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Health, Education and Human Services Division

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February 11, 1997

The Honorable William M. Thomas
Chairman, Subcommittee on Health
Committee on Ways and Means
House of Representatives

Dear Mr. Chairman:

The administration has publicly discussed its intention to propose, as part of its Medicare reforms, shifting from the part A (Hospital Insurance) trust fund to the part B (Supplementary Medical Insurance) trust fund the costs of most home health care services, such as skilled nursing and therapy. You noted in your February 4, 1997, letter that we had evaluated the potential effects of a similar proposal made in 1988[1] and asked us to update that report on the basis of the particulars of the administration's current proposal.

The specifics of the administration's proposal were not available as of February 10, 1997, but we were told that this proposal would be similar to the one in the President's 1996 Medicare legislative package. Therefore, we based our analysis on the specifics in the 1996 package. We also reviewed Medicare and Congressional Budget Office (CBO) projections of home health costs and utilization and made rough estimates of the dollar effects of the proposal.

In summary, we found three potential effects from shifting most home health costs from part A to part B. First, as expected, the depletion date for the part A trust fund would be extended because the majority of home health payments would no longer come from that fund. CBO estimated last year that the shift would add about 3 years to the 2001 depletion date it then estimated. Second, the shift would result in the need for more general revenues to fund part B in direct proportion to the costs shifted from part A. Available information indicates about $95 billion would be needed over the fiscal year 1998 through

[1]Medicare: Potential Effects of Shifting the Home Health Benefit From Part A to Part B (GAO/HRD-88-79, Mar. 25, 1988).

2002 period, assuming no other changes to the home health benefit are made. The administration and others also propose additional changes to the home health benefit designed to hold down its cost growth, and to the extent that such proposals are implemented, the amount shifted from part A to part B would be reduced. The shift, however, would not affect the reported budget deficit amount because both funds are included in the unified budget, and the increase in general fund expenditures would be offset by an equal decrease in part A trust fund expenditures. Third, Medicare beneficiaries would not be affected except that they would have less opportunity to appeal home health denials to administrative law judges because the dollar threshold for such appeals is $100 under part A but $500 under part B.

MEDICARE AND HOME HEALTH CARE

Medicare, authorized by title XVIII of the Social Security Act, is a health insurance program that helps almost all Americans aged 65 and over and some disabled persons pay for needed health services. Medicare consists of two parts:

- Part A, Hospital Insurance Benefits for the Aged and Disabled, covers inpatient hospital services, skilled nursing facility services after a hospitalization, hospice services, and home health services. Part A is financed primarily by Social Security taxes on wages. To be eligible for part A, a person must (1) be 65 years or older and eligible for payments under Social Security's old age retirement and survivors program, (2) have received Social Security disability benefits for 24 months, or (3) suffer from end-stage renal disease and be fully or currently insured under title II of the act. In fiscal year 1996, part A expenditures totaled about $125 billion.

- Part B, Supplementary Medical Insurance Benefits for the Aged and Disabled, is a voluntary program that covers physician services and a number of other health services, such as laboratory, outpatient hospital, and home health. Part B is financed by enrollee premiums (currently set by law at an amount necessary to cover 25 percent of total costs) and federal general revenues. For most kinds of services, beneficiaries are responsible for a $100 annual deductible and 20 percent coinsurance. Any citizen, or legal alien who has resided in the United States for at least 5 years, aged 65 or older is eligible for part B. In addition, disabled persons and end-stage renal disease patients eligible for part A are also eligible for part B. In fiscal year 1996, part B expenditures totaled about $69 billion.

Home health services consist of skilled nursing services; physical, speech, and occupational therapy; and medical social services provided in a patient's home. If the patient requires skilled nursing or therapy services, home health aid services, which have more of a personal care nature, such as assistance with bathing, are also covered.

Medicare's deductibles and coinsurance do not apply to home health services,[2] and no limit is placed on the number of visits. Home health services are covered under both part A and part B. However, payment for such services is always made under part A unless the beneficiary is only covered by part B.

The Health Care Financing Administration (HCFA), within the Department of Health and Human Services (HHS), administers Medicare. HCFA is assisted by insurance companies that contract with it to process and pay claims. Part A contractors are called intermediaries, and they process all home health claims.

PROPOSAL TO SHIFT HOME HEALTH BENEFIT FROM PART A TO PART B

The administration's 1996 proposal, which we were told is expected to be similar to what will be proposed this year, would result in part A paying for only the first 100 visits after a hospitalization of at least 3 days. All other covered visits would be paid by part B unless the beneficiary was only covered by part A, in which case part A would continue to pay for all covered visits. The proposal would exclude from the determination of beneficiary premium amounts all costs transferred to part B as a result of the change.

The administration's proposal would move coverage back toward what was authorized before the Omnibus Reconciliation Act of 1980 liberalized the home health benefit. Before that act, part A covered up to 100 visits after a hospitalization and part B covered up to 100 visits per year.

Potential Effect on the Solvency of Part A Trust Fund

Current projections by the Medicare Board of Trustees and CBO show the part A trust fund becoming insolvent in the year 2001. Because the administration's

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[2]The exception is durable medical equipment, such as hospital beds and oxygen equipment, furnished by home health agencies for which beneficiaries are required to pay 20-percent coinsurance.

proposal would shift the majority of home health costs from part A to part B, the date the part A trust fund is exhausted would be extended. CBO estimated that the transfer of costs to part B that would have occurred under the 1996 proposal would move the part A trust fund's depletion date forward by about 3 years, all other things being equal. Because 4 years of cost shifting are now available rather than the 5 years available at the time of CBO's estimate, the effect on the trust fund's depletion date would now be somewhat less.

Potential Effect on the Need for General Revenues

Part B is funded by beneficiary premiums and general revenues. Because the proposal would preclude the home health benefit costs transferred to part B from affecting the amount of beneficiary premiums, all of the increase in costs would have to be covered by general revenues.

HCFA data indicate that 30 percent of home health visits were preceded by a hospital stay and were within the first 100 visits.[3] This means that under the proposal, the costs for about 70 percent of visits would be transferred from part A to part B. HCFA estimates that Medicare will spend about $21.9 billion on home health care in fiscal year 1998. Thus, in 1998, about $15.3 billion in payments would be transferred to part B and need to be covered by general revenues. HCFA estimates that during fiscal years 1998 through 2002, about $135 billion will be spent on home health services, which indicates that about $95 billion would be shifted to part B and need to be funded by general revenues if the 70 percent remains constant over that period.[4] CBO projects slightly lower home health care costs over this period, which would mean a somewhat smaller estimate for the total amount shifted.

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[3]This estimate is based on a hospital stay of any length. To the extent that beneficiaries had lengths of stay of fewer than 3 days, use of the 30-percent estimate would understate the amount to be transferred from part A to part B.

[4]This estimate does not reflect the amount paid to risk contract health maintenance organizations to cover their obligation to furnish home health care. Payments to these organizations are apportioned to the two trust funds by HCFA, and presumably a greater portion would be allocated to part B if the proposal is enacted. Currently, about 10 percent of beneficiaries are enrolled in these organizations, which means roughly 10 percent more, or about $9 billion, might be transferred from part A to part B.

The administration's 1996 proposal as well as other proposals introduced in the Congress included provisions designed to hold down the increase in the growth of home health expenditures. To the extent that any cost-saving proposals are enacted and are effective, the amount of general revenues needed to cover costs transferred from part A to part B would be less than the amount discussed in the previous paragraph. A preliminary HCFA estimate, which considered the effects of other possible legislative changes, showed that about $82 billion would be transferred from part A to part B.

Regarding the need to control home health care cost growth, our report, Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS-96-16, Mar. 27, 1996), discussed the reasons home health costs have been increasing rapidly. We concluded that changes in the home health industry, revisions to Medicare law and regulations, and a lessening of administrative controls over the benefit combined to produce growth rates much higher than those for the overall Medicare program. We also concluded that the home health benefit had moved from its original purpose of treating patients for acute illnesses and injuries to more of a long-term care benefit for chronic conditions. We suggested that the Congress consider whether the home health benefit should continue to become more of a long-term care benefit or if it should be limited primarily to a posthospital acute care benefit. We also suggested that the Congress consider providing additional administrative resources so that controls against abuse of the benefit could be better enforced.

Potential Effect on Beneficiaries and Home Health Agencies

Because the 1996 proposal to shift home health costs from part A to part B by itself would not change the level of services, out-of-pocket costs for beneficiaries, or administration of the benefit, the proposal should have no direct effect on beneficiaries or home health agencies.[5] The one exception is that appeal rights for denied claims would change for some beneficiaries. Under part A, the amount in dispute must total at least $100 for a beneficiary to seek a hearing before an administrative law judge after exhausting appeals at

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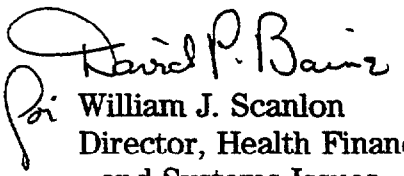
[5]The administration's 1996 proposal would protect beneficiaries covered only by part A or only by part B though covering all home health care for them under whatever part they have. Without this provision, beneficiaries would have to buy the part they are not currently eligible for to maintain full coverage for home health care.

the intermediary level. Under part B, the amount in dispute must be at least $500. Thus, beneficiaries whose home health claims would have been paid by part A before but now would be paid by part B and who have amounts in dispute between $100 and $500 might not be able to get a hearing before an administrative law judge.

I trust that the information in this letter satisfies your needs. We will make this letter available to others on request. If you or your staff have any questions, please contact me on (202) 512-7114 or Tom Dowdal, Senior Assistant Director, on (202) 512-6588. Peter Oswald, Senior Evaluator, also contributed to this letter.

Sincerely yours,



William J. Scanlon
Director, Health Financing
and Systems Issues

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