. 1980 to Dec. 1987)

Public law	Title	Date
96-212	Refugee Act of 1980	Mar. 17, 1980
96-265	Social Security Disability Amendments of 1980	June 9, 1980
96-272	Adoption Assistance and Child Welfare Act of 1980	June 17, 1980
96-369	Funding of Abortions	Oct. 1, 1980
96-422	Refugee Education Assistance Act of 1980	Oct. 10, 1980
96-473	Status of Applications in Regard to Medicare Entitlement	Oct. 19, 1980
96-499	Omnibus Reconciliation Act of 1980	Dec. 5, 1980
97-12	Funding of Abortions, Resettlement of Refugees	June 5, 1981
97-34	Economic Recovery Tax Act of 1981	Aug. 13, 1981
97-35	Omnibus Budget Reconciliation Act of 1981	Aug. 13, 1981
97-51	Funding of HHS Activities	Oct. 1, 1981
97-85	Funding of HHS Activities	Nov. 23, 1981
97-92	Funding of HHS Activities	Dec. 15, 1981
97-248	Tax Equity and Fiscal Responsibility Act of 1982	Sept. 3, 1982
97-276	Funding of HHS Activities	Oct. 2, 1982
97-377	Funding of HHS Activities	Dec. 21, 1982
97-414	Orphan Drug Act	Jan. 4, 1983
97-448	Technical Corrections Act of 1982	Jan. 12, 1983
98-8	Funding—Home Health Services	Mar. 4, 1983
98-21	Social Security Amendments of 1983	Apr. 20, 1983
98-94	DOD Authorization Act of 1984	Sept. 24, 1983
98-107	Funding for Health Planning	Oct. 1, 1983
98-139	Appropriations Act for Labor, HHS, Education & Related Agencies Act, 1984	Oct. 31, 1983
98-151	Funding for Health Planning and Refugee Assistance	Nov. 14, 1983
98-369	Deficit Reduction Act of 1984	July 18, 1984
98-460	Social Security Disability Benefits Reform Act of 1984	Oct. 9, 1984
98-473	Funding of HHS Activities	Oct. 12, 1984
98-527	Developmental Disabilities Act of 1984	Oct. 19, 1984
98-619	Appropriations Act for Labor, HHS, and Related Agencies	Nov. 9, 1984
99-107	Emergency Extension Act of 1985	Sept. 30, 1985
99-177	Balanced Budget and Emergency Deficit Control Act of 1985	Dec. 12, 1985
99-272	Consolidated Omnibus Budget Reconciliation Act of 1985	Apr. 7, 1986
99-509	Omnibus Budget Reconciliation Act of 1986	Oct. 21, 1986
99-576	Veterans' Benefits Improvement and Health-Care Authorization Act of 1986	Oct. 28, 1986
100-93	Medicare and Medicaid Patient and Program Protection Act of 1987	Aug. 18, 1987
100-119	Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987	Sept. 29, 1987
100-203	Omnibus Budget Reconciliation Act of 1987	Dec. 22, 1987

Health Care Financing Administration's Estimates of Six Major Laws' Effects on Medicare Costs

Table II.1: Effects of ORA

Dollars in millions

Section	Part A provisions	Effective date	Fiscal Years 1981	1982	1983	1984	1985
901	Nonprofit hospital philanthropy	On enactment	[a]	[a]	[a]	[a]	[a]
902	Reimbursement for inappropriate inpatient hospital services	July 1, 1981	[a]	$−35	$−40	$−45	$−55
904	Hospital providers of long-term care	July 1, 1981	[a]	[a]	[a]	[a]	[a]
914	Coordinated audits under the Social Security Act	Apr. 1, 1981	$−4	−4	−4	−4	−4
918	Reimbursement of clinical laboratories	Apr. 1, 1981	−14	−22	−26	−29	−34
Section	**Part B provisions**						
930	HHA services:	July 1, 1981					
	Remove 100-visit limit		[a]	5	7	8	10
	Remove 3-day prior hospitalization stay requirement		2	12	13	15	16
	Remove HHA under part B from $60 deductible requirement		[a]	[a]	[a]	[a]	[a]
	Occupational therapy included as qualifying service		4	35	41	46	52
	Remove licensure requirement for proprietary HHA		[a]	[a]	5	10	15
931	Alcohol detoxification facility services	Apr. 1, 1981	40	70	90	110	120
932	Preadmission diagnostic testing	On enactment	[a]	[a]	[a]	[a]	[a]
933	Comprehensive outpatient rehabilitation facility services	July 1, 1981	5	13	15	17	20
934	Outpatient surgery	On enactment	0	−1	−4	−6	−9
936	Dentists' services	July 1, 1981	2	17	19	22	25
937	Optometrists' services	July 1, 1981	0	2	2	3	3
938	Antigens	Jan. 1, 1981	[a]	[a]	[a]	[a]	[a]
939	Treatment of planter warts	July 1, 1981	0	2	2	2	2
941	Presumed coverage provisions	Jan. 1, 1981	0	0	0	0	0
942	Payment to providers of services	On enactment	−5	−7	−9	−10	−12
943	Limitation on payments to radiologists and pathologists	July 1, 1981	0	−14	−20	−26	−30
944	Physician treatment plan for speech pathology	Jan. 1, 1981	0	0	0	0	0
945	Reenrollment and open enrollment in part B	Apr. 1, 1981	2	16	18	20	23
946	Determination of reasonable charge	July 1, 1981	−157	−226	−231	−250	−279
947	Shortened part B termination period for certain individuals whose premiums Medicaid has ceased to pay	Apr. 1, 1981	0	0	0	0	0
948	Reimbursement of physicians' services in teaching hospitals	Jan. 1, 1981	[a]	[a]	[a]	[a]	[a]
950	Hospital transfer requirement for SNF coverage	On enactment	[a]	[a]	[a]	[a]	[a]
953	Medicare liability secondary where payment can be made under liability or no fault insurance	On enactment	0	0	−25	−39	−45
954	Payment for physicians' service where beneficiary has died	Jan. 1, 1981	0	0	0	0	0
956	Payment where beneficiary not at fault	Jan. 1, 1981	[a]	[a]	[a]	[a]	[a]
957	Technical renal disease amendments	On enactment	[a]	[a]	[a]	[a]	[a]
959	Temporary delay in periodic interim payments	Sept. 1981	[a]	[a]	[a]	[a]	[a]

[a]Negligible, not available, or indeterminate.

[b]Not applicable.

Source: HCFA's Office of the Actuary.

Table II.2: Effects of OBRA-81

Dollars in millions

Section		Effective date	Fiscal years 1982	1983	1984	1985	1986
2101	Payments to promote closing and conversion of underutilized facilities	Oct. 1, 1981	[a]	[a]	[a]	[a]	[a]
2102	Adjustment in payment for inappropriate hospital services	Sept. 1, 1981	$−10	$−10	$−10	$−15	$−20
2121	Elimination of part A coverage of alcohol detoxification facility services	Aug. 23, 1981	−70	−90	−110	−120	−130
2122	Elimination of need for occupational therapy as a basis for initial entitlement to home health services	Dec. 1, 1982	−35	−41	−46	−52	−58
2133	Deletion of part B deductible carryover provision	Jan. 1, 1982	−55	−55	−55	−55	−55
2134	Increase in part B deductible	Jan. 1, 1982	−120	−210	−240	−250	−260
2141	Limitation on cost differentials	Oct. 1, 1981	−100	−125	−155	−190	−235
2142	Limitation on reasonable cost and reasonable charge for outpatient services	On enactment	[a]	[a]	[a]	[a]	[a]
2146	Medicare payments secondary in cases of end-stage renal disease	Jan. 1, 1982	[a]	[a]	[a]	[a]	[a]
2151	Elimination of unlimited open enrollment	Oct. 1, 1981	−3	−10	−11	−13	−14
2155	Elimination of temporary delay in periodic interim payments	On enactment	−522	[b]	[b]	[b]	[b]

[a]Negligible, not available, or indeterminate.

[b]Not applicable

Source: HCFA's Office of the Actuary.

Table II.3: Effects of TEFRA

Dollars in millions

Section	Part A provisions	Effective date	Fiscal years 1983	1984	1985	1986	1987
101	Payment for inpatient hospital services	Oct. 1, 1982	$−405	$−1,240	$2,490	$−3,640	$−4,195
102	Single reimbursement limits for SNFs	Oct. 1, 1982	−15	−40	−40	−45	−50
103	Elimination of the nursing salary cost differential	Oct. 1, 1982	−93	−115	−128	−144	−162
105	Single reimbursement limits for HHAs	Oct. 1, 1982	−3	−6	−6	−7	−8
106	Prohibiting payment for Hill-Burton free care	On enactment	[b]	[b]	[b]	[b]	[b]
107	Prohibiting payment for anti-unionization activities	On enactment	[a]	[a]	[a]	[a]	[a]
108	Reimbursement of provider-based physicians	Oct. 1, 1982	235	320	380	430	485
109	Prohibiting recognition of payments under percentage arrangements	On enactment	[a]	[a]	[a]	[a]	[a]
110	Eliminating "lesser of cost or charges" provision	When HHS specifies to the Congress	[a]	[a]	[a]	[a]	[a]
111	Elimination of private room subsidy	Oct. 1, 1982	[a]	[a]	[a]	[a]	[a]
114	Health maintenance organizations and other competitive medical plans	Sept. 30, 1982	0	0	[a]	[a]	[a]
116	Medicare payments secondary for working aged	Jan. 1, 1983	−145	−260	−300	−355	−375
117	Interest charges on overpayments and underpayments	On enactment	[a]	[a]	[a]	[a]	[a]
119	Private sector review initiative	On enactment	−267	−322	−377	−437	−502
120	Temporary delay in periodic interim payments	Sept. 1983 and Sept. 1984	−750	−100	870	0	0
121	Medicare coverage of federal employees	Jan. 1. 1983	25	50	75	105	155
122	Hospice care	Nov. 1, 1983	0	70	110	140	210
123	Coverage of SNF services without regard to 3-day prior hospitalization requirement	[c]	[a]	[a]	[a]	[a]	[a]
126	Extending Medicare proficiency examination authority	On enactment	[a]	[a]	[a]	[a]	[a]
Section	**Part B provisions**						
104	Elimination of duplicate overhead payments for outpatient services	Oct. 1, 1982	−75	−135	−175	−210	−255
108	Reimbursement for provider-based physicians	Oct. 1, 1982	−300	−400	−480	−540	−610
109	Prohibiting recognition of payments under certain percentage arrangements	On enactment	[a]	[a]	[a]	[a]	[a]
110	Elimination of lesser amount, either cost or charges	When HHS specifies	[a]	[a]	[a]	[a]	[a]
112	Reimbursement of inpatient radiology and pathology services	Oct. 1, 1982	−150	−210	−245	−280	−315
113	Reimbursement for assistants at surgery	Oct. 1, 1982	−95	−125	−150	−170	−195
114	Health maintenance organizations and other competitive medical plans	Oct. 1, 1983	[a]	[a]	[a]	[a]	[a]
116	Medicare secondary payer for working aged	Jan. 1, 1983	−30	−55	−65	−75	−85

(continued)

Section	Part A provisions	Effective date	Fiscal years 1983	1984	1985	1986	1987
124	Temporarily holding part B premium at constant percentage of cost	July 1, 1983	−25	−175	−405	−440	−460
125	Special enrollment for merchant seamen	On enactment	[a]	[a]	[a]	[a]	[a]

[a]Negligible, not available, or indeterminate.

[b]Hill-Burton costs are about $15 million per year. These costs, however, are not included in the health insurance estimates.

[c]The provision will be enacted when HHS determines that it will not lead to program costs.

Source: HCFA's Office of the Actuary.

Table II.4: Effects of DEFRA

Dollars in millions

Section	Part A provisions	Effective date	Fiscal years 1984	1985	1986	1987
2301	Modification of working aged	Jan. 1, 1985	$0	$−155	$235	$−260
2308	Lesser of cost or charges	Oct. 1, 1984	[a]	[a]	[a]	[a]
2310	Limitation on increase in hospital costs case	Oct. 1, 1984	0	0	−245	−370
2311	Classification of certain rural hospitals	Oct. 1, 1983	0	0	0	0
2314	Revaluation of assets:					
	Hospital		[a]	[a]	[a]	[a]
	SNF	Oct. 1, 1984	[a]	[a]	[a]	[a]
2316	PPS wage index	Oct. 1, 1983	0	0	0	0
2319	SNF reimbursement	Oct. 1, 1982	[a]	[a]	[a]	[a]
2320	Payment for costs of hospital-based mobile intensive care units	On enactment	[a]	[a]	[a]	[a]
2321	Cost sharing for durable medical equipment furnished as a home health benefit	On enactment	[a]	−8	−10	−11
2322	Services of clinical psychologists provided to members of a health maintenance organization	On enactment	[a]	[a]	[a]	[a]
2337	Normalization of trust fund transfers	Sept. 1, 1984	0	0	0	0
2344	Medicare recovery against certain third parties	On enactment	[a]	[a]	[a]	[a]
Section	**Part B provisions**					
2301	Modification for working aged	Jan. 1, 1985	0	−50	−80	−85
2302	Part B premium[b]	Jan. 1, 1986	0	109	−266	−802
	Impact of the change in financing		0	0	−439	−988
	Impact of all other provisions on premium income		0	109	173	186
2303	Payment for clinical diagnostic lab	July 1, 1984	−30	−135	−235	−290
2304	Pacemaker reimbursement review and reform tests	Oct. 1, 1984	[a]	[a]	[a]	[a]
2305	Elimination of special payment provisions for preadmission diagnostic testing	On enactment	[a]	[a]	[a]	[a]
2306	Limit on physician fee to prevailing and customary charge levels participating physician incentives	July 1, 1984	−75	−350	−325	−275
2307	Payment for services—teaching physicians	July 1, 1984	[a]	[a]	[a]	[a]
2309	Study of Medicare part B payments	Dec. 31, 1985	[a]	[a]	[a]	[a]
2318	Emergency room services	On enactment	[a]	[a]	[a]	[a]
2323	Hepatitis B vaccine coverage	Sept. 1, 1984	0	10	5	5
2324	Hemophilia clotting factor	On enactment	[a]	[a]	[a]	[a]
2325	Removal of infected toenails	On enactment	[a]	[a]	[a]	[a]
2341	Includes podiatrists in definition of physician for outpatient physical therapy services; includes podiatrists and dentists in definition of physician for outpatient ambulatory surgery	On enactment	[a]	[a]	[a]	[a]

[a]Negligible, not available, or indeterminate.

[b]Includes impact of all sections on premium income.

Source: HCFA's Office of the Actuary.

Table II.5: Effects of COBRA

Dollars in millions

Section	Provisions	Effective date	Fiscal years 1986	1987
9101	Rate of increase in payment for inpatient hospital services	May 1, 1986	$35	$200
9102	1-year extension of PPS transition	On enactment	[a]	10
9104	Payment to hospitals for indirect costs of medical education	May 1, 1986	−175	−630
9105	Payment to hospitals for disproportionate share of low-income patients	May 1, 1986	200	0
9107	Return on equity capital for inpatient hospital services	Oct. 1, 1986	0	−40
9123	Extension and payment for hospice care	Apr. 1, 1986	5	55
9124	Limiting penalty for late enrollment in part A	July 1, 1986	[a]	5
9126	Access to SNFs	Oct. 1, 1986	0	30
9129	New Medicare coverage of state and local employees	On enactment	23	182
9201	Extension of working aged provisions	May 1, 1986	[a]	−225
9202	Payment to hospitals for direct costs of medical education	July 1, 1986	20	50
9301	Physician payment provisions	May 1, 1986	−125	−450
9303	Payment for clinical lab services	July 1, 1986	−5	10
9304	Inherent reasonableness of charges and customary charges by certain physicians	May 1, 1986	[a]	[a]
9306	Limit on payment of post-cataract surgery	Apr. 1, 1986	−10	−25
9307	Payment for assistant at surgery for certain cataract operations	Apr. 1, 1986	−15	−35
9313	Part B premium (income)	Jan. 1, 1988	0	0

[a]Negligible, not available, or indeterminate.

Source: HCFA's Office of the Actuary.

Table II.6: Effects of OBRA-86

Dollars in millions

Section	Provisions	Effective date	Fiscal year 1987
9001	Elimination of 3-percent trigger for cost-of-living increase (income)	Jan. 1, 1986	$700
9301	Inpatient hospital deductible	Jan. 1, 1987	300
9302	Inpatient hospital payment rate	Oct. 1, 1986	200
9303	Capital costs	Oct. 1, 1986	−200
9304	PPS in Puerto Rico	Oct. 1, 1987	[a]
9311	PIP and Prompt Payment:		
	Part A	Apr. 1, 1987	900
	Part B	Apr. 1, 1987	−100
9312	HMO-Repeal of 2-for-1	Apr. 1, 1987	[a]
9314	Direct costs of graduate medical education	July 1, 1987	[a]
9315	Home health services	July 1, 1986	[a]
9318	Organ procurement	Oct. 1, 1987	[a]
9319	Working disabled	Jan. 1, 1987	−300
9320	Certified registered nurse anesthetists	Jan. 1, 1989	0
9331	Physician services	Jan. 1, 1987	100
9334	Cataract surgical procedures	Jan. 1, 1987	−100
9335	End stage renal disease services	Oct. 1, 1986	100
9336	Vision care	Apr. 1, 1987	100
9337	Occupational therapy	July 1, 1987	[a]
9338	Physician assistant	Jan. 1, 1987	[a]
9339	Clinical diagnostic lab test	Jan. 1, 1987	[a]
9340	Parenteral and enteral nutrition	Jan. 1, 1987	[a]
9343	Ambulatory surgery	Jan. 1, 1987	[a]

[a]Negligible, not available, or indeterminate.

Source: HCFA's Office of the Actuary.

The President's Legislative Proposals and Estimated Cost Savings

Dollars in millions

FY 81 proposed legislation	Administration cost saving estimates 1981	1982	1983	1984	1985	Comments
Medicare:						
Eliminate the routine nursing cost differential	$191	$245	$305	$375	$455	OBRA-81 reduced the differential and TEFRA eliminated it.
Make Medicare secondary payer when accident or liability insurance is available	0	30	35	40	45	ORA included a similar provision.
FY 82 proposed legislation	**1982**	**1983**	**1984**	**1985**	**1986**	
Medicare:						
Modify contracting method for claims processing to include competition	23	47	78	119	127	DEFRA authorized less extensive authority for fixed price contracting—two competitive contracts each for parts A and B in fiscal years 1985 and 1986. OBRA-86 extended the authority through fiscal year 1989.
Eliminate routine nursing cost differential	250	285	350	435	530	OBRA-81 reduced the differential and TEFRA eliminated it.
Eliminate occupational therapy as qualifying basis for home health care coverage	35	41	46	52	58	Enacted as part of OBRA-81.
Eliminate part A coverage of alcohol detoxification facility services	70	90	110	120	130	Enacted in OBRA-81.
Eliminate additional dental coverage	17	19	22	25	28	Not enacted.
Eliminate temporary delay in periodic interim payments	522	0	0	0	0	Enacted in OBRA-81.
Repeal utilization review requirements	66	70	103	106	108	Not enacted.
Eliminate coverage for pneumococcal vaccine	55	45	45	50	55	Not enacted.
Medicaid:						
Establish cap on Medicaid appropriations that would be adjusted annually	1,039	2,012	2,963	3,950	5,055	OBRA-81 reduced federal sharing rates for 3 years; states could avoid reductions by taking specific actions and/or holding down the percentage increase in Medicaid costs.
FY 83 proposed legislation	**1983**	**1984**	**1985**	**1986**	**1987**	
Medicare:						
Delay eligibility for benefits until the month after the month in which a person reaches age 65	$131	$165	$196	$228	$262	Not enacted.
Annually increase part B deductible by percentage increase in consumer price index	46	105	188	250	339	Not enacted.

(continued)

FY 83 proposed legislation	1983	1984	1985	1986	1987	
Make Medicare secondary payer for persons age 65 to 70 covered by employer-sponsored health plans	$287	$368	$421	$478	$536	Similar provision enacted in TEFRA.
Require coverage of federal employees for part A	594	794	858	964	1,010	Similar provision enacted in TEFRA.
Impose 5-percent coinsurance on home health care	35	65	70	80	85	Not enacted.
Change reasonable charge update to October 1 and limit increase in prevailing charge levels	257	293	300	296	298	DEFRA changed fee screen year to October 1 and froze physician fees; subsequent legislation extended the freeze and changed the fee screen year to January 1.
Eliminate 100-percent reimbursement rate for certain radiologists and pathologists	160	210	250	280	320	Enacted in TEFRA.
Reduce hospital reimbursement by 2 percent	688	889	995	1,149	1,304	TEFRA limited the rate of increase in Medicare payments per case for a 3-year period.
Eliminate utilization review requirements for hospitals and skilled nursing facilities	83	86	89	93	96	Not enacted.
Medicaid:						
Eliminate federal sharing for buying recipients into Medicare and reduce sharing rate for family planning services	258	276	300	322	344	Not enacted.
Reduce federal sharing for costs of services and recipients not required to be covered by federal law	600	670	740	810	890	Not enacted.
Require recipient copayments for certain services and authorize copayments for other services	329	370	415	460	520	TEFRA authorized nominal copayments for most services.
Allow states to attach liens on property of the institutionalized	183	200	221	241	263	TEFRA included some of the proposed modifications or variations of them.
Reduce period of eligibility from 4 months to 30 days after recipients lose AFDC because of increased earnings	75	85	95	105	115	Not enacted.
Eliminate utilization review requirements for hospitals and skilled nursing facilities	16	17	17	17	17	Not enacted.
Eliminate, by FY 89, federal match in erroneous expenditures when thresholds are exceeded	59	130	225	329	363	Similar provision included in TEFRA.
Establish limitation on total federal funds available for sharing in state administrative costs	227	294	404	466	542	Not enacted.

(continued)

FY 84 proposed legislation	1984	1985	1986	1987	1988	
Medicare:						
Use Medicare economic index to increase annually the part B deductible	$46	$119	$198	[a]	[a]	Not enacted.
Increase part B premiums to 35 percent of program costs by 1988	151	245	1,292	[a]	[a]	TEFRA set the premium at 25 percent of part B costs, and this has been extended a number of times, currently through 1989.
Reduce hospital payment rate to market basket index	80	170	200	[a]	[a]	Modified provision included in DEFRA.
Freeze physicians' reasonable charge levels for 1 year	700	900	1,000	[a]	[a]	DEFRA included a physician fee freeze provision.
Eliminate utilization review requirements for hospitals and skilled nursing facilities	[a]	[a]	[a]	[a]	[a]	Not enacted.
Clarify provisions related to Medicare recovery from liable third parties	[a]	[a]	[a]	[a]	[a]	Similar provision included in DEFRA.
Establish hospital prospective payment system	[a]	[a]	[a]	[a]	[a]	Modified provision in Social Security Amendments of 1983.
Medicaid:						
Reduce federal matching payments by 3 percent for FY 85 and succeeding years	[a]	[a]	[a]	[a]	[a]	Not enacted.
Change provision concerning third party payments	[a]	[a]	[a]	[a]	[a]	Similar provision included in COBRA.
Require copayments for certain services and permit them for other services	[a]	[a]	[a]	[a]	[a]	Not enacted.
Eliminate utilization review requirements for hospitals and skilled nursing facilities	[a]	[a]	[a]	[a]	[a]	Not enacted.
FY 85 proposed legislation	**1985**	**1986**	**1987**	**1988**	**1989**	
Medicare:						
Use Medicare economic index to increase part B deductible annually	$37	$84	$155	$242	$341	Not enacted.
Provide for eligibility for Medicare in first full month all eligibility requirements are met	249	287	320	353	397	Not enacted.
Increase part B premium to 35 percent of program costs by 1990	290	1,053	2,200	3,512	5,087	DEFRA extended through 1987 the TEFRA provision that the premium produce 25 percent of estimated program costs.
Prospective payment for ambulatory surgery in hospital outpatient department	[a]	[a]	[a]	[a]	[a]	Similar provision in OBRA-86.

(continued)

FY 85 proposed legislation	1985	1986	1987	1988	1989	
Medicaid:						
Make permanent the provision that limits federal payments to state	$567	$493	$541	$592	$642	Not enacted.
Require copayments for certain services and authorize them for other services	270	278	289	299	309	Not enacted.
FY 86 proposed legislation	**1986**	**1987**	**1988**	**1989**	**1990**	
Medicare:						
Establish voucher program	[a]	[a]	[a]	[a]	[a]	Not enacted.
FY 87 proposed legislation	**1987**	**1988**	**1989**	**1990**	**1991**	
Medicare:						
Increase part B deductible to $100 and annually thereafter increase by percentage increase in the Medicare economic index	$310	$490	$615	$730	$850	Not enacted.
Provide for eligibility for Medicare in first full month all eligibility requirements are met	$265	$300	$325	$350	$380	Not enacted.
Require 1-percent coinsurance for home health services	100	110	130	140	160	Not enacted.
Over a 5-year period, increase part B premium to 35 percent of program costs	690	1,420	2,760	4,320	6,120	Not enacted.
Make Medicare secondary payer for disabled persons covered by employer-sponsored group health plans	330	350	380	415	455	Similar provision included in OBRA-86.
Apply deductible and coinsurance to services provided in ambulatory surgical centers	10	10	10	10	10	Similar provision included in OBRA-86.
Reduce indirect medical education add-on payment to hospitals	465	615	695	780	860	OBRA-86 extended the COBRA adjustments through FY 89. OBRA-87 reduced the indirect medical education adjustment but not as much as proposed.
Freeze fee schedule rates for clinical laboratory tests	40	30	30	35	35	OBRA-87 froze Medicare payments from January 1, 1988, through March 31, 1988, and set ceilings thereafter.
Reduce hospital payments for direct medical education costs	275	300	330	360	390	Similar provision included in OBRA-86.
Require uniform modifications to the Medicare economic index	80	40	5	0	0	OBRA-86 set the amount of increase in the index for 1987 and prohibited HHS from revising the method of computing it.
Medicaid:						
Place cap on federal funds available for Medicaid sharing	882	2,200	3,024	3,891	4,878	Not enacted.
Eliminate special higher sharing rates for administrative costs	260	268	278	288	297	Not enacted.

(continued)

FY 88 proposed legislation	1988	1989	1990	1991	1992	
Medicare:						
Annually adjust part B deductible by percentage increase in the Medicare economic index	$25	$75	$150	$200	$275	Not enacted.
Permanently set part B premium at 25 percent of program costs for current enrollees and 35 percent for new enrollees	571	1,829	3,059	4,449	5,759	Not enacted.
Secondary payer provisions to include disabled beneficiaries	120	150	165	180	195	Enacted in OBRA-86 and modified by OBRA-87.
Eliminate separate occupational therapy benefit	60	70	85	95	110	Not enacted.
Restrict optometrists' services	210	230	260	290	320	Not enacted.
Provide for eligibility for Medicare in first full month all eligibility requirements are met	295	335	370	395	425	Not enacted.
Require coverage of all state and local government employees	$1,600	$2,200	$2,200	$2,200	$2,200	COBRA had required Medicare coverage of state and local government employees hired after December 1985. This extension was not enacted.
Permit determination of PPS update factor	510	620	660	710	750	OBRA-87 set update rates for FY 88 and FY 89.
Restrict payments for direct costs of medical education	310	365	375	385	395	Similar provision in OBRA-86.
Reduce payments for indirect costs of medical education	835	1,165	1,265	1,345	1,430	OBRA-86 extended the COBRA adjustments through FY 89. OBRA-87 reduced the indirect medical education adjustment but not as much as proposed.
Set rate for capital-related costs	0	0	350	360	360	Similar provision enacted in OBRA-87.
Require reduction in payments for cataract surgery	100	100	100	100	100	Related provision in OBRA-87.
Change provision concerning durable medical equipment	15	20	25	25	30	Similar provision enacted in OBRA-87.
Eliminate PIP for certain hospitals	1,180	90	100	90	90	Not enacted.
Limit customary charges for new physicians	70	120	130	140	160	Related provision in OBRA-87.
Medicaid:						
Place cap on federal sharing in Medicaid	1,300	2,544	3,591	4,768	6,152	Not enacted.
Eliminate federal requirements for state payment rates	[a]	[a]	[a]	[a]	[a]	Not enacted.
Eliminate increased matching rates for administrative costs	255	265	273	280	286	Not enacted.

[a]Not available or no savings indicated.

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