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STATEMENT OF

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HUMAN RESOURCES DIVISION

BEFORE THE

SUBCOMMITTEE ON HEALTH

COMMITTEE ON WAYS AND MEANS

HOUSE OF REPRESENTATIVES

ON

FUNDING OF CONTRACTORS FOR MEDICARE CLAIMS PROCESSING

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss a number of issues presented in our just issued report, Medicare: Existing Contract Authority Can Provide for Effective Program Administration. This report reflects the results of the GAO review required by the Deficit Reduction Act of 1984 (DEFRA).

As requested, our testimony today will address the adequacy of the funding available to the contractors who process and pay Medicare claims, the relationship between the funding levels and the accuracy of program payments and quality of services, and the Health Care Financing Administration's (HCFA's) use of competitive authority provided by DEFRA.

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GAO'S VIEW OF THE CONTRACTOR FUNCTION

We view Medicare contractor operations from two perspectives:

--Is Medicare receiving fair value for what it pays the contractors? That is, are contractor operations efficient and economical?

--Are the contractors adequately protecting Medicare against erroneous payments and providing quality services to beneficiaries and providers? That is, are they effective?

We have made many recommendations over the years to improve contractor operations from both perspectives. The recommendations have included controlling administrative costs by terminating high-cost contractors, requiring more uniformity in contractor operations to better safeguard program payments, and improving beneficiary and provider services. Balancing efficiency and economy of contractor operations with effectiveness is not easy for HCFA, and the contractor budget process is an important tool for doing so. As discussed in our current report, we are concerned that in recent years budgetary controls on the efficiency and economy side of the equation may be degrading the effectiveness side. While we recognize that HCFA needs to control contractor costs, we do not believe it should do so at the expense of contractor effectiveness in making accurate and timely program payments or providing

quality beneficiary services. Overemphasis on reducing the 1.3 percent of Medicare costs paid to contractors could result in reduced contractor effectiveness in controlling the 97.5 percent paid out as benefits.

With these general comments in mind, I will now provide some background information on contractors and then turn to the specific questions you asked us to discuss.

THE ROLE OF MEDICARE CONTRACTORS

HCFA contracts with insurance companies--called intermediaries for part A and carriers for part B--to process Medicare claims. Currently, Medicare has intermediary contracts with six commercial insurance companies, two Blue Cross plans, and the Blue Cross and Blue Shield Association, which in turn subcontracts with 45 local Blue Cross plans. Medicare has carrier contracts with nine commercial insurance companies and 28 Blue Shield plans.

In fiscal year 1985, the government paid intermediaries and carriers about $933 million to process about 330 million claims for health services provided to about 31 million beneficiaries. The claims resulted in payments of over $60 billion from the Medicare Trust Funds.

Since the inception of Medicare, benefit payments have increased dramatically year after year, while intermediary and carrier costs have increased more moderately. For example, during the period 1980 to 1984, benefit payments nearly doubled

from $33 billion to $59.9 billion, but total contractor administrative costs increased by only about a third, from $614 million to $822 million. On a cost-per-claim basis, in constant 1970 dollars, from 1970 to 1984 the unit cost of processing part A claims decreased from $6.34 to $2.33, while the unit cost of part B claims decreased from $3.16 to $.85.

Currently, administrative costs represent only 2.5 percent (about 1.3 percent for Medicare contractors) of total program payments. This compares favorably with the administrative costs incurred by large private insurers, which are about 7 percent of premium revenues. To their credit, HCFA and the contractors have kept Medicare administrative costs relatively low even though required to implement many programmatic changes. During the past few years, contractors have had to adjust their operations to implement

--the Prospective Payment System for hospitals;

--the Medicare Secondary Payer Program;

--new benefits, such as payments to hospices and comprehensive outpatient rehabilitation facilities;

--a new uniform bill used by providers for Medicare and other payers;

--a new medical coding system for part B services;

--toll-free telephone lines for beneficiaries and participating physicians; and

--expanded program safeguard activities.

IS MEDICARE'S CONTRACTOR FUNDING ADEQUATE?

Our report extensively discusses the adequacy of contractor funding. Basically, we concluded that the administration's budget requests for contractor funding in fiscal years 1985 and 1986 were inadequate, particularly when considered in light of the legislative and agency-imposed additional work requirements that occurred after the budgets were submitted to the Congress. Although HHS did not request additional funds, the Congress did appropriate additional amounts for both fiscal years. However, total contractor funding for fiscal year 1985 was still inadequate and probably resulted in contractors absorbing some Medicare costs as well as an increased claims backlog.

While the amount appropriated by the Congress for contractor funding in fiscal year 1986 (which exceeded the administration's request by $43.5 million) was probably adequate, the Gramm-Rudman-Hollings reduction that occurred in March sequestered $42 million and again left contractor funding very tight.

Our report does not cover the fiscal year 1987 budget. However, the administration's fiscal year 1987 budget request for contractor funding asks for an increase of only about 3 percent over the amount appropriated by the Congress in fiscal year 1986. While the request represents about an 8-percent increase over the lower level of funds actually available for fiscal year 1986 after sequestration, it could still be

inadequate. Because of the expected increase in contractor workloads and the likelihood of additional work for the contractors resulting from the budget reconciliation/Gramm-Rudman-Hollings process, we believe the administration's contractor budget request for fiscal year 1987 may be inadequate.

Our primary concerns are that inadequate contractor funding can lead to (1) a degradation of services to beneficiaries and (2) a loosening of safeguards over program payments. As discussed in our report, the latest HCFA data indicate that both of these undesired outcomes are occurring. The Consolidated Omnibus Budget Reconciliation Act, which became law a few weeks ago, promises relief to the potential budget crunch. It authorizes $105 million in additional contractor funding in each of fiscal years 1986, 1987, and 1988 for safeguard activities. Assuming these funds are appropriated, our concern about the program safeguard area would be alleviated. However, most of the recent funding cuts ($90 million in fiscal years 1985 and 1986) have come from the portion of the budget covering the claims processing subfunction, which is crucial to both the identification of claims for review by safeguard activities and the timely and accurate payment of claims. Thus, we believe that the adequacy of funding for claims processing needs to be looked at by the Congress during the appropriations process.

IS THE USE OF "COST CAPS" APPROPRIATE?

To stay within the administration's budget request for fiscal years 1985 and 1986, HCFA used formula-based contractor "cost caps." In effect the formula required all contractors to reduce their costs. HCFA justified cost-per-claim caps under the authority provided under DEFRA to restrict payments to contractors to the cost of an efficient and economical contractor. However, we believe that HCFA inappropriately used this authority.

The conference report on DEFRA shows that this authority was to be used to control payments to inefficient contractors, that a standard for efficiency was to be used, and that individual contractor circumstances were to be considered in any cost cutting measures. Although HCFA did consider some individual contractor circumstances in developing the cost caps, it did not consider other important ones that result in legitimate differences in contractor costs. Such factors as the percentages of paperless claims and assigned claims were not considered. And HCFA's formula-based cost caps resulted in reductions for all contractors without applying a standard for efficiency.

In summary, we believe that the process HCFA used to set the cost caps was based on available funds rather than on a true standard of economy and efficiency and was used to spread estimated budget shortfalls among all contractors rather than to

reduce the costs of inefficient ones. We also believe the cost caps have had an adverse effect on contractor performance. The latest HCFA data show that claims backlogs and average processing times are both increasing.

WHAT WILL RESULT FROM INCREASED CLAIMS BACKLOGS?

Because of limits on contractor funding, HCFA is permitting contractors to slow down the average time to pay claims and to increase claims backlogs. While the average time to process a part B beneficiary claim was 12.3 days during fiscal year 1984, it increased to 20.3 days in January 1986. Also, average backlogs increased from 7.7 million claims in fiscal year 1984 to 13.7 million claims in January 1986. The primary benefit of slower claims payment is that invested Medicare Trust Fund money can earn more interest. But increased backlogs create risks and costs.

Intentionally letting backlogs grow is risky because it leaves no margin for unexpected problems. In numerous instances in our past Medicare work, we have noted large backlogs caused by problems in implementing new data processing systems or HCFA initiatives. Program and system changes are common, and problems can be expected. However, the additional backlogs caused by these problems could be particularly damaging to beneficiaries and providers when backlogs are already high. Also, large backlogs and slower claims payment can increase program administrative costs because they can generate more

beneficiary and provider inquiries as well as more claim resubmissions. This, in turn, increases contractor workloads and can further exacerbate backlogs and slow down claims payment.

You asked that we discuss how increased backlogs and slower claims payment would affect provider participation, assignment rates, beneficiary liability, and provider cash flow. Because many part A providers (such as hospitals and home health agencies) receive periodic interim payments based on their past claims history, neither their cash flow nor their program participation should be affected much. However, part B providers, mainly physicians, would have their cash flow affected. We are not able to predict what effect this could have on participation or assignment rates, but it certainly should not increase these rates. To the extent, if any, that assignment rates decrease, beneficiary liability would increase.

WHAT ARE THE POTENTIAL EFFECTS OF A GRAMM-RUDMAN-HOLLINGS CUT IN FISCAL YEAR 1987?

We do not know if a Gramm-Rudman-Hollings sequestration will occur in fiscal year 1987 or, if one does, the extent of such a sequestration for Medicare contractor funding. This funding is subject to a sequestration just like other nonexempt spending. Of course, any cut in funding would probably affect contractor performance, and the larger the cut, the more adverse the effect. Backlogs and average payment time could increase further, and payment error rates could go up.

USE OF DEFRA COMPETITIVE BIDDING AUTHORITY

HCFA has not yet used the DEFRA authority to obtain competitive bids for contracts but has told us that it plans to conduct two competitions this year. As discussed in our report, HCFA has interpreted the DEFRA provision as only providing authority to seek competitive bids for cost contracts. We disagree and believe that HCFA can use the authority to award competitive fixed-price contracts.

We have concluded that limited authority to competitively award Medicare contracts could be a useful tool in a coordinated HCFA strategy for managing contractors, and we believe that the Congress should consider extending this limited authority.

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This concludes my prepared remarks. I will be pleased to address any questions.