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SUMMARY OF GAO TESTIMONY BEFORE THE
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
HOUSE COMMITTEE ON ENERGY AND COMMERCE

The Reconciliation Instructions contained in the Conference Report of the First Concurrent Resolution on the budget for fiscal year 1984 provides that none of the savings to be achieved from the Medicare program shall come from provisions to increase costs to beneficiaries or from reductions in services to them. Rather, savings are to be obtained from improved controls on provider services.

Several legislative proposals aimed at changing the way Medicare pays for diagnostic laboratory services are consistent with this criteria.

GAO supports the Administration's proposal authorizing Medicare to become a "prudent buyer" of certain miscellaneous health services which are usually chosen by physicians rather than by beneficiaries, but believes that it should be expanded to include renal dialysis supplies and equipment. GAO also believes that savings of more than the $9 million estimated by the Administration could be realized if this authority were adopted.

The proposal to freeze physician fee levels for 1984 at an estimated savings of $700 million might not meet the intent of the reconciliation instruction because a substantial part of these savings would be shifted as an increased cost to Medicare beneficiaries.

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STATEMENT OF

RICHARD L. FOGEL, DIRECTOR
HUMAN RESOURCES DIVISION

BEFORE THE SUBCOMMITTEE ON HEALTH
AND THE ENVIRONMENT OF THE HOUSE
COMMITTEE ON ENERGY AND COMMERCE

ON

COST SAVING PROPOSALS RELATING TO THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE PROGRAM (MEDICARE PART B)

Mr. Chairman and members of the Committee, we are pleased to be here today to discuss certain proposals for reducing Medicare Part B costs as they relate to the criteria contained in the Conference Report of the First Concurrent Resolution on the 1984 Budget. These reconciliation instructions were that none of the savings to be achieved from the Medicare program shall come from provisions to increase costs to beneficiaries or from reductions in services to beneficiaries. Rather, savings are to be obtained from improved controls on provider services.

For the various programs under the jurisdiction of the House Committee on Energy and Commerce, the reconciliation instructions provided for $400 million in spending reductions for 1984, $500 million for 1985, and $800 million for 1986 or a total of $1.7 billion.

My testimony will focus on three points:

Several proposals are aimed at changing the way Medicare pays for diagnostic laboratory services when labs bill directly for such services. One such proposal, H.R. 1106, the Fair Lab Payments Act of 1983, is consistent with the criteria contained in the reconciliation instructions because it would reduce Medicare's estimated outlays by a total of about $80 million for fiscal years 1984 through 1986. It would also reduce the liabilities for Medicare beneficiaries by over $150 million during the same period.

We support the Administration's proposal aimed at authorizing HCFA to become a "prudent buyer" of certain miscellaneous health services such as diagnostic laboratory services, durable medical equipment, and prosthetic devices where the items and services are usually chosen by physicians and other providers rather than by beneficiaries. However, we believe it should be modified to include home dialysis supplies and equipment. We estimate additional maximum savings of $6 million a year would be available through negotiated bulk purchase arrangements for these items.

The most significant cost saving provision proposed by the Administration pertaining to Medicare Part B involves the freezing of physicians' fee levels for fiscal year 1984. Although the President's Budget assigns a $700 million savings for fiscal year 1984 to this proposal, it might not meet the

intent of the 1984 reconciliation instruction. A substantial part of these savings would be shifted to the Medicare beneficiaries for those claims where the doctors do not accept assignment and the beneficiary is liable for the doctors' full charge. Currently, the difference between the submitted charges and the Medicare allowed charges on unassigned claims is about $2 billion a year.

BACKGROUND

For 1984, an estimated 29 million people will be enrolled in Medicare Part B of which about 20 million will satisfy their annual $75 deductible and receive reimbursed services. Under present law, the President's Budget shows an estimated $20.3 billion in benefit payments in 1984 of which $15.3 billion or 75 percent is for physicians services; about $3.7 billion or 18 percent is for outpatient services in hospitals, renal dialysis centers and clinics; about $500 million or 3 percent is for inpatient radiology and pathology services; and $750 million or about 4 percent is for other medical and health services such as independent clinical laboratory services, durable medical equipment, and prosthetic devices.

PAYMENTS FOR CLINICAL LABORATORY SERVICES

The Congressional Budget Office's (CBO's), 1984 baseline projections for Medicare allowed charges for directly billed laboratory tests by the 3,400 clinical labs participating in Medicare is $265 million.

Two of the provisions included in the Administration's proposed Health Care Financing Amendments of 1983 (H.R. 2576) would modify the way Medicare pays for independent laboratory services. One provision (section 105) would correct a provision included in the 1972 Amendments (now section 1833(h)) which authorized Medicare to negotiate fee schedules with independent laboratories and to pay 100 percent of the resulting allowed charges instead of the usual 80 percent, thereby eliminating the need for the laboratory to collect the remaining 20 percent from the patient. The 1972 Amendment was never implemented however, because it did not provide for the waiver of Medicare's annual part B deductible, which the labs might still have to collect. Section 105 of H.R. 2576 would correct this by eliminating the deductible for diagnostic tests performed in a laboratory which has entered into a negotiated rate agreement with Medicare.

Section 113 of the proposed Health Care Financing Amendments of 1983 would authorize HCFA to enter into exclusive agreements and negotiated rates for seven types of services listed under section 1861(s) of the Social Security Act. These services include diagnostic laboratory tests as well as durable medical equipment, ambulance services and prosthetic devices. According to the President's 1984 Budget, the total savings associated with this proposal are $9 million for that year. But there is no breakout as to how much would be saved for specific services.

A third proposal introduced by Congressman Wyden on January 31, 1983, (H.R. 1106, the Fair Labs Payment Act) also would provide that Medicare waive the beneficiaries' deductible and coinsurance amounts for low-cost diagnostic tests. In addition, the bill would establish statewide or areawide payment rates for such tests based on the amounts laboratories commonly charge doctors for such tests, and the laboratories that wished to participate would agree to accept Medicare payment as the full charge for the tests.

This proposal recognizes the fact that diagnostic labs often have two price lists for the same tests. One price list with "wholesale" prices is for doctors and another "retail" price list is for patients and their third party payors such as Medicare. Under Medicare's reasonable charge methodology, the allowed charges for services directly billed by laboratories are based on the "retail" price. According to various studies by HCFA and the Subcommittee on Oversight and Investigations of the House Committee on Energy and Commerce, the laboratories' "wholesale" charges to physicians for low cost tests are, on the average, about 35 percent below Medicare's allowed charges for the same tests. CBO has estimated that H.R. 1106 would reduce Medicare outlays by about $21 million for 1984. Also, the waiver of the deductible and coinsurance amounts would reduce the Medicare beneficiaries' liability by over $50 million for the same year.

Both the Administration's proposals and H.R. 1106, would assist the Congress to realize budgetary savings from providers consistent with the reconciliation instruction. But the latter is obviously preferable if the primary objective is to save as much money as possible. Also, the Administration's proposal merely authorizes--not requires--HCFA to enter into negotiated rate agreements so assigning specific savings to this proposal might be difficult.

MEDICARE AS A PRUDENT BUYER OF SERVICES

Under Medicare Part B, the controls over the levels of payment for non-institutional providers such as doctors, are based on complicated reasonable charge methodologies which are principally based on the historical charges submitted by providers. To some extent this situation resulted from by section 1802 of the Act which provided that any individual entitled to Medicare benefits may obtain health services from any institution, agency or person qualified to participate if such institution, agency or person undertakes to provide the beneficiary such services. This "freedom of choice" provision is meaningful for persons seeking to choose their own doctor or other primary provider of care, but we believe, it has little practical application for such covered services as diagnostic laboratory tests, and medical supplies and equipment because the services beneficiaries get and who they get them from are usually determined by their physicians.

As previously discussed, section 113 of the proposed Health Care Financing Amendments of 1983 would authorize HCFA to enter into exclusive agreements and negotiated rates for seven of the medical and other health services listed in section 1861(s) of the act, without regard to the "freedom of choice" provision. The Administration's 1984 Budget assigned an estimated savings of $9 million to this provision or about one percent of the $750 million of benefit payments in these categories. We believe more savings could be achieved if this authority to be a "prudent buyer" were adopted.

For example, in Massachusetts, we noted that a few home health agencies participating in Medicare have routinely negotiated agreements with suppliers for the rental of durable medical equipment such as wheelchairs and oxygen equipment and for the purchase of low cost items such as canes and walkers which are about 20 percent less than what Medicare allows the same suppliers for the same items.

Under Medicaid, States have used the authority contained in section 2175 of the Omnibus Reconciliation Act of 1981 (Public Law 97-35 enacted August 13, 1981) to waive "freedom of choice" and to enter into bulk purchasing arrangements for eyeglasses and hearing aids. Although these items are not covered by Medicare, States have reported savings ranging from 15 to 50 percent through such direct contracting methods.

We believe, however, that, if adopted, section 113 should be modified to include paragraph (2)(F) of section 1861(s). This paragraph includes home dialysis supplies and equipment--areas where our work has shown that although Medicare is the primary payor for such items it has not acted as a "prudent buyer."

Under Medicare's End Stage Renal Disease Program, home dialysis patients have the option of obtaining other supplies and equipment either through a supporting facility or directly from suppliers. Under the first option, Medicare pays the facility based on a composite rate reflecting the costs of both home and facility dialysis treatment, regardless of where the patient dialyses. In a recent review[1] we found that about 70 percent of the home patients were obtaining their equipment and/or supplies directly from suppliers who in turn were paid by Medicare. The cost of direct purchase of supplies and the rental or purchase of equipment was usually lower for those patients than the composite rate because the rate included the higher costs of facility dialysis. Therefore it would be economically advantageous for most home patients to continue dealing directly with suppliers considering the difference in Medicare's 20 percent coinsurance amount they would have to pay.

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[1]Opportunities to Reduce Medicare Costs Under the End Stage Renal Disease Program for Home Dialysis Patients (GAO/HRD-83-28, dated January 21, 1983).

We estimated that for calendar year 1980, the total costs of obtaining dialysis supplies and equipment for all direct-dealing home patients was about $75 million. Almost half the patients are on hemodialysis and the remainder are on other modes of treatment.

Most direct dealing hemodialysis patients rent their equipment which over the 5-year life of a dialysis machine is the most expensive way to pay for it.

Outright purchase of machines with an annual maintenance contract is the least costly method which over the 5-year life of a machine is about half the cost of the extended rentals. The estimated savings through purchase is about $20 per treatment which for the estimated 1,460 direct-dealing home hemodialysis patients represents a savings of about $3.7 million a year. Although HHS believes our estimates of savings are too high and we recognize that outright purchase may not always be practical because of the sizeable lump sum coinsurance requirements ranging from $1,500 to $2,000, we also noted that one State sponsored program had negotiated lease purchase arrangements which were 20 to 40 percent less costly than Medicare's method of paying on the basis of rental only.

Disposable supplies account for about 70 to 90 percent of the cost of home dialysis treatment, depending on the mode of treatment used. We noted that Medicare allows about 25 percent more than the Veterans Administration (VA) pays suppliers under

its home dialysis supply contracts. The VA contract prices includes delivery to the patient's home and are available for VA patients nationwide. Because Medicare covers about 90 percent of all dialysis patients it should be able to negotiate prices at least as low as VA negotiates. We estimate that this could result in savings of about $2.5 million for direct-dealing hemodialysis patients alone.

FISCAL YEAR 1984
FREEZE ON PAYMENTS
FOR PHYSICIAN'S SERVICES

Section 112 of H.R. 2576 provides that in determining the reasonable charges for physicians' services, the prevailing and customary charge levels that apply to services furnished after June 1982 but before July 1983 shall also apply to services furnished after June 1983 but before July 1984. According to the President's 1984 Budget this 1-year freeze on Medicare's reasonable charges for physicians services would save $700 million or about 4.5 percent of the total projected Medicare payment for such services.

Under Medicare, however, not all payments are made to physicians. They are often made to the beneficiaries who in turn are responsible for paying their doctors. This depends on whether the physician accepts assignment of the claim and agrees to accept Medicare's determination of the reasonable charge as the full charge. In 1982, about 53 percent of the Medicare claims were assigned. These assignment rates,

however, varied considerably throughout the country. In Massachusetts, Rhode Island, and Michigan the assignment rates were over 70 percent whereas in Indiana, Minnesota, Oklahoma, Nebraska, Montana, North and South Dakota, Wyoming, Arizona, Oregon, Idaho, and Washington the rates were about 35 percent or less.

We believe it is fair to assume that in the latter States most of the savings to Medicare resulting from any freeze on reasonable charges for physician services would merely be shifted to the Medicare beneficiaries in the form of larger differences between what the doctors bill the patients and what Medicare allows.

Currently, the difference between the submitted charges and what Medicare allows on unassigned claims is about $2 billion a year or about 23 percent of the submitted charges. This beneficiary liability is in addition to the beneficiaries' 20 percent coinsurance liability based on the allowed charges.

Therefore, we question whether this proposal is consistent with the intent of the instructions in the first 1984 Concurrent Resolution that none of the savings to be achieved from the Medicare program shall come from provisions to increase costs to beneficiaries.

This concludes my formal statement. We would be pleased to respond to any questions this Subcommittee may have.