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MEDICARE AND MEDICAID

BUDGET ISSUES

Statement of
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Before the
Subcommittee on Health
Senate Committee on Finance

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the views of the General Accounting Office about issues related to the budget for Medicare and Medicaid. Since the beginning of these programs, we have worked extensively with this Committee, and other Senate and House Committees, to devise legislative changes to these programs that would contain costs while attempting to prevent adverse effects on program beneficiaries.

During the last 6 years, many changes have been made to these programs in an effort to control their cost growth. Today I would like to summarize what has happened as a result of these changes and comment on some areas where additional changes could be warranted.

MEDICARE AND MEDICAID CHANGES FOR FISCAL YEARS 1981-87

Since 1980, the Congress has enacted at least 34 pieces of legislation that have affected Medicare and Medicaid. While these laws included some benefit expansion and revenue increase provisions, the primary thrust has been cost containment. The most significant acts over this period have been the six reconciliation bills enacted from 1980 through 1986. The Congressional Budget Office estimated that the first five reconciliation acts would result in a net reduction of about

$22 billion in Medicare expenditures through fiscal year 1986 and a reduction of about $3.8 billion in federal Medicaid expenditures during the same period. Some of the major changes resulting in reduced federal costs have been:

-- Requiring liability insurance and employer-sponsored health insurance to be the primary payor for Medicare beneficiaries covered by such insurance.

-- Limiting federal sharing in state Medicaid costs during fiscal years 1982-84.

-- Establishing ceilings in 1982 for Medicare payments of hospital operating costs. The savings from this provision were carried over to Medicare's prospective payment system (PPS) through its "budget neutrality" provision.

-- Freezing Medicare payment rates for physician services from July 1984 through December 1986.

-- Increasing Medicare Part B beneficiary costs by raising the deductible from $60 to $75 and requiring higher premiums.

Overall, most of the anticipated savings came from controlling payments to providers of health services (primarily hospitals) and requiring other insurers (and thus employers through higher premiums) to pay. But significant federal cost reductions also came from increasing Medicare beneficiary costs.

There also were two provisions that resulted in substantial increases in revenues from payroll taxes for part A of Medicare

-- Coverage of federal employees.

-- Coverage of state and local government employees hired after April 1, 1986.

The Department of Health and Human Services (HHS) also made a number of regulatory changes to Medicare and Medicaid in the last 6 years. However, the savings from those changes were probably small in comparison to savings resulting from the changes enacted by the Congress.

AREAS WHERE FURTHER CHANGE MAY BE WARRANTED

You asked us to comment on areas where we believe additional changes could be made either (1) to further reduce Medicare and Medicaid costs or (2) to enhance the programs in areas that may have been cut too severely. You also asked for areas where administration of the programs can be improved to save money or better serve the public. I will primarily address the first issue. We have done and are currently doing extensive work related to controlling costs. Our ongoing and past work related to areas that may have been cut too much has not yielded firm conclusions to date because of a lack of data necessary to address such questions as the effect of program changes on the quality of and access to care.

Rebasing PPS Rates

The first issue I would like to address is the need to rebase PPS; that is, recompute the payment factor for PPS on the basis of recent, audited cost data. Currently, this payment

factor is about $3,000 for urban hospitals, which means that on average Medicare pays these hospitals this amount for all the operating costs associated with a discharge of a Medicare patient. This amount is based on the average Medicare payment in 1981 with numerous adjustments that were supposed to account for changes since then.

We have issued a series of reports on problems with the data bases used to compute PPS payment rates.[1] We reported on

-- inflation of PPS rates because unaudited cost data were used to compute them;

-- overstatement of rates because unreasonably high costs, which might not be eliminated even if the cost data were audited, were included in cost data; and

-- PPS rates being higher because the costs of services that were not medically necessary were included in the data bases.

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[1]Need to Eliminate Payments for Unnecessary Hospital Ancillary Services, GAO/HRD-83-74, September 30, 1983; Excessive Respiratory Therapy Cost and Utilization Data Used in Setting Medicare's Prospective Payment Rates, GAO/HRD-84-90, September 28, 1984; Medicare's Policies and Prospective Payment Rates for Cardiac Pacemaker Surgeries Need Review and Revision, GAO/HRD-85-39, February 26, 1985; Use of Unaudited Cost Data Resulted in Overstatement of Medicare's Prospective Payment System Rates, GAO/HRD-85-74, July 18, 1985; Additional Changes to the Medicare Reimbursement Rates for Major Joint Procedures Are Needed, GAO-85-109, September 12, 1985; Medicare: Past Overuse of Intensive Care Services Inflates Hospital Payments, GAO/HRD-86-25, March 7, 1986.

PPS gave hospitals incentives to eliminate unreasonably high costs and unnecessary services, and we believe that hospitals have reacted to these incentives. And we see no reason why payments should be based on unaudited costs that historically have included 3-percent unallowable costs. We have recommended that HHS rebase PPS using recent, audited cost data so that PPS rates would be based on reasonable cost data reflecting the changes that have occurred under PPS. HHS has not responded favorably to this recommendation. It indicated that it may lack authority to rebase although we pointed out how HHS could in effect rebase under current law.

Because of the numerous adjustments that HHS and the Congress have made to PPS payment rates over the years, we cannot be certain that savings would result from rebasing. However, given the magnitude of the problems with the data bases, we believe that it is reasonable to expect some savings. On the other hand, if rebasing would result in increased payments, this would address the Committee's concerns that cuts in some areas may have been too severe. In effect, if increased payments resulted from rebasing, it would indicate that PPS rates are inadequate.

In either case, we believe it is time to rebase PPS so that there is some assurance that payment rates reflect the costs hospitals must incur to efficiently provide medically necessary care. This is the criterion established by law for PPS payments.

Cost-Reporting Requirements

An area closely related to that of rebasing PPS is the continued availability to the government of adequate data on hospital costs. Current law requires hospital cost reporting through 1987. We believe that hospitals should continue to report their costs in the future, and that Medicare should continue to audit those cost reports. While there are Medicare and hospital costs associated with cost reporting, we believe the benefits can be substantial.

Adequate cost data are necessary for rebasing. Accurate data are also important for determining the effect of new technology on hospital costs, for if Medicare payments are not appropriately adjusted to reflect changing technology, Medicare, as the largest payor of hospitals, could provide disincentives to adopting improved technology.

Finally, we expect that hospitals will continue to maintain internal cost reporting for their management purposes. Medicare as a payor should have an independent source of cost data so that the government does not have to rely on the hospital industry as the sole source of such data. Audited cost reports would serve this purpose.

Paying for Hospital Capital Costs

Another area related to Medicare hospital payments is how to pay for capital costs. From Medicare's inception, hospitals were paid their actual reasonable capital costs. When the Congress enacted PPS, it directed HHS to study and recommend whether capital should be included in the prospective rates. In 1986, HHS proposed that all capital costs be paid prospectively with a 4-year transition program. The Congress precluded HHS from administratively finalizing this proposal and instead required that capital payments be reduced by 3, 7, and 10 percent in fiscal years 1987, 1988, and 1989, respectively.

In August 1986,2, we issued a report analyzing HHS's prospective capital proposal and the proposals of a number of other organizations and individuals. Because of hospitals' relative inability to adjust their capital costs in response to prospective payments and because of the potential adverse effects of prospective capital payments on the ability of hospitals to raise capital funds, we proposed three alternatives to HHS's prospective capital payment plan. They were

-- using a long transition period to lessen the immediate affects of prospective payment;

-- initially using prospective payment only for equipment costs which would lessen the immediate effects and provide some experience with prospective capital payment; and

-- modifing the cost reimbursement system by establishing limits to capital payments designed to remedy the same ills that PPS is supposed to.

Although we have not seen all the details of HHS's new prosposal, we understand that it includes a 10-year transition period to prospective payment for the capital costs of hospitals' plants with immediate coverage of the capital costs of equipment. The proposal would reduce payments by the levels specified in the 1986 reconciliation act mentioned above. This HHS proposal appears to be better than last year's and more or less incorporates two of our alternatives. However, we continue to believe our third option--modified cost reimbursement--is a viable option that could be targeted at problem hospitals.

The Fraud and Abuse Bill

In the last Congress, the House passed H.R. 1868, a bill designed to protect Medicare and Medicaid patients from incompetent practitioners and improve these programs' antifraud and abuse provisions. This Committee favorably reported a modified version of that bill, but the Senate was unable to act on it before adjournment. Major portions of this bill address gaps in HHS's practitioner sanctioning authority that we

reported on in May 1984.3 Other provisions were recommended by the HHS Inspector General. We testified in support of this and predessor bills three times.

While enactment of this bill would probably not result in large dollar savings, it would provide better protection for program beneficiaries from unfit or unethical practitioners and give HHS the tools it says it needs to combat fraud and abuse in Medicare and Medicaid.

Health Maintenance Organizations (HMOs) and Competitive Medical Plans (CMPs)

Medicare and Medicaid both contract with HMOs, CMPs, and similar capitated plans to provide care to beneficiaries. The administration has proposed and will this year propose initiatives to expand the use of these organizations by both programs. The concept behind HMOs and CMPs is good--pay a fixed amount per beneficiary for all covered services the beneficiaries need. The contractor assumes the risk, which in turn provides incentives to hold down costs. If the contractor succeeds in keeping costs down, it realizes a profit.

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[3]Expanded Federal Authority Needed to Protect Medicare and Medicaid Patients From Health Practitioners Who Lose Their Licenses, GAO/HRD-84-53, May 1, 1984.

GAO has issued a number of reports since 1974 on Medicare and Medicaid use of HMOs, CMPs, and similar health plans.[4] The three general thrusts of those reports have been

-- problems with setting payment rates,

-- inadequate mechanisms to assure quality of care, and

-- administrative problems in controlling enrollment and disenrollment of beneficiaries.

Our latest work in this area, Medicare's use of HMOs in Florida and the Arizona Medicaid program's use of CMPs, shows that these problems continue. Last year the Congress took action to strengthen quality-of-care controls and alleviate administrative problems. For example, outside medical review of HMOs with Medicare contracts was mandated, and enrollment and disenrollment issues were clarified. We also recommended that

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[4]Better Controls Needed for Health Maintenance Organizations Under Medicaid in California, B-164031(3), September 10, 1974; Deficiencies in Determining Payments to Prepaid Health Plans Under California's Medicaid Program, MWD-76-15, August 29, 1975; Relationships Between Nonprofit Prepaid Health Plans with California Medicaid Contracts and For-Profit Entities Affiliated with Them, HRD-77-4, November 1, 1976; Medicaid Insurance Contracts--Problems in Procuring, Administering, and Monitoring, HRD-77-106, January 23, 1978; Foundation Community Health Plan of the Medical Care Foundation of Sacramento, HRD-78-62, March 6, 1978; HEW's Contract with Group Health Cooperative of Puget Sound Covering Medical Care Provided to Medicare Beneficiaries--Noncompliance with Open Enrollment Requirements and Other Selected Issues, HRD-80-3, October 15, 1979; Problems in Administering Medicare's Health Maintenance Organization Demonstration Projects in Florida, GAO/HRD-85-48, March 8, 1985; Arizona Medicaid: Nondisclosure of Ownership Information by Health Plans, GAO/HRD-86-10, November 22, 1986, Medicare: Issues Raised by Florida Health Maintenance Organization Demonstrations, GAO/HRD-86-103, July 16, 1986

HHS take a number of actions, including improving its rate-setting methodology for Medicare.

We believe that it would be prudent to see if the changes that have been made are effective before launching major new efforts to expand the use of HMOs and CMPs by Medicare and Medicaid.

Overpriced Physician Procedures

When a new, complex medical procedure is introduced, physician charges for performing it are often high. Over time, more physicians become capable of performing the procedure, and improvements in techniques and technology can greatly reduce the risk of the procedure and the physician time necessary to perform it. However, in general the physician charges for the procedure stay high.

Last year the Congress required that payments for cataract surgery, a procedure that fits the pattern I just described, be reduced by 10 percent. The Congress has also directed the Physician Payment Assessment Commission to look for other overpriced procedures that are provided in quantity.

We believe this area presents a potential for significant savings. One example of a potentially overpriced procedure is cardiac pacemaker implants. During our work on Medicare payments to hospitals for pacemaker surgery patients,[5] we gathered operating room time data for 1,063 implants. When pacemakers were introduced, their implantation was considered relatively major surgery. Now, implants are generally done under local anesthesia, and in some hospitals implants are performed in areas other than operating rooms. Overall, about 100,000 pacemaker implantations are done a year.

The data we gathered showed average operating room times of a little less than 80 minutes for implantation of dual chamber pacemakers and about 50 minutes for single chamber pacemakers. The Medicare prevailing charge for pacemaker implantation vary by geographic area but were generally in the $1,000 to $1,500 range in 1986. Considering the physician time involved in implanting a pacemaker, the payment for this operation, and the decreased complexity of the procedure, pacemaker implantation may be overpriced.

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[5]Medicare's Policies and Prospective Payment Rates for Cardiac Pacemaker Surgeries Need Review and Revision, GAO/HRD-85-39, February 26, 1985.

Third-Party Liability

Medicaid has always been the payor of last resort; that is, any other insurance available to the recipient should pay before Medicaid. Since 1980, the Congress has enacted a series of provisions expanding the types of insurance that are primary to Medicare and has directed HHS to improve Medicaid third-party liability programs, as we recommended. Both programs have realized large savings from these actions.

Additional Medicare savings are available from better administration of its secondary payor program. I have with me advance copies of a report we will be issuing to the Committee's ranking minority member. This report recommends several actions to increase third-party liability savings on hospital costs. Implementation of those recommendations should save hundreds of millions of dollars for Medicare--we estimate that in 1985 Medicare paid at least $527 million in hospital costs that should have been covered by other insurers. We will also be looking at the administration of Medicare's secondary payor program for part B to see if savings can be increased there.

Medicare's Administrative Budget

In 1982 we testified about the savings that could be realized from expanding Medicare's cost effective programs of

auditing provider cost reports and screening part B claims to identify claims for noncovered and unnecessary services.[6] The Congress provided $45 million in additional funding specifically for these activities in fiscal years 1983-85 and $105 million additional for these functions and the third-party liability program in fiscal year 1986. The Congress also authorized $105 million in additional funds for fiscal years 1987 and 1988.

Last year we reported and testified on Medicare's administrative budget for processing and paying claims.[7] The thrust was that we were concerned that the administration's efforts to cut the administrative budget were adversely affecting beneficiary and provider services and program safeguard activities. For example, average claims processing times had doubled, and many claims processing contractors were not meeting program safeguard standards.

Over the last few years the Congress has consistently appropriated more funds than the administration has requested for Medicare administration. We have not yet had the opportunity to analyze the administration's fiscal year 1988

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[6]Testimony on the President's Budget Proposals before the Subcommittee on Health, House Committee on Ways and Means, on June 15, 1982.

[7]Medicare: Existing Contracting Authority Can Provide for Effective Administration, GAO/HRD-86-48, April 22, 1986, and testimony on this report and related issues before the Subcommittee on Health, House Committee on Ways and Means, on May 1, 1986.

budget request for Medicare administration but we would encourage the Congress to again take a hard look at the sufficiency of the request to assure adequate beneficiary and provider service as well as program safeguard activities.

Home Health Care

One area that has consistently been of concern to this Subcommittee has been home health care. In fact, while the Congress has been acting to reduce costs in most other services, it has expanded benefits under home health care. One of the reasons for this is that home health care can be a cost-effective alternative to inpatient care.

Our latest report on home health care,[8] issued in December 1986, presents two different kinds of problems related to home health care. First, Medicare is not doing enough to assure that it only pays for services that are covered and medically necessary under current law. Second, there are a substantial number of persons who do not receive or have difficulty obtaining all the supportive services they need to stay in their homes. Such supportive activities include homemaker services, chore services, and meals on wheels, which are normally not

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[8]Medicare: Need to Strengthen Home Health Care Payment Controls and Address Unmet Needs, GAO/HRD-87-9, December 2, 1986.

covered under Medicare. We also point out that many people receive supportive services from family or friends and that covering these services under a government program could result in substitution of government-paid services for those currently provided by family and friends, thus increasing federal costs more than necessary to meet unmet needs only.

Catastrophic Insurance for the Elderly

The final area I would like to discuss are the proposals that have been made to provide protection against catastrophic health care costs for the elderly. We believe that the information presented in our October 1986 report on Medigap insurance[9] will be useful to the Congress in considering these proposals. The information should be particularly useful regarding whether catastrophic protection for Medicare-covered services should be added to the Medicare program or whether the private sector should be encouraged to provide such protection.

We found that the loss ratio for the $1.3 billion in Medigap insurance policies sold by commercial insurers in 1984 averaged 60 percent; that is, only $0.60 of every $1 in earned premiums was returned to policyholders as benefits. For the 13 Blue Cross/Blue Shield plans included in our review, the average

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[9]Medigap Insurance: Law Has Increased Protection Against Substandard and Overpriced Policies, GAO/HRD-87-8, October 17, 1986.

loss ratio was 81 percent for their $780 million in earned premiums in 1984. In contrast, Medicare pays about 97 percent of its costs as benefits. About $1 billion goes to the carriers and intermediaries for administering the program. Thus it appears that, in 1984 the private sector spent as much to administer the $5 billion Medigap market as the government paid the carriers and intermediaries to administer the $65 billion Medicare program.

This concludes my prepared remarks. I would be glad to answer any question you have.