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MEDICARE: Cutting Payment Safeguards Will Increase Program Costs

Statement of
Michael Zimmerman, Director,
Medicare and Medicaid Issues
Human Resources Division

Before the
Subcommittee on Labor, Health and
Human Services, and Education
Committee on Appropriations
United States Senate

SUMMARY

Medicare program costs have grown rapidly during the 1980s, increasing at an average annual rate of 12.4 percent. Program costs for fiscal year 1990 are estimated to exceed $109 billion. The budget proposes $1.5 billion for Medicare claims processing contractors in fiscal year 1990.

Without the payment controls contained in the claims processing and payment safeguard activities of Medicare contractors, program costs would have been $20 billion higher in fiscal year 1988. The claims processing and payment safeguard activities work interdependently, and both need to be funded adequately to assure that Medicare pays only for medically necessary care at the rate authorized by law and that the program is protected from fraud and abuse.

The budget request envisions a 4-percent decrease in the amount allocated per claim for the claims processing activity, but calls for a one-third reduction in the payment safeguard function. Based on the estimated cost/benefit ratio of the fiscal year 1989 payment safeguard investment, the $134 million reduction in payment safeguard funding could result in an increase of $1.1 billion in erroneous benefit payments.

While GAO has suggested for many years that claims processing and payment safeguards be adequately funded, it has also recommended a number of actions to improve these activities. Although GAO does not believe that all Medicare contractor functions are performed as efficiently and effectively as possible, reducing the funding for payment safeguards by $134 million would not be cost effective.

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the payment safeguard functions performed by Medicare's claims processing contractors--called intermediaries for part A hospital insurance and carriers for part B supplementary medical insurance.[1] As you requested, we will first review the history of Medicare's cost growth. Then we will discuss trends in contractor costs and the importance of contractor payment safeguard activities in assuring the integrity of the Medicare trust funds. Payments to contractors cover primarily four functions: provider and beneficiary services; claims processing; payment safeguards and investments to improve contractor systems.

Let me say at the outset that we believe that reducing the amount Medicare's claims processing contractors receive for payment safeguard activities, by $134 million as proposed by the budget request, would not be cost effective. In fiscal year 1988 these activities saved $4.3 billion on an investment of $305 million. The administrative savings achieved by reducing funding

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[1]Intermediaries and carriers are insurance companies that contract with Medicare to process and pay claims for Medicare benefits. These contractors are responsible for assuring that only claims for covered, medically necessary services are paid and that the amount paid is in accordance with Medicare rules. They are also the main channel for communication with beneficiaries and providers about matters relating to claims and coverage of services.

for payment safeguards could be greatly exceeded by the increase in erroneous benefit payments.

GROWTH OF THE MEDICARE PROGRAM

Medicare is the fourth largest category of federal expenditures after defense, social security, and interest payments on the national debt. During fiscal year 1990, Medicare is expected to provide health coverage for over 33 million aged and disabled persons at a total cost of $109 billion. Of this amount, $1.9 billion or 1.7 percent represents administrative costs, including those incurred by the Health Care Financing Administration (HCFA) and those paid to the Medicare contractors for processing about 560 million claims.

Throughout Medicare's history, benefit costs have grown faster than both the general inflation rate and the gross national product, just as health expenses in general have. Benefit costs increased from $34.6 billion in 1980 to $87.5 billion in 1988, an average annual increase of about 12.4 percent. One reason for the high growth rate has been an increasing number of beneficiaries. During the period 1980 through 1988, Medicare beneficiaries increased about 14 percent, from 28.1 million to 32 million. Another reason has been that, on average, each beneficiary has received more services and more

expensive types of services in part because of the availability of new technology. When viewed from the perspective of average cost per beneficiary, however, Medicare cost-growth rates have not been as high as the overall figures indicate. The average cost per beneficiary increased from $1,247 in fiscal year 1980 to $2,754 in fiscal year 1988, an average annual increase of about 10.5 percent.

Turning now to the costs for administering the Medicare program, from 1984 through 1989 the total amount paid to the Medicare contractors increased from $862 million to about $1.5 billion, an average annual increase of 11.5 percent. However, the number of claims processed increased even more rapidly. Thus, on a cost-per-claim-processed basis, administrative costs actually decreased during that period--dropping from $3.08 in 1984 to an estimated $2.98 in 1989, an average annual decrease of about 0.3 percent.

The amount Medicare contractors are paid just for the claims processing function has decreased more dramatically--falling from $1.73 per claim in 1984 to an estimated $1.34 per claim in 1989, an average annual decrease of about 4 percent. Put another way, the claims volume increased 72 percent during this period--from 280 to 490 million claims, but the amount that Medicare contractors were paid to process these claims increased by only 36 percent--from $484 to $657 million.

IMPORTANCE OF PAYMENT SAFEGUARD ACTIVITIES

Medicare is a complex program with numerous rules about the types of services covered, the conditions under which the services qualify for payment, and the method for determining the payment amount for covered services. These rules are designed to assure that (1) only medically necessary and appropriate care is provided to beneficiaries, (2) the amount paid for such care is reasonable, and (3) the program is protected from fraud and abuse. Most of the money carriers and intermediaries receive from Medicare is for enforcing these rules.

Carriers and intermediaries perform two functions to assure the accuracy of Medicare payments--claims processing and payment safeguard reviews. The claims processing activity involves more than just receiving, processing, and paying claims. A very important part of this function is assuring the accuracy of payments. This involves a myriad of checks--both automated and manual--to verify that services are covered, that charges are reasonable, that the claim is not a duplicate, and that numerous other payment criteria have been met. Thus, the claims processing function can result in the outright denial of claims

or in identifying claims that need further review through payment safeguard activities. For example, during fiscal year 1988, carriers denied payment in whole or in part on 64.7 million claims (17 percent of all claims). These denials prevented $7.3 billion in erroneous payments. By enforcing Medicare's reasonable charge criteria, carriers also reduced submitted charges by $12.9 billion in fiscal year 1988.

Contractor payment safeguard activities complement the normal claims processing activities by providing an additional means to assure that Medicare payments are appropriate. Payment safeguards include three types of activities. First, the contractors perform medical and utilization review of submitted claims to determine if the services furnished were medically necessary and appropriate.[2] The contractors look for such things as overprovision of services and furnishing of services not necessary for the treatment of the patient's condition. In fiscal year 1988, carrier and intermediary medical and utilization review activities saved Medicare $866 million.

The second major payment safeguard activity is intermediary audits of the cost reports for providers that are reimbursed on a cost basis, such as home health agencies and for certain

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[2]Intermediaries do not review inpatient hospital claims for medical necessity or appropriateness. This function is performed by peer review organizations, commonly referred to as PROs, which contract with Medicare specifically for this function.

hospitals' services paid on a cost basis. In fiscal year 1988, intermediary auditing and settlement activities resulted in program savings of $2 billion.

The third safeguard activity is assuring that other insurers, whose coverage is primary to Medicare, pay claims before the Medicare program does. This safeguard is called the Medicare Secondary Payer (MSP) program. In fiscal year 1988, carrier and intermediary MSP activities saved Medicare $1.4 billion.

In addition to these three payment safeguard activities, carriers and intermediaries are important sources of referrals to and information for the HHS Inspector General's Office in its efforts to identify and prosecute instances of fraud and abuse against the Medicare program.

In summary, without the combined control mechanisms provided by the claims processing and payment safeguard functions, Medicare costs in fiscal year 1988 would have been at least $20 billion higher. To continue to be effective, both these functions need to be adequately funded. Underfunding claims processing can result in identifying fewer claims for review, and underfunding payment safeguards can result in inadequate review of claims identified during processing.

MEDICARE CONTRACTOR BUDGET

REQUEST INADEQUATE

The fiscal year 1990 budget request for Medicare contractors represents an increase of $78.6 million or 5.4 percent above the fiscal year 1989 appropriation. While this would appear to be a reasonable increase, a closer analysis indicates otherwise. The major increase in funding is for activities related to the Medicare catastrophic health insurance program's drug benefit (a $128-million increase). In other major areas, the budget request actually represents a decrease in funding. Claims are expected to grow by 14 percent, but the budget request for the claims processing function represents only a 2-percent increase. On a cost-per-claim basis, this represents a 4-percent decrease. Payment safeguard funding would be reduced by almost one-half, from an overall average expenditure of 75 cents per claim to 41 cents per claim.

This reduction in funding for payment safeguard activities could have a significant affect on Medicare program costs. In fiscal year 1988, payment safeguard funding was $305 million and resulted in savings of $4.3 billion--for every $1 spent, $14 was saved. HCFA estimates that fiscal year 1989 expenditures of $363 million will produce $3 billion in savings, a cost to savings ratio of $1 to $8. The fiscal year 1990 budget request for $229

million is expected to result in savings of $1.9 billion or a cost to savings ratio of $1 to $12. This request is $134 million less than appropriated for fiscal year 1989. Applying HCFA's $1 to $8 estimated cost to savings ratio for fiscal year 1989 to fiscal year 1990 indicates that the $134 million reduction in program safeguard funding could cost Medicare about $1.1 billion in erroneous benefit payments. Reducing payment safeguard funding appears to be penny-wise and pound-foolish.

PAYMENT SAFEGUARD ACTIVITIES COULD BE IMPROVED

We have supported adequate funding for claims processing and payment safeguards for many years. We have also recommended actions to improve the efficiency of claims processing and the effectiveness of these safeguards. For example, in November 1988,[3] we reported that Medicare was still paying many claims that other insurers should pay because they do not have adequate incentives to comply with Medicare's secondary payer provisions. We recommended that the Congress amend the Social Security Act to provide for Medicare to collect from insurers twice the amount owed when they do not properly treat Medicare as the secondary payer. We also recommended that HCFA improve its evaluation of contractors' MSP-related performance.

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[3]Medicare: Incentives Needed to Assure Private Insurers Pay Before Medicare, GAO/HRD-89-19, Nov. 29, 1988.

In another November 1988 report,[4] we pointed out that, while improving Medicare's methods of determining the allowable amount for physician and other services is important, payment reforms in themselves would not control overall costs because they would not control the quantity of services furnished. We suggested that benchmarks should be developed for the extent of services considered medically necessary to treat specific illnesses and justification should be required before paying for services exceeding the benchmarks. Carriers could use these benchmarks to improve the effectiveness of their utilization-review activities.

After our last major review of contractor operations, we concluded that HCFA could better use its contract authority to improve contractor performance and to remove from the program those contractors who consistently perform poorly.[5] We made several recommendations along these lines.

As I indicated earlier, we do not believe that all carrier and intermediary functions are performed as efficiently or as effectively as possible. However, reducing the amount these contractors receive for payment safeguard activities, as proposed

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[4]Transition Series: Health and Human Services Issues, GAO/OCG-89-10TR, Nov. 1988.

[5]Medicare: Existing Contract Authority Can Provide for Effective Program Administration, GAO/HRD-86-48, Apr. 22, 1986.

by the budget request, is not, in our opinion, the way to improve operations. Such a reduction could result in a significant increase in erroneous benefit payments and increase the risk of fraud and abuse.

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This concludes my prepared statement. I will be happy to answer any questions you may have.