United States General Accounting Office

GAO

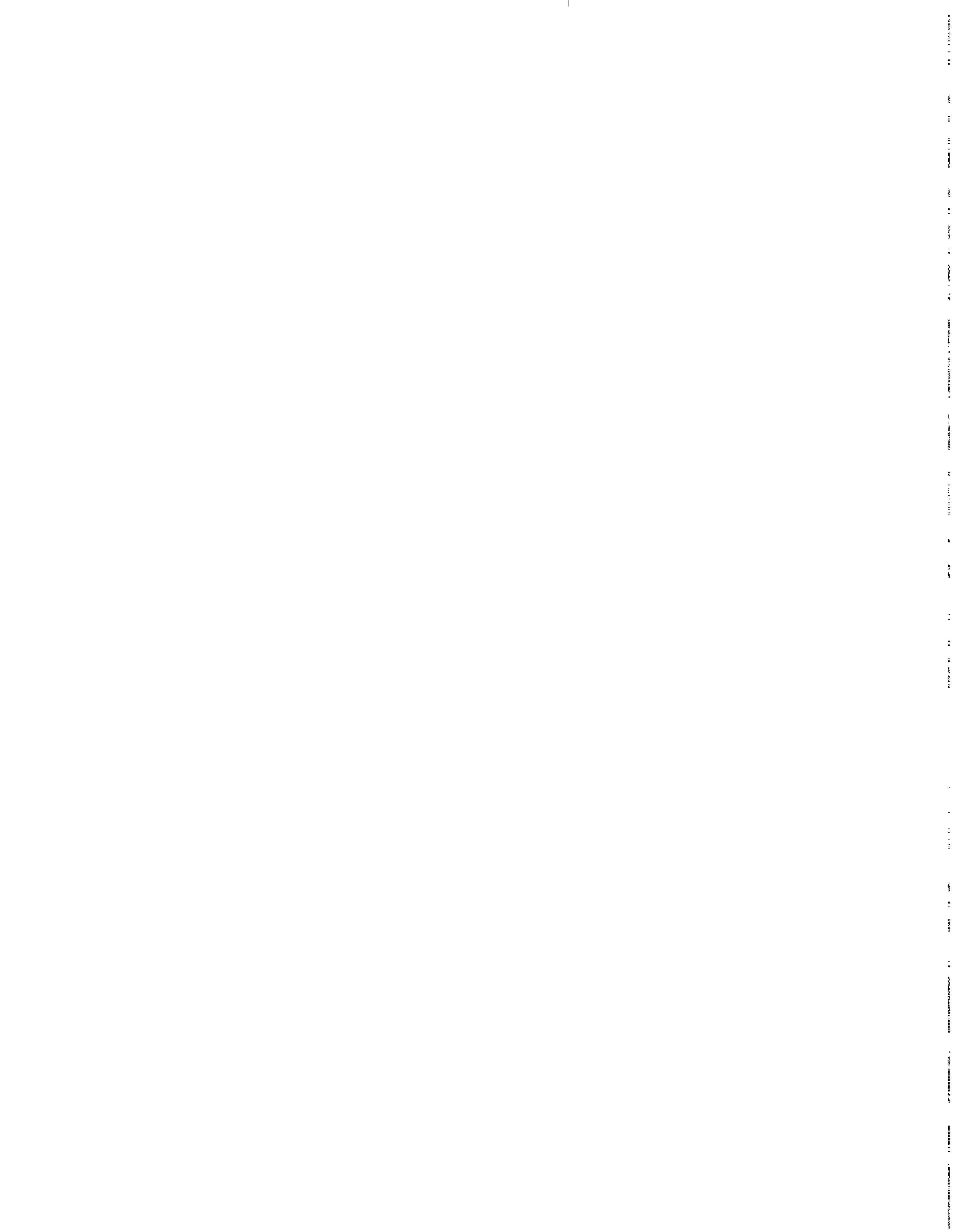
Report to Congressional Committees

April 1994

MEDICARE

Impact of OBRA-90's Dialysis Provisions on Providers and Beneficiaries

GAO/HEHS-94-65



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

Health, Education, and
Human Services Division

B-252171

April 25, 1994

The Honorable Daniel Patrick Moynihan
Chairman
The Honorable Bob Packwood
Ranking Minority Member
Committee on Finance
United States Senate

The Honorable John D. Dingell
Chairman
The Honorable Carlos J. Moorhead
Ranking Minority Member
Committee on Energy and Commerce
House of Representatives

The Honorable Dan Rostenkowski
Chairman
The Honorable Bill Archer
Ranking Minority Member
Committee on Ways and Means
House of Representatives

To help control rising Medicare costs, Congress has enacted a series of amendments to the Social Security Act to require that, in certain cases, employer-sponsored group health plans[1] covering Medicare beneficiaries pay medical claims before Medicare pays for services. Since 1981, such a requirement has been in place for patients with end-stage renal disease (ESRD), a condition that requires regular blood cleansing (dialysis) or a kidney transplant. The Omnibus Budget Reconciliation Act of 1990 (OBRA-90) extended the period during which employer-sponsored plans are required to pay before Medicare does.[2] OBRA-90 also required us to report on the various effects this extension was having on dialysis costs.

This is the second of two reports intended to meet OBRA-90's requirement. Our first report analyzed the number of beneficiaries affected by the

[1]In this report, employer health plans include any group health insurance provided through employment, including a labor union group health plan.

[2]Specifically, OBRA-90 extended the Medicare secondary payer (MSP) provision for ESRD beneficiaries from the first year of treatment to the first 18 months of entitlement. Because of complexities in the law governing Medicare entitlement for ESRD, the length of the OBRA extension varies from beneficiary to beneficiary. For most beneficiaries, the OBRA extension potentially lengthens the employer coverage by 6 to 9 months.

extension, the extent to which the extension shifted costs from Medicare to employer-sponsored plans, and the extension's effect on ESRD patients' ability to obtain employment and health care coverage.[3] This second report examines the extension's impact on (1) the amount of money that dialysis providers receive and (2) the out-of-pocket payments made by Medicare beneficiaries as their share of medical costs.

Background

In 1991, Medicare paid nearly $6 billion in health care expenditures for about 150,000 patients with ESRD. Medicare pays for dialysis on the basis of a predetermined amount per treatment session. This predetermined amount, called the "composite rate," is based on the national median cost of furnishing dialysis treatments but varies from provider to provider to reflect differences in labor costs in different areas and conditions such as whether the provider is a hospital or a freestanding provider.[4] Medicare pays separately for other ESRD-related services, which include administration of erythropoietin (a drug used in ESRD treatments), physician services, and laboratory tests.

In 1981, the Congress amended the Social Security Act to make Medicare the secondary payer for the first year's medical expenses of certain ESRD beneficiaries. OBRA-90 extended this period to the first 18 months of Medicare entitlement. Under this provision, the employer-provided plan pays up to the limits of its coverage. As the secondary payer during this period, Medicare then pays any remaining amount up to the Medicare composite rate, or the billed amount, whichever is lower.[5] After this 18-month period has ended, the roles are reversed: Medicare becomes the primary payer, and the employer-provided plan becomes the secondary payer. When Medicare is the primary payer, it pays 80 percent of the composite rate, and the secondary payer is responsible for the remaining 20 percent. In both scenarios, there is generally little beneficiary out-of-pocket expense, as long as the employer plan coverage remains in force.[6] Table 1 summarizes these payment responsibilities.

[3]See Medicare: Millions in End-Stage Renal Disease Expenditures Shifted to Employer Health Plans (GAO/HRD-93-31, Dec. 31, 1993).

[4]Freestanding providers offer specific health care services outside the traditional settings of hospitals, nursing homes, and physicians' offices.

[5]When Medicare pays approved providers, providers must accept the Medicare composite rate as payment in full, and cannot bill beneficiaries for additional amounts.

[6]A beneficiary could have out-of-pocket expenses if the employer plan payment were insufficient to pay for Medicare's deductible and coinsurance. However, the results of our study show this situation to be highly unlikely.

Table 1: Summary of ESRD Payment Responsibilities

	Payment responsibility during first 18 months of Medicare entitlement	Payment responsibility after 18 months of Medicare entitlement
Who pays as primary	Employer-provided group health plan	Medicare
Method of determining primary payment	Up to the limit of its coverage	80 percent of composite rate (or charges, if lower)
Who pays as secondary	Medicare	Employer-provided group health plan
Method of determining secondary payment	Remainder needed to bring total payment to composite rate	20 percent of composite rate

The Congress has continued to examine the question of how long the primary payment period should be for employer-provided health plans. The Omnibus Budget Reconciliation Act of 1993 continued the 18-month period through September 30, 1998, after a provision to extend the period to 24 months was rejected in conference committee. The administration's Health Security Act, as introduced in the Congress in 1993, proposes to make the MSP ESRD provisions permanent.

In our first report, we estimated the OBRA extension would shift $56 million of medical expenditures from Medicare to employer-provided plans each year. Since that time, more complete data have become available.[7] We recomputed our estimate using this more complete information and now project the annual Medicare savings from the OBRA extension to be $87 million.

Scope and Methodology

To assess the effect of the OBRA extension on the amounts providers receive for dialysis, we reviewed records from a nationwide sample of 55 dialysis providers.[8] For each provider, we obtained relevant billing and payment documents for services provided between December 14 and December 21, 1992, to patients with an employer group health plan (EGHP) that was the primary payer. We compared the amounts received by

[7]Our original estimate used data from a 2-month period (November-December 1991) as a basis for the annual projection. For our new estimate, we were able to use more complete data that had since become available (November 1991-July 1992).

[8]Our sample excludes three providers who had no dialysis patients during the sample time frames, and one provider who indicated that the billing documents for the time frame were lost. The sample of providers was based on random selection of those dialysis providers that we found in our earlier review to be treating beneficiaries affected by the OBRA ESRD extension. Appendix I provides more details on our sampling approach.

providers for dialysis when EGHPs were the primary payer with amounts the providers would have received if Medicare had been the primary payer.

To assess the extension's effect on out-of-pocket costs borne by Medicare beneficiaries, we discussed payment rules and employer-plan actions with dialysis providers and with officials of the Health Care Financing Administration (HCFA), the agency responsible for the general administration of the Medicare program, and we reviewed relevant Medicare regulations. Appendix I contains a more detailed discussion of our methodology.

Results in Brief

The OBRA extension of employer-provided health care plans' obligation as primary payer has increased amounts that providers receive for dialysis by an estimated $41 million per year. This increase occurred because employer-sponsored plans generally paid dialysis providers more than the cost-based Medicare rates. The additional revenue is relatively small when viewed in the aggregate, increasing total provider revenues for dialysis by about 1.8 percent. However, because the higher payments involve no increase in the type or level of services provided, they generally represent profits for the providers that receive them.

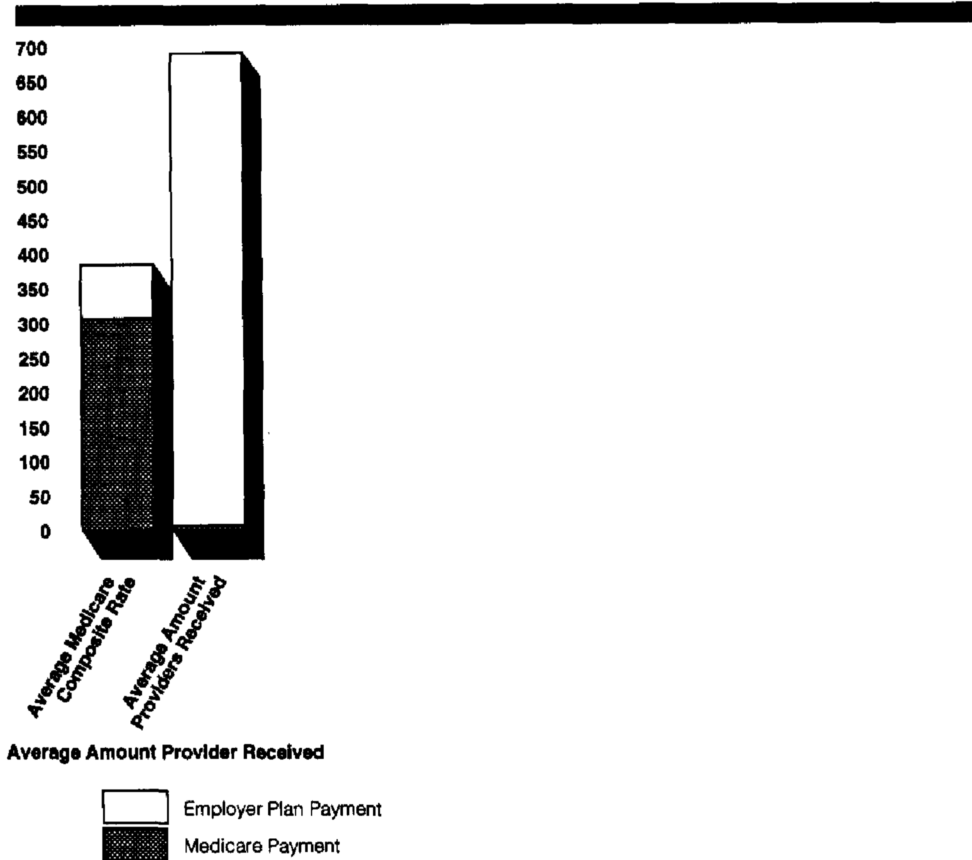
The extension should not affect most ESRD patients' out-of-pocket expenses, because specific payment provisions insulate ESRD patients with dual coverage from being singled out for increased out-of-pocket expenditures. A beneficiary's out-of-pocket expenses could increase significantly if employer plans responded to higher ESRD costs by limiting dialysis coverage for all beneficiaries, not just those with ESRD. However, we found only a few instances in which this situation had occurred.

Extension Results in Higher Payments to Providers

The providers in our sample received an average of 80 percent more when employer-provided health insurance plans acted as the primary payer for kidney dialysis services than they would have received if Medicare had been the primary payer. On average, providers received $690 per week for such services, compared with $383, which they would have received under the Medicare composite rate (see fig. 1). Medicare paid very little of the $690 as a secondary payer—on average, about $6—because 50 of the 55 providers received payments from employer-provided plans that, on

average, already exceeded the providers' composite rate for Medicare.[9] If Medicare had been the primary payer, on average it would have paid $306 of the $383 composite rate, and the employer-provided plans would have paid the remaining $77.

Figure 1: Amounts Providers Receive for Dialysis When Medicare Is Primary Payer Versus When Medicare Is the Secondary Payer



Notes: The average Medicare composite rate for dialysis was $383 in 1992. With Medicare as primary payer, Medicare would pay $306 of this amount, and the employer health care plan, $77. With Medicare as the secondary payer, the average amount received by the provider was $690. Of that amount, the employer health care plan paid $684 and Medicare, $6.

[9] Average payments under employer-provided plans ranged from $36 less than the Medicare composite rate to more than $1,000 above it. In all, 39 of the 50 plans whose payments were above Medicare's composite rate exceeded the composite rate by more than $100, and 8 exceeded it by more than $600.

Because erythropoietin is used directly in dialysis treatments, and because of congressional interest in knowing about the extension's effect on expenditures for erythropoietin, we also compared the amounts received for erythropoietin from employer-sponsored plans with amounts that would have been received if Medicare had been the primary payer.[10] As with payments for dialysis, payments for erythropoietin were also considerably higher than they would have been if Medicare had been the primary payer. The mean amount for the employer plan payment was about $17 for 1,000 units of erythropoietin, about 55 percent more than the $11 per 1,000 units the provider would have received if Medicare were the primary payer.

The increased payments to providers reflect higher levels of reimbursement provided under most employer-sponsored plans than under Medicare. While Medicare bases its composite rate on an analysis of how much dialysis actually costs, most employer-sponsored plans base their payment on reimbursing the provider for a certain percentage of the bill. Some employer plans set flat rates for dialysis that were more than twice the provider's Medicare composite rate.

The increased payments were particularly pronounced at for-profit providers. (In our sample, most freestanding facilities were for-profit operations, while hospitals and some freestanding facilities were nonprofit.) On average, for-profit providers charged higher rates than nonprofit providers did and, as a result, received substantially more in payments from employer plans. Dialysis payments to nonprofit providers averaged $184 more than Medicare rates, while payments to for-profit providers averaged about $415 more than Medicare rates.

A few of the employer-sponsored plans providing reimbursements to the providers in our sample have established payment rates closer to the Medicare amounts. As a result, plans differed substantially in the amounts they would pay for dialysis. Appendix II shows the variance in weekly payments to providers for individual patients.

[10]We did not study payments for physician services, for separately billable laboratory tests, or for pharmaceuticals other than erythropoietin.

Extension Increases Provider Revenues Marginally, but Adds to Profits

Although dialysis providers were paid about 80 percent more than the Medicare composite rate for dialysis treatments when insurers were billed as the primary payer, the extension applies to only about 2.3 percent, or about 2,700, of dialysis patients at any given time in the United States.[11] As a result, we estimate that the overall impact of this provision is to increase provider revenues for dialysis services by about 1.8 percent, or an estimated $41 million per year.[12]

Although the increase represents a small portion of total ESRD revenues, it can create a substantial increase in profit for individual providers. In May 1993, we reported that when non-hospital-based providers were reimbursed at the Medicare rate, their median profit margin was about 12.7 percent.[13] Because the OBRA-90 extension increases provider revenue without affecting provider costs, the additional revenue amounts, in most cases, represent additional profits for providers that treat patients who fall under the extension.[14]

Impact on Out-of-Pocket Costs Is Insignificant Unless Employer Health Plans Limit Dialysis Coverage

Out-of-pocket costs for an ESRD beneficiary who has both Medicare and employer coverage are generally not affected by the OBRA extension. Our review of payment rules indicates that only rarely will it matter to the beneficiary whether Medicare or the employer plan pays first. In particular, specific provisions insulate ESRD patients with dual Medicare-employer coverage from the likelihood of out-of-pocket expenditures for such services as dialysis, transplant surgery, and in-patient hospital admissions.

[11]The percentage of dialysis patients covered by the OBRA-90 extension of the MSP provision is low for several reasons. First, the OBRA-90 MSP extension applies only to those beneficiaries who are between their first 12 months of treatment and 18 months of entitlement. Second, under the OBRA extension in effect at the time of our review, Medicare was not the secondary payer for ESRD beneficiaries eligible for Medicare because of age or disability. OBRA-93 extended the provision to include ESRD beneficiaries that also become entitled to Medicare because of age or disability. We estimate that this change would increase the number of beneficiaries covered by the extension by about 5 percent.

[12]This estimate is based on multiplying the following three factors: (1) the $19,000 average cost of providing a full year of dialysis treatment to Medicare beneficiaries, (2) the average increase of 80 percent that our sample of dialysis providers were receiving when billing employer-provided plans as the primary payer, and (3) the 2,700 dialysis patients covered under the OBRA-90 extension at any given time.

[13]See Medicare: Renal Facility Cost Reports Probably Overstate Costs of Patient Care (GAO/HRD-93-70, May 18, 1993).

[14]We estimate that the additional 1.8 percent in revenue caused by the extension would increase the median profit margin for non-hospital-based providers from its current level of 12.7 percent to 14.2 percent.

ESRD patients may experience increased out-of-pocket expenses, however, if an employer plan limits dialysis coverage. In the absence of employer plan coverage, Medicare may become the sole payer,[15] and beneficiaries may be required to pay the 20-percent Medicare copayment—a copayment that amounts to over $390 per month for the average Medicare dialysis and erythropoietin usage rate we found in our study.

While at the time of our review few plans had dropped benefits for ESRD beneficiaries, we found evidence that some plans may be considering limiting their coverage. Plans could limit their coverage in several ways.

- They could eliminate dialysis coverage for all beneficiaries, not just those with ESRD. The Internal Revenue Code imposes a 25-percent excise tax on employers' health insurance expenses if the plan differentiates between benefits provided ESRD individuals and others. In a July 1993 written response to an inquiry by the Health Insurance Association of America, HCFA stated that eliminating dialysis only for ESRD patients would violate the nondifferentiation provision. However, HCFA also stated that plans would not violate the provision if they eliminated coverage for all types of dialysis—that is, not only the chronic, long-term dialysis (generally outpatient) provided ESRD patients, but also the acute, short-term (generally inpatient) dialysis provided to non-ESRD patients.
- They could limit the length of coverage. One employer plan in our study has for at least 5 years—well before the effective date of OBRA-90—limited dialysis coverage to 18 months, ceasing to pay for dialysis about 3 months before Medicare would normally become the primary payer.[16] This 18-month limit renders ineffective the secondary payer provision for its last 3 months and makes the patient the secondary payer thereafter, greatly increasing out-of-pocket costs. While the limit applies to all dialysis patients, it may have a disproportionate effect on ESRD patients because only ESRD patients would normally require a regular course of dialysis to live. Similar concerns exist with regard to a second employer plan we found that limits its coverage to 12 dialysis treatments per year—approximately 1 month of dialysis. HCFA commented that, in its view, these coverage limitations do not violate the nondifferentiation provision.

[15]Medicaid and other income-based assistance programs may be available to assist poorer patients.

[16]Employer plans generally are the sole payer for the first 3 months of dialysis because Medicare entitlement generally does not begin until the start of the third month after the month in which dialysis began. Employer plans then become the primary payer, with Medicare as the secondary payer, for the next 18 months.

- They could limit their role as secondary payer. According to one provider in our sample, since January 1993 (nearly 2 years after the OBRA-90 effective date), some plans have restructured their benefits so they pay only the first 80 percent of charges. Once they are no longer the primary payer, to Medicare or any other insurer, they pay nothing on the grounds that the 80 percent for which they are responsible has been paid by another payer. (Formerly, as secondary payer to Medicare, they usually paid everything left over after Medicare had paid the first 80 percent of the Medicare allowable rate.) This change in plan structure can leave the Medicare beneficiary responsible for a copayment of up to an estimated $400 per month for dialysis and erythropoietin, based on our sample of patients. HCFA's position is that this action does not violate the ESRD nondifferentiation provision.

  One provider told us of other employer plans that dropped coverage for dialysis as soon as employer plan patients become entitled to Medicare. Since, according to HCFA, this practice would probably violate the Medicare secondary payer statute, we have referred these cases to HCFA field offices for investigation and possible referral to the Internal Revenue Service for enforcement action.

Conclusion

Extending employer-provided plans' obligation as primary payer for ESRD patients so far has not generally caused employer group health plans either to (1) limit their payments for dialysis to Medicare rates or (2) react in ways that would adversely affect beneficiaries' out-of-pocket costs. Most plans continue to reimburse providers at rates that are substantially above what Medicare would pay.

As employer-sponsored plans react to increasing costs, they will have greater incentive to search for ways to reduce their expenditures. Although during the 18-month coordination period employer-provided plans cannot reduce benefits in ways that discriminate against ESRD patients who are Medicare-eligible, they could conceivably reduce these benefits—as a few plans already have done—by making across-the-board changes that apply to all beneficiaries, not just to those who are Medicare-eligible. Alternatively, to reduce costs, EGHPs could set dialysis payment rates similar to those that Medicare uses.

Agency Comments

In providing written comments on our draft report, HCFA clarified its position that insurers can, in certain ways, limit dialysis coverage for

Medicare beneficiaries without violating the MSP provisions. Accordingly, we revised our draft to characterize HCFA's position as it was expressed in its written comments.

HCFA further expressed the view that employers may increasingly include these and other permitted coverage limitations in their plans as they become more aware of them in the future.

HCFA suggested other technical changes, which we incorporated into the draft where appropriate. A copy of HCFA's detailed comments is in appendix III.

We are sending copies of this report to the Secretary of Health and Human Services, the Administrator of the Health Care Financing Administration, the Director of the Office of Management and Budget, and other interested parties. Copies also will be made available to others upon request.

Please call me on (202) 512-7123 if you have any questions about this report. Other major contributors to this report are listed in appendix IV.

Leslie G. Aronovitz
Associate Director,
Health Financing Issues

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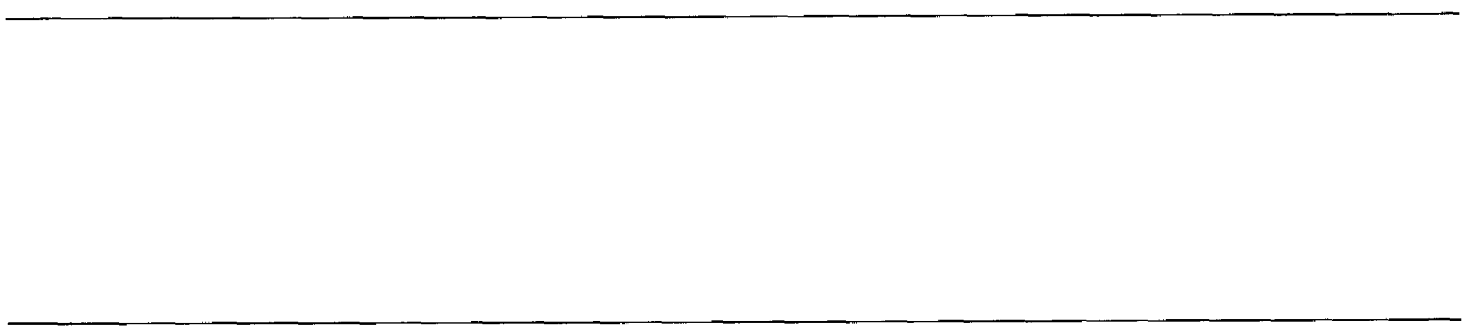
Abbreviations

EGHP	employer group health plan
ESRD	end-stage renal disease
HCFA	Health Care Financing Administration
MSP	Medicare secondary payer
OBRA-90	Omnibus Budget Reconciliation Act of 1990
OBRA-93	Omnibus Budget Reconciliation Act of 1993



Objectives, Scope, and Methodology

The Omnibus Budget Reconciliation Act of 1990 modified the Medicare secondary payer provision for end-stage renal disease beneficiaries by effectively extending the period during which employer group health plans are required to pay before Medicare does.[1] OBRA-90 directed that GAO study the impact of this change in the MSP provision and submit a final report not later than January 1, 1995. Our 1992 report, Medicare: Millions in End-Stage Renal Disease Expenditures Shifted to Employer Health Plans, addressed three of the reporting objectives.[2] This report addresses two other objectives, namely to provide information relating to the act's impact on

- the amount of money that dialysis providers receive and
- the out-of-pocket payments made by Medicare beneficiaries as their share of medical costs.

Estimating the Effect of OBRA-90 on the Amount Providers Receive for Dialysis

To estimate the effect of OBRA-90 on the amount paid for dialysis treatments for ESRD-only beneficiaries with employer coverage, we used a sample of 59 of the over 1,700 U.S. kidney dialysis providers (1988 data). To determine this sample, we first identified the 373 ESRD-only beneficiaries in the beneficiary sample we obtained for our earlier report who were still in need of dialysis as of February 1, 1991, and who responded to our questionnaire that they had employer coverage on February 1, 1991. After removing 12 for whom we had no dialysis-provider identification and 2 who received dialysis at a federal facility, we randomly selected 60 beneficiaries and identified the 59 dialysis providers that our Health Care Financing Administration beneficiary data showed as the most recent dialysis provider for these beneficiaries. We used these dialysis providers as our study group.

From these 59 dialysis providers, we requested copies of all bills submitted to employer group health plans (or their health insurance carriers/administrators) as primary payers for services rendered to Medicare beneficiaries during the period December 14-18, 1992. We also asked for copies of all matching explanation-of-benefit statements received from the employer group health plans. We received documents

[1]Specifically, OBRA-90 modified the MSP provision for ESRD beneficiaries by applying it to the first 18 months of Medicare eligibility or entitlement rather than the first 12 months of treatment. Medicare entitlement generally begins 3 months after the start of treatment.

[2]GAO/HRD-93-31, Dec. 31, 1993. OBRA-90 also asked GAO to report on the appropriateness of applying the extension to all group health plans. However, prior to beginning our work, Committee staff informed us that this subject was no longer of interest to the Committees. Accordingly, we did not include this objective in our review.

from 55 providers for nearly 600 patients. Three of the 59 providers in our sample had no dialysis patients in this time frame who had payers primary to Medicare. Another provider reported that the billing documents for December 1992 were lost. We held telephone discussions with providers to clarify bills, payments, or billing practices used when Medicare was the primary payer.

To simplify our analysis of dialysis charges, we first restated in terms of a weekly amount all the charges for dialysis, whether administered three times a week at a medical facility, daily in the beneficiary's home, or in any other way. Finally, we determined the amount by which the carrier payment exceeded or fell short of the Medicare composite rate—the amount that Medicare and the employer plan would pay jointly if Medicare were the primary payer. In making this determination, we applied three simplifying assumptions:

- We assumed that, if the provider had billed Medicare as the primary payer, the provider would have received the full composite rate (the first 80 percent from Medicare, the final 20 percent from the employer plan). This assumption is based on Medicare payment rules that prevent providers from billing the employer plan as secondary payer more than is necessary to bring their total reimbursement up to the Medicare composite rate.
- We established a cutoff date of June 30, 1993, for our study—more than 6 months after the services had been provided. In the 41 instances where the employer plan had not paid the provider by this cutoff date, we assumed that the provider would eventually receive payment equal to the Medicare composite rate. In some cases, we subsequently learned of payments received after June 30, 1993, which were greater than the Medicare composite rate. This assumption may, therefore, be a conservative one in that in these cases it understates payments by employer plans.
- In instances where the employer plan paid less than the Medicare composite rate and less than the provider's charge, we discussed secondary billing with the provider. When the provider's practice was to bill Medicare as the secondary payer, we adjusted the amount received by the provider to account for the additional payment for which Medicare would be responsible.[3]

Over all the patients in our study, we calculated the mean amount by which the weekly payment made by the employer plan exceeded the

[3]In making this adjustment, we assumed that Medicare would pay the difference between the EGHP payment and the Medicare composite rate.

Medicare composite rate for a week. We also performed this calculation for each individual dialysis provider.

Finally, in formulating our methodology, we visited dialysis centers and held discussions with management and financial staff about their billing practices. We also held discussions with HCFA officials in regard to payment rules.

Determining the Effect of OBRA-90 on Out-of-Pocket Expenditures for ESRD Individuals

To determine the specific effect of the OBRA-90 extension on out-of-pocket expenditures for ESRD individuals, we held discussions with HCFA officials and examined payment rules. In addition, when we contacted dialysis providers by telephone as part of our work under the previous objective, we asked whether any EGHPs had limited the number of months for which they covered dialysis since February 1, 1991—the effective date of the OBRA-90 ESRD Medicare secondary payer provision. We obtained further detailed information about any such limits and also discussed the limits with representatives of the EGHPs setting them. We were particularly concerned with such limits because they would greatly increase out-of-pocket costs for beneficiaries; in the absence of employer-plan coverage for dialysis, the beneficiaries would be responsible for the coinsurance amount, paying 20 percent of the Medicare allowable rate (this 20 percent would equal over $300 per month for dialysis alone).

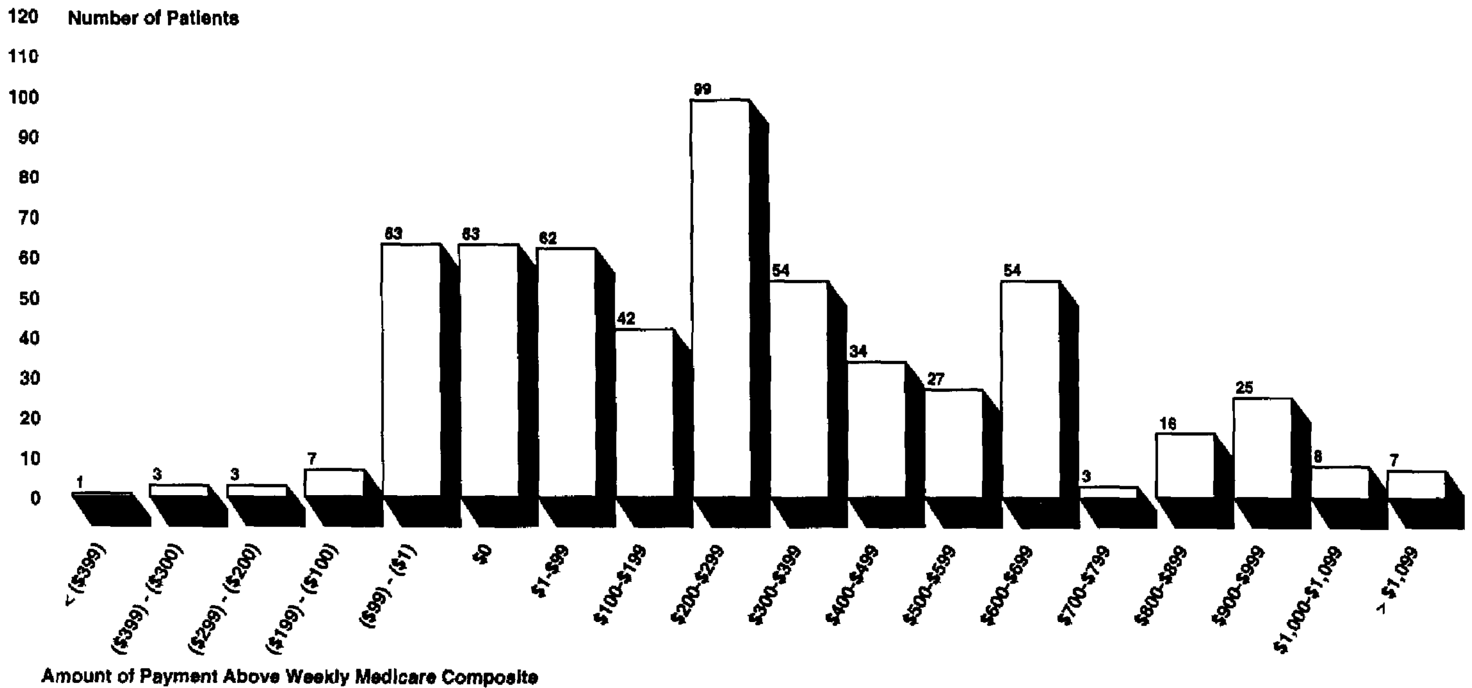
Finally, we obtained information from an attorney at the Department of Health and Human Services and a HCFA official on the legality of such limits and reviewed correspondence between the Health Insurance Association of America and HCFA on this matter.

We performed our work from March 1993 to September 1993. We did not independently examine the internal and automatic data processing controls for HCFA's database of dialysis providers, from which we drew certain information about the providers in our sample. With this exception, we performed our work in accordance with generally accepted government auditing standards.

Distribution of Medicare Composite Rates

Appendix II provides a distribution of the amounts by which weekly payments for individual patients differed from the weekly Medicare composite rate. As shown, the spread of values is substantial. While weekly payment levels for 139 of the 583 patients exceeded the matching Medicare rates by $500 or more, for 77 patients the weekly payment levels were actually lower than the matching Medicare rates.

Figure II.1: Amounts by Which EGHP Weekly Payments for Dialysis Differed From the Medicare Composite Rate



Note: For 41 patients, the dialysis provider had not received payment as of June 30, 1993, and we set the payment amount equal to the Medicare rate on the conservative assumption that the provider would get at least that much.

Comments From the Health Care Financing Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

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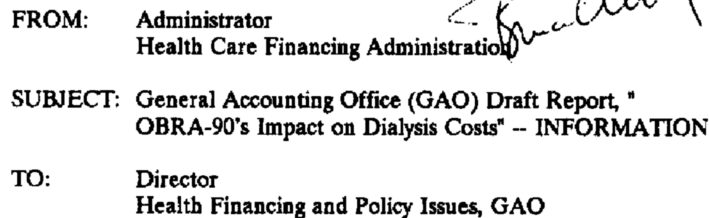

FROM: Administrator
Health Care Financing Administration

SUBJECT: General Accounting Office (GAO) Draft Report, " OBRA-90's Impact on Dialysis Costs" -- INFORMATION

TO: Director
Health Financing and Policy Issues, GAO

We have reviewed the GAO draft report which discusses the impact of the Omnibus Budget Reconciliation Act of 1990 (OBRA-90) on (1) the amount of money that dialysis providers receive and (2) the out-of-pocket payments made by Medicare beneficiaries as their share of medical costs.

We would note that the limitations cited at the bottom of page 8 through the top of page 9 would not violate the nondifferentiation provision. GAO may wish to reflect this view in the last sentence of the second bullet point on page 8. Also, GAO may wish to note that we believe that when employers become more generally aware that these limitations do not violate the Medicare secondary payer (MSP) statute, they may increasingly include such coverage limitations in their plans.

We believe that the most likely scenario is that plans will increasingly limit dialysis coverage across the board to a finite number of treatments, such as 50 or 100 treatments per year, or lifetime, under the policy. Such a limitation would result in adequate coverage for most acute dialysis patients, who generally require dialysis only for a short period of time, but would result in plans being primary payers for dialysis treatments required by end stage renal disease (ESRD) patients during only a small portion of the 18-month coordination period envisioned by Congress. In that event, Medicare Trust Fund savings anticipated under the ESRD-MSP provision could be substantially reduced.

We would also note that in the second parenthetical in the first full paragraph on page 9, the word "charges" should read "Medicare payment rate." Medicare does not pay 80 percent of charges, but rather 80 percent of the Medicare allowable rate. The beneficiary is responsible for 20 percent of the Medicare rate, not 20 percent of charges. The changed wording is consistent with wording elsewhere in the report, e.g., page 2, last paragraph, and second line of the chart, top of page 3.

Page 2

Additionally, on pages 8 and 9 of the report, GAO uses the expression "anti-discrimination provision" in three places and "non-discrimination provision" once. Within section 1862(b)(1)(C) of the Social Security Act (the Act) there are two separate provisions that could be described as "anti-discrimination" or "non-discrimination" provisions. The first is the "take into account Medicare entitlement" provision that prohibits a plan from doing so during the 18-month coordination period when plans are primary payers. The second is the "nondifferentiation" provision, which applies at all times and prohibits plans from differentiating based on ESRD, the need for renal dialysis or in any other manner. It is not always clear from GAO's discussion on these pages which provision GAO means to address. It appears that GAO is addressing only the "nondifferentiation" provision. Accordingly, we recommend that GAO use the term "nondifferentiation."

We also note that on page 8 of the report, in the first bullet point, the second sentence is possibly misleading. This sentence states that the Internal Revenue Code provides "unfavorable tax treatment for employers whose health plans discriminate." OBRA-1989 repealed the Internal Revenue Code provisions that denied tax deductions for employers whose plans violated certain prohibitions, and enacted somewhat similar provisions into section 1862(b)(1)(C) of the Act. The prohibitions are enforced by a 25 percent excise tax on employers and employee organizations that contribute to nonconforming group health plans; i.e., in this context plans that do not conform to the requirements of section 1862(b)(1)(C) of the Act. It would be preferable and more accurate to describe the 25 percent excise tax instead of "unfavorable tax treatment" as the consequences for having a plan that discriminates.

There is a statement on page 9 of the report indicating that HCFA has not taken a position regarding whether plans may decline to pay secondary to Medicare after the coordination period is expired. Our view is that this is plainly permitted by section 1862(b)(1)(C) of the Act, which provides:

> . . . clause (ii) [nondifferentiation provision] shall not prohibit a plan from taking into account that an individual is entitled to or eligible for benefits under this title under section 226A [ESRD entitlement provisions] after the end of the 12 [18]-month period described in clause (i).

Thus, plans may take into account Medicare entitlement after the 18-month period by terminating the coverage of the Medicare beneficiary. This would be discriminatory if plans coordinate benefits with other plans for non-Medicare enrollees but refuse to coordinate benefits with Medicare. While discriminatory, such action is plainly permissible under the present wording of the statute.

Page 3

Finally, we would offer the following technical comments.

- Page 3, Table 1: In the last column, second row, add "lesser of charges or" before "composite rate."

- Page 4: At the end of the penultimate sentence of the second paragraph of "Results in Brief" add "or by declining to pay secondary benefits once Medicare becomes the primary payer."

- Page 9: In the third line from the bottom of the first full paragraph after "secondary payer statute" add "as well as the prohibition against taking into account Medicare eligibility or entitlement during the first 18 months of that eligibility or entitlement."

- Page 9: In the last paragraph after the first word of the second sentence add "during the 18-month coordination period."

- Page 11, footnote 16: In the third line before "entitlement" add the words "eligibility or." The 18-month coordination period is either a period of ESRD-based eligibility or entitlement.

- Page 12, footnote 17: In the last line the phrase "up to 80 percent of the composite rate" should be deleted. When Medicare is the secondary payer, it pays the difference between the primary payment and the Medicare allowable rate. This is because the primary payment is applied to the beneficiary's Medicare deductible and coinsurance obligations.

Should you have any questions or require any additional information, kindly contact Ron Miller of the Executive Secretariat at (410) 966-5237.

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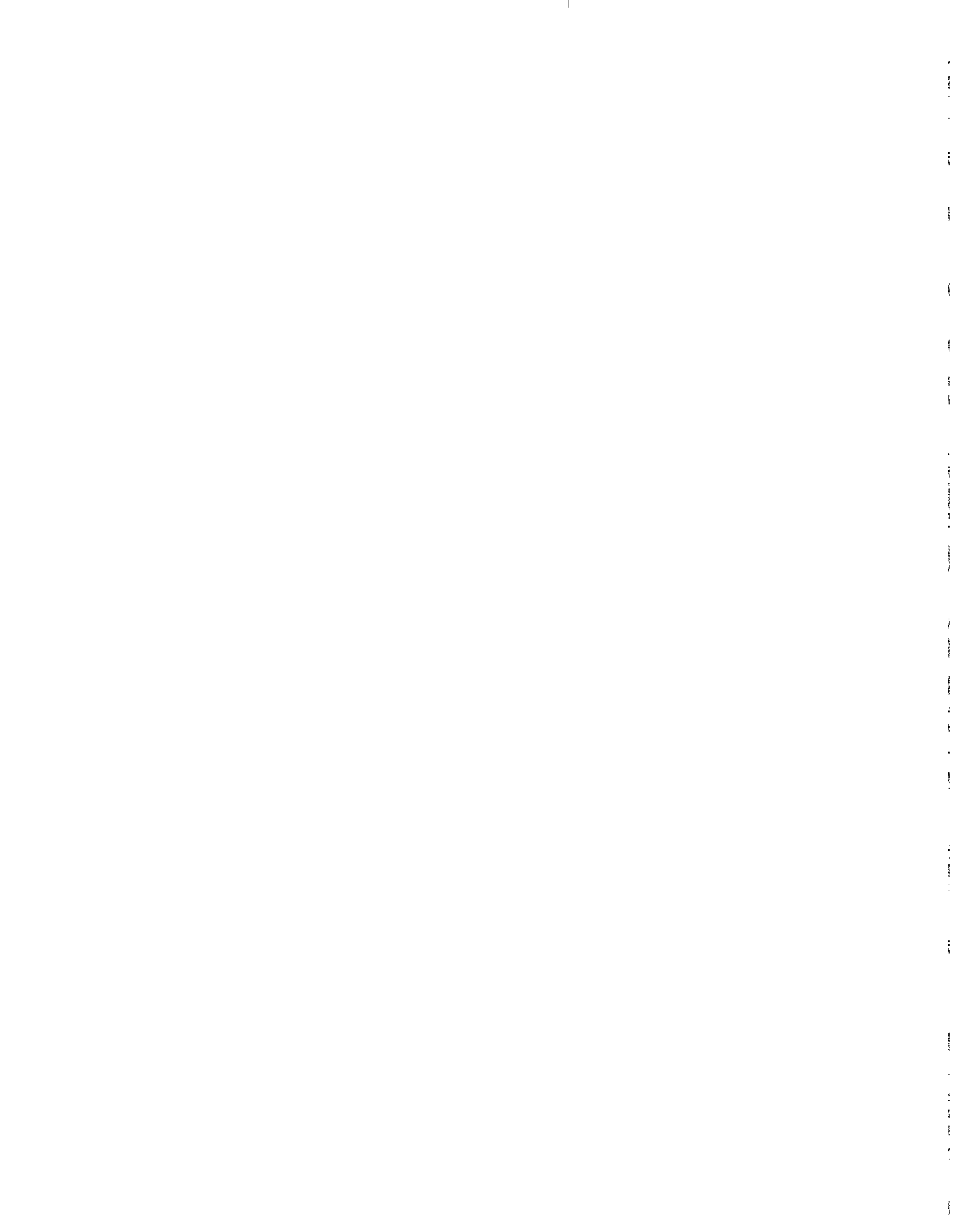

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