
Deficit Reduction Act of 1984: Provisions Related to the Medicare and Medicaid Programs*

This article summarizes the principal provisions of the Deficit Reduction Act of 1984 that relate to the Medicare and Medicaid programs. Among other things, the new legislation freezes customary and prevailing charges for physician services for 15 months at the June 1984 levels, reduces the allowable increase in hospital costs per case to one-fourth of 1 percentage point for fiscal years 1984-85, introduces new rules for the revaluation of a provider's assets, and establishes fee schedules for clinical diagnostic laboratory tests on a statewide, regional, or carrier-wide basis. It also normalizes the practice for trust fund transfers, waives the late enrollment surcharge and provides a special enrollment period for persons aged 65-69 who defer part B enrollment while participating in employer-sponsored group health insurance plans, makes changes in contracts for claims processing, and maintains the part B premium rate, through calendar year 1987, at the level necessary to produce income equal to one-fourth of program costs for aged enrollees. Under Medicaid, the coverage requirements for pregnant women and children have been modified, and applicants must now assign their rights to third-party payments to the State as a condition of eligibility.

On July 18, 1984, President Reagan signed into law H.R. 4170,¹ the Deficit Reduction Act of 1984 (Public Law 98-369). This legislation contains a number of provisions affecting the Old-Age, Survivors, and Disability Insurance (OASDI), Supplemental Security Income (SSI), Medicare, Medicaid, and Aid to Families with Dependent Children (AFDC) programs. The principal provisions related to the Medicare and Medicaid programs are summarized in this article. A companion article, which begins on page 3 of this issue of the **Social Security Bulletin**, covers those provisions of the new law that relate to the OASDI and SSI programs. It is expected that an upcoming issue of the **Bulletin** will contain an article discussing the AFDC aspects of the new legislation.

* Prepared by the Office of Legislation and Policy, Health Care Financing Administration.

¹ H.R. 4170, as contained in the conference committee report adopted by the House of Representatives and the Senate on June 27, included several technical errors that were corrected by H.Con.Res. 328 (adopted by both Houses on June 29) before the bill was sent to the President for his signature. This summary reflects these corrections.

Medicare Reimbursement and Benefit Changes

Modification of working aged provision (section 2301). Medicare is a secondary payor for workers and their spouses aged 65 to 70 who are covered by an employer's group health insurance. The employer must offer these aged employees the same health benefits as other workers. This provision extends the rule of Medicare as secondary payor to the spouses aged 65 to 70 of workers under age 65 whose employer group health insurance covers such spouses. It is effective on January 1, 1985.

Part B premium (section 2302). The Supplementary Medical Insurance, or part B, program is financed by a combination of premiums from enrollees and general revenue contributions. Through calendar year 1985, the monthly premium amount is calculated so as to produce premium income equal to 25 percent of estimated program costs for enrollees aged 65 or older. Beginning with calendar year 1986, the premium calculation would have reverted to an earlier method under which the premium amount is the lower of (1) an amount suffi-

cient to cover half the program costs for the aged, or (2) the current premium amount increased by the percentage by which cash benefits were most recently increased under the cost-of-living adjustment (COLA) provisions of the Social Security program. This provision extends the requirement that the part B premium produce income equal to 25 percent of program costs through 1987. However, the increase in the part B premium may not exceed the dollar amount of the Social Security COLA adjustment. It is effective with premiums for January 1986.

Payment for clinical diagnostic laboratory tests (section 2303). Outpatient diagnostic laboratory services are reimbursed on the basis of reasonable charges, subject to the part B deductible and coinsurance, when furnished by an independent laboratory or a physician. Assignment is permitted on a case-by-case basis. Physicians may bill for laboratory services regardless of whether or not they personally performed or supervised the test and are permitted to bill a nominal amount to cover specimen collection and handling fees in the case of those tests performed by an independent laboratory. To prevent unreasonable markups, certain limits are applied on the amount Medicare and Medicaid will pay a physician for laboratory services furnished by an independent laboratory.

Payment for hospital laboratory services to outpatients is made on the basis of the lower of charges or reasonable costs. Hospitals providing these services to their outpatients must accept assignment. No assignment is required in the case of nonhospital patients receiving laboratory services from a hospital serving as an independent laboratory. Medicare is permitted to waive the coinsurance requirements for those tests furnished by a laboratory that has a negotiated rate agreement in effect with the Department.

The new legislation modifies existing law by establishing fee schedules on a statewide, regional, or carrier-wide basis for the fee screen year beginning July 1, 1984. For independent laboratories, physicians, and hospital laboratories acting as independent laboratories (that is, furnishing tests to nonhospital patients), the fee schedule is set initially at 60 percent of prevailing charges; for hospital laboratories serving hospital outpatients, the initial level is 62 percent of prevailing charges. After 3 years, payment for laboratory services furnished by independent laboratories and physicians is to be made on the basis of a national fee schedule and, for hospital laboratory services to outpatients, on the basis of cost reimbursement unless Congress includes these laboratories in a national fee schedule.

The fee schedules will be adjusted annually to reflect increases or decreases in the Consumer Price Index for All Urban Consumers. The Secretary of Health and Human Services may also make adjustments or exceptions to the fee schedules to assure adequate reimburse-

ment for emergency laboratory tests needed for bona fide emergency services; certain low-volume, high-cost tests where highly sophisticated equipment or highly skilled personnel are necessary to assure quality; technological changes; and the relative difference between a region's or local area's wage rates and the wage rate presumed in the data on which the schedule is based. Federal matching funds will not be available to the extent that a State paid more for a laboratory test than would be paid for such a test under the Medicare fee schedules.

The provision modifies the current assignment and billing options. Independent and hospital laboratories are required to accept assignment. Physicians may continue to accept assignment on a claim-by-claim basis. All assigned laboratory tests will be paid at 100 percent of the fee schedule amount (or, if lower, the actual charge). The coinsurance and deductible will not be applied to assigned laboratory charges. Unassigned laboratory bills will be paid at 80 percent of the fee schedule amount, subject to the deductible and coinsurance amounts.

Direct billing is required for all part B laboratory services. That is, physicians may bill for laboratory services only when they personally perform or supervise the test. However, the Secretary may permit an independent laboratory to bill for all tests performed for a patient even if some (but not all) of the tests were referred to another laboratory.

Anyone who furnishes laboratory services may bill a nominal amount for the collection of a patient specimen. Only one collection fee per patient encounter will be permitted, however.

The Secretary is required to simplify current billing requirements for laboratory services and to assure that the information collected is sufficient to prevent fraud and abuse. The Secretary is also required to report on the advisability and feasibility of providing for direct payment to physicians for all clinical diagnostic tests ordered by them. The General Accounting Office is to report on the impact of the fee schedule on services, the potential impact of the move to national rates, and the impact of such a fee schedule on hospital outpatient services. Both reports are due January 1, 1987. Covered under this provision are Medicare diagnostic tests provided on or after July 1, 1984, and Medicaid payments for calendar quarters beginning on or after October 1, 1984.

Limitation on physician fee prevailing and customary charge levels; participating physician incentives (section 2306). Medicare pays for physicians' services on the basis of Medicare-determined "reasonable charges." Reasonable charges are the lesser of (1) a physician's billed charge, (2) the customary charge made by an individual physician for a specific service, or (3) the prevailing level of charges made by all physicians for services in a geographic area. The customary and prevailing

charges are updated annually, on July 1, to reflect changes in physician charging practices. Increases in the prevailing charge levels are limited by an economic index, which reflects changes in the physicians' practice costs and changes in general earnings levels. Physicians may also decide, on a claim-by-claim basis, to accept assignment—that is, for each claim, a physician may decide either (1) to accept the amount paid by Medicare (the reasonable charge) as payment in full (except for cost-sharing amounts) or, (2) to bill the patient for the entire bill, including any amount in excess of the Medicare reasonable charge. The patient is then responsible for paying the physician for the full amount of the bill and for submitting the claim to Medicare for payment of 80 percent of the reasonable charge under the Medicare program.

Under the new legislation, for 15 months beginning July 1, 1984, Medicare customary and prevailing charges for physician services are frozen at the levels that were in effect for the 12-month period ending June 30, 1984. In addition, during the period of the freeze, nonparticipating physicians are not permitted to increase their actual billed charges to Medicare patients. Participating physicians are allowed normal increases in their actual charges to Medicare patients during the freeze period. These normal increases will be recognized in future calculations of customary charges of participating physicians.

A participating physician is one who voluntarily signs an agreement before October 1 in a year to accept assignment of all services provided to Medicare patients during the following 12-month period. Nonparticipating physicians are allowed to accept assignment on a claim-by-claim basis.

Incentives for physician participation include directories of participating physicians, dissemination of names of participating physicians via toll-free telephone lines, and provision for electronic receipt of claims by carriers. Increases in actual charges of nonparticipating physicians during the freeze period will not be recognized in future customary charge screen calculations. Nonparticipating physicians who increase their actual charges could be subject to civil money penalties and/or exclusion from the Medicare program for up to 5 years. Effective date of the provision is July 1, 1984.

Limitation on increase in hospital costs per case (section 2310). Effective October 1, 1982, the Tax Equity and Fiscal Responsibility Act (Public Law 97-248) expanded limits on Medicare routine costs per day to total costs per case. It also established a target rate reimbursement system that limited allowable rates of increase in Medicare payments per case over fiscal years 1983-85. The target rate is equal to the previous year's allowable operating costs per case (or, after the first year, the previous year's target amount) increased by the percentage increase in the cost of the mix of goods

and services used to provide inpatient hospital services (market basket) plus 1 percentage point.

The Social Security Amendments of 1983 (Public Law 98-21) provided for the establishment of a prospective payment system for certain hospitals. For fiscal years 1984 and 1985, payment amounts for hospitals operating under the prospective payment system and for hospitals and hospital units exempt from the system would be increased by the market basket plus 1 percentage point. For fiscal years beginning on or after October 1, 1985, the rate of increase is left to the discretion of the Secretary.

Under the new legislation, the rate of increase of hospitals operating under the prospective payment system and for exempt hospitals and hospital units will be equal to the market basket plus one-fourth of 1 percentage point in fiscal year 1985, subject to budget neutrality. In fiscal year 1986, the rate of increase shall not exceed the market basket plus one-fourth of 1 percentage point. The provision is effective with cost reporting periods beginning and discharges occurring on or after October 1, 1984.

Revaluation of assets (section 2314). Medicare reimburses hospitals and other providers for their capital-related costs, including depreciation costs, interest, and, for proprietary facilities, return on equity capital. Regulations allow revaluation upward to the lower of the selling price, fair market value, or current reproduction cost. The costs of the transaction, such as legal fees, negotiations, and settlements are allowed. Rental charges are limited by regulation to the amount that would be allowable if the provider had title on sale and leaseback arrangements. When an asset is sold above its depreciated value, Medicare shares in the gain, up to the amount of depreciation paid on the asset.

The new legislation restricts reimbursement for capital on the change of ownership of a hospital or skilled-nursing facility to the lesser of the cost under Medicare to the owner of record on enactment (or, if later, the first owner of record) or to the purchase price, thereby eliminating upward revaluation. Costs of legal fees, negotiation, or settlement of the sale are not reimbursable. The Secretary is required to take into account the limit on revaluation when establishing reimbursable rental charges in sale and leaseback agreements. The recapture of depreciation up to the full value of the initial asset under Medicare is required. This provision is effective with contracts obligated on or after the date of enactment.

Under the new legislation, the States are also required to provide assurances satisfactory to the Secretary that the methodologies used to establish capital reimbursement of hospitals, skilled-nursing facilities, and intermediate care facilities can reasonably be expected not to increase those rates more than they would increase under Medicare policy as the result of a change in

ownership. This provision is effective with medical assistance provided on or after October 1, 1984, except that, in those cases where State legislation is required, the State will not be deemed out of compliance until the first calendar quarter after the close of the first regular session of the State legislature that starts after the date of enactment.

Contracts for Medicare claims processing (section 2326). Medicare contracts with intermediaries and carriers to perform the day-to-day operational work for part A (Hospital Insurance) and part B of the program, respectively. Providers are permitted to nominate an intermediary, but they may be reassigned by the Secretary if such reassignment results in more effective administration of the program. Intermediaries and carriers are reimbursed for these activities on a reasonable cost basis, subject to the budgetary limitations imposed by the Health Care Financing Administration. Selection of carriers and intermediaries on the basis of competitive bidding is allowed only on an experimental basis. The Secretary is required to establish by regulation the standards and criteria with regard to effective administration of the part A program by intermediaries.

The new legislation allows a waiver of the provider's right to nominate the intermediary when a contract is competitively bid for the duration of that contract. Competitive bids may be made to replace contractors whose performances have repeatedly ranked in the lowest 20th percentile. Such competitions must be among health insuring organizations and are limited to two part A and two part B contracts in fiscal year 1985 and fiscal year 1986. These contractors must meet all regular contract standards and perform the full range of contractor functions.

The new legislation requires that, in determining a contractor's necessary and proper costs, the Secretary shall take into account the amount that is reasonable and adequate to meet costs incurred in an efficient and economically run organization.

It requires that the standards and criteria for part A and part B contracts be published in the Federal Register and that an opportunity be provided for public comment before implementation. It also reduces the number of home health agency regional intermediaries to not more than 10 by July 1, 1987.

The General Accounting Office has been instructed to study the Medicare contracting process and report to the Congress on whether contractor costs are excessive, whether standards for evaluating costs and performance are adequate and properly applied, and whether the Secretary's authority is sufficient to deal with inefficient contractors either through negotiation and budget review or replacement. These provisions are effective with agreements and contracts entered into or renewed on or after October 1, 1984. The study is due 1 year after enactment.

Medicare Administrative and Miscellaneous Changes

Normalization of trust fund transfers (section 2337). This provision reestablishes the former practice (followed before the Social Security Amendments of 1983) of transferring funds as needed during the month into the Hospital Insurance (HI) Trust Fund from the Treasury, rather than making all transfers for anticipated needs on the first of the month.

Enrollment and premium penalty with respect to working aged provision (section 2338). A 10-percent part B premium surcharge is normally imposed for each 12-month period after age 65 for which a Medicare beneficiary fails to enroll. This provision provides that any month in which a beneficiary aged 65-69 does not enroll because that individual is covered by employer group health insurance will not be taken into account in calculating the amount of the premium surcharge. In addition, special enrollment periods are established to apply upon the termination of coverage by employer group insurance and at age 70 when the working aged provision no longer applies. The penalty relief provision is effective with respect to months beginning with January 1983 for premiums for months beginning at least 30 days after enactment.

Medicaid Provisions

Medicaid coverage for pregnant women and children (section 2361). States must provide Medicaid to poor women and children receiving cash assistance under the Aid to Families with Dependent Children (AFDC) program. The States have had the option of extending coverage at their current Federal matching rates to the following additional groups meeting AFDC income and resource requirements: first-time pregnant women who would be eligible for AFDC if the child were born, two-parent families where the principal breadwinner is unemployed, pregnant women in two-parent families, and children under age 18 or 21 in two-parent families.

Under the new legislation, the States are required to provide categorically needy Medicaid coverage at regular Federal matching rates to the following groups meeting AFDC income and resources requirements: (1) first-time pregnant women who would be eligible for AFDC (or would be eligible as AFDC-unemployed parents if the State covered this group) if the child were born, from medical verification of pregnancy; (2) pregnant women in two-parent families where the principal breadwinner is unemployed, from medical verification of pregnancy; and (3) children born on or after October 1, 1983, up to age 5, in two-parent families. The provision is effective October 1, 1984, except that where State legislation is necessary, the State shall not be considered out of compliance before the first day of the first calen-

dar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment.

Mandatory assignment of rights of payment by Medicaid recipients (section 2367). Under the new legislation, the States are mandated (they formerly were permitted) to require Medicaid applicants to assign to the State

their rights to third-party payments as a condition of eligibility. The effective date is October 1, 1984, except that where State legislation is necessary, the State shall not be considered out of compliance before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment.