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MEDICARE

Further Changes Needed to Reduce Program and Beneficiary Costs

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Human Resources Division

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May 15, 1991

The Honorable Fortney H. (Pete) Stark
Chairman, Subcommittee on Health
Committee on Ways and Means
House of Representatives

Dear Mr. Chairman:

Paying for about 25 percent of all hospital and physician services, Medicare is the fourth largest category of federal expenditures after defense, social security, and interest payments on the national debt. As the nation's largest payer for health care services, the Medicare program bears a responsibility to be a leader in health care reform.

To a large extent, Medicare has met its leadership responsibility. In the early 1970s, it initiated utilization review programs to assess the necessity and quality of care. It established the first nationwide prospective payment system for hospital care, which has helped constrain cost growth in that area. And it is revising the physician payment system so that prices paid will be based on the relative value of services rather than on historical charge patterns.

Many other payers have followed or will follow Medicare's lead. Consequently, given its leadership role, Medicare needs especially to assure that its payment rates are fair to beneficiaries, providers, and taxpayers and result in incentives for providers to treat patients efficiently while furnishing high-quality care.

Despite attempts to constrain costs, Medicare spending and beneficiary out-of-pocket costs have risen at troubling rates. Medicare expenditures rose from about $70 billion in 1985 to $106 billion in 1990, while average beneficiary out-of-pocket costs rose from about $630 to over $1,000 for Medicare-covered services. Medicare's high cost and continued rapid cost growth are evidence of inadequate economic incentives for patients and providers to contain costs. Consequently, much remains to be done in translating recent payment reforms into fully functioning systems. In response to your December 18, 1990, request, we have identified issues that the Congress might want to focus on to (1) help assure that the current Medicare reforms achieve their objectives and (2) identify additional opportunities to reduce Medicare beneficiary and program costs.

Background

The Medicare program, authorized by title XVIII of the Social Security Act, helps pay medical costs for about 31 million people aged 65 years and older, as well as for about 3 million individuals with disabilities. Medicare is administered by the Health Care Financing Administration (HCFA), within the Department of Health and Human Services (HHS). Benefits are provided under two parts. Part A covers inpatient hospital, skilled nursing facility, home health, and hospice care services. Part B covers physician services, outpatient hospital services, durable medical equipment, and various other health services, such as laboratory tests and diagnostic X-rays.

Over the past several years, we have issued reports discussing opportunities to refine or alter existing Medicare payment systems. This report draws on our past and ongoing efforts in five general areas: hospital prospective payment, physician payment, other part B services payment, health maintenance organizations, and payment safeguard activities. Our findings and proposals are summarized below and discussed more fully in appendix I.[1]

Hospital Prospective Payment

In the early 1980s the Congress began implementing fundamental Medicare payment reforms. The first of these, adopted in 1983, established a prospective payment system (PPS) for inpatient services in covered hospitals. PPS has constrained Medicare's expenditure growth for inpatient services and has provided hospitals with incentives to become more cost conscious. Last year, more than half of the total Medicare budget, about $58 billion, was spent on inpatient hospital care. Without the implementation of PPS, Medicare would have spent substantially more. Medicare growth in hospital payments averaged 15.7 percent annually in the 3 years before PPS but only 6.3 percent since.

Partly in response to PPS, hospital care has undergone substantial change. This change has resulted in declining hospital occupancy rates and profits. In this environment of constraint, PPS must be closely monitored to assure that Medicare payments are accurate and equitable. Consequently, we have focused our PPS work on issues of payment accuracy and equity. Specifically, we have addressed three general issues: (1) to what extent have PPS payments caused rural hospital closures; (2) are special PPS payments to teaching hospitals reasonable; and (3) is PPS appropriately classifying patients for the purposes of Medicare payment.

[1]GAO's Medicare and related reports are listed in appendix II and annotated in appendix III.

PPS Not a Major Cause of Rural Hospital Closures

Many rural hospitals have closed since 1980, and others are at risk of closure. The Congress has taken a number of steps aimed at improving rural hospitals' financial viability. These include giving such hospitals across-the-board increases in PPS payment rates and establishing new grant programs.

While these changes have increased rural hospitals' Medicare revenues, we found that losses on Medicare patients were not a major factor underlying most closures. Rural hospitals are more vulnerable than urban hospitals because they more often have characteristics, such as low occupancy, associated with a high risk of closure. But urban hospitals with similar characteristics are just as likely to close.

The wide range of factors influencing rural hospital closures suggest that additional Medicare PPS payments would not necessarily guarantee their financial viability. We believe HHS could take a more active role in using its authority to help assure that rural areas continue to retain their access to essential health care services. If the Congress decides to take additional actions to assist rural hospitals, it could consider a targeted approach to direct support to hospitals that appear to have a reasonable chance of becoming financially viable and whose closure would significantly affect a community's access to essential services. (See p. 19.)

Medicare Overpays Teaching Hospitals

Another PPS payment issue is whether the costs associated with teaching hospitals are recognized appropriately. In 1990 teaching hospitals received about $2.5 billion for their indirect medical education costs. These additional PPS payments were for the higher patient care costs associated with graduate medical education.

We and others have reported that the additional payments are too high. Our best estimate is that such payments should be reduced by about a third, which would have been about $840 million in 1990, to more accurately reimburse hospitals' for their indirect medical education costs. We share the concern expressed by others that a reduction in the additional payments for teaching costs might have an adverse effect on certain hospitals—mainly large inner city hospitals that provide high levels of charity care. We believe, however, that concerns about charity care costs should be addressed through a direct and targeted approach, not through PPS's indirect teaching adjustment. (See p. 20.)

Need to Address Variation in Treatment Costs

A remaining issue with PPS is whether the payment system creates incentives for hospitals to serve less severely ill patients. Under PPS, hospitals are paid a predetermined fixed amount for each patient based on the patient's diagnosis as it relates to diagnosis-related groups (DRGs). For PPS to encourage hospitals to operate efficiently while providing quality care, it must group patients whose treatment requires similar resources.

Some variation in treatment costs among patients falling under a given DRG is expected. However, we have found that (1) about one-third of the DRGs exhibited wide variation in treatment costs within a given DRG and (2) high and low expected treatment cost cases were not evenly distributed among hospitals. Consequently, hospitals can profit or lose depending on their mix of patients rather than on their level of efficiency. To remove this inequity, the DRGs should be refined to reduce the wide variations in treatment costs. While HCFA has taken some action in this direction, we believe this area requires HCFA's continuing attention, as DRG payment rates are the foundation of Medicare's inpatient payment system. (See p. 22.)

Concerns With Physician Payments

Medicare payments for physician services are expected to exceed $33 billion in fiscal year 1991. Further, part B is the most rapidly growing part of Medicare, and physician services are the largest component of part B. Between 1975 and 1990, Medicare benefit payments for physician services increased at a compound annual rate of 16.1 percent. The largest factor contributing to this increase since 1984 has been growth in the volume and complexity of services per enrollee.

Volume Control Is Critical

The Congress restructured the Medicare physician payment system by adopting a fee schedule to be phased in over the 1992-96 period. To discourage physicians from increasing the volume of services to counteract any resulting constraints on fees, the new system also establishes overall physician expenditure standards. Because volume plays such an important role in driving part B expenditure growth, the success of these physician payment reforms in achieving cost-containment goals hinges on HHS's implementation of the Medicare physician expenditure standards. Under the new payment system, HCFA and the carriers that process and pay claims for part B services will need to identify and closely monitor sources of inappropriate utilization. This will expand carrier responsibilities. Over the years, however, carriers' budgets have not kept pace with program changes. Continued inadequate funding by

the Medicare program could compromise the successful implementation of physician payment reform. (See p. 24.)

Beneficiary Costs Can Be Reduced

Another physician issue is the inability of hospitalized beneficiaries to avoid physicians' bills in excess of the amount approved by Medicare. When Medicare patients are admitted to the hospital, they choose the admitting physician or surgeon, but generally do not have the option of choosing other physicians who will provide services, such as a radiologist, anesthesiologist, or pathologist. A significant portion of these physicians do not accept assignment—that is, they charge more than Medicare's allowed amount and bill the beneficiary for the difference. Because of these unique circumstances, the Congress may wish to consider strengthening Medicare provisions that limit the amounts such nonadmitting physicians can charge hospitalized beneficiaries or mandating the acceptance of assignment. (See p. 26.)

Eliminate Time-Based Anesthesia Payments

Another part B concern is payment for anesthesia services, which, unlike payments to other physicians, is based on units of time. Medicare payments for physician anesthesia services totaled about $1.2 billion in fiscal year 1988.

Wide differences in Medicare reimbursement for the same anesthesia services resulted from variations in anesthesia time. Considerable variation occurred before surgery started (preoperative time) and was controlled largely by anesthesiologists. We concluded that variation during this period was for the most part unexplained. We observed, however, that time-based reimbursements provided a financial incentive to prolong anesthesia service delivery and may have contributed to the unexplained time variations.

We recommended that Medicare sever the direct link between anesthesia time and payment amount. We estimate that if fees were based on a procedure's median anesthesia time, Medicare payments would be reduced by over $50 million annually. (See p. 27.)

Other Part B Payment Concerns

About 35 percent of part B funds, or $15.4 billion, is spent on nonphysician services. We have identified three areas of concern with this portion of part B expenditures—the pricing of diagnostic laboratory services, excessive payments for new technology, and excessive payments for surgery in hospital outpatient departments.

Diagnostic Laboratory Service Payments Can Be Reduced

Although Medicare payment rates for clinical diagnostic laboratory services provided by independent laboratories have been reduced, payments for such services are still too high. Even when the recent fee reductions are taken into account, for the five largest laboratories, profits on Medicare patients are estimated to be 11 percent higher than these companies' overall profit rates. We believe Medicare payments for clinical laboratory services could be reduced so that Medicare's contribution to laboratories' profits do not exceed their overall profit rates. This could save Medicare about $150 million annually. (See p. 28.)

Payments for Emerging Technologies Can Be Reduced

Another part B payment issue involves how Medicare pays for emerging technology. The rapid development and increased use of new medical technologies is widely acknowledged as a key factor influencing health care cost inflation. Diagnostic imaging, particularly magnetic resonance imaging (MRI), is an often-cited example of this phenomenon. Since HCFA developed its method of paying MRI providers in 1985, both equipment costs and time per procedure have decreased appreciably. Though these factors have resulted in significant reductions in providers' costs per image, HCFA has no systematic method to make corresponding decreases in Medicare payments. Overpaying providers encourages an oversupply of the equipment because profits can be earned even with inefficient operation. To avoid this, we believe that HCFA needs to develop procedures for reducing Medicare payments as new technologies mature and the costs of efficiently using them fall. (See p. 29.)

Payments for Ambulatory Surgery Can Be Reduced

Medicare's methods of paying for ambulatory surgery in hospital outpatient departments are another area of concern. New technology and changing practice patterns have enabled hospitals to provide an increasing number of surgical services in outpatient settings. We have identified two technical problems with the way Medicare pays hospitals for ambulatory surgery that result in beneficiaries and Medicare paying more than necessary. These could be corrected in one of two ways. One alternative would result in substantial beneficiary savings and modest savings to Medicare. The second would result in lower Medicare expenditures but no savings to beneficiaries. We believe the Congress should consider requiring HCFA to implement one of these alternatives. (See p. 31.)

HMOs: Problems in Payments, Quality Assurance, and Oversight

Out of concern that delivering services on a fee-for-service basis encourages excessive utilization, HHS has promoted the use of health maintenance organizations (HMOs). These organizations provide medical care to members for a fixed payment and thus have incentives for efficiency. By fiscal year 1990, about 1.2 million Medicare beneficiaries were enrolled in HMOs at an annual cost to the program of about $4.2 billion.

Although enrollment of Medicare beneficiaries in HMOs has potential advantages for the Medicare program and its beneficiaries, we have found persistent problems with payment methods and program oversight. Specifically, HCFA is

- paying more than it should for enrolled beneficiaries,
- not sufficiently monitoring the quality of care delivered to Medicare beneficiaries in HMOs, and
- ineffective in dealing with HMOs having recurring problems complying with Medicare and other federal requirements.

We have several legislative and administrative recommendations aimed at correcting these problems or mitigating their effects. (See p. 33.)

Program Administration and Payment Safeguard Activities

Our final set of concerns addresses the administration and control functions of the Medicare program, specifically the degree to which it is vulnerable to waste, abuse, and mismanagement. Medicare typically contracts with insurance companies to process and pay Medicare claims. These contractors are responsible for assuring that only claims for covered, medically necessary services are paid and that payment amounts are in accordance with Medicare rules.

In recent years, the funds available to pay contractors have not kept pace with program growth. Funding for the contractor program safeguard activities declined $26 million (about 7 percent) from fiscal year 1989 to 1990. Achieving savings by simply reducing contractor budgets is not a viable strategy because it is likely to increase overall program expenditures. For instance, in 1989, the program safeguards cost about $358 million but saved Medicare about $4 billion by avoiding or recovering erroneously paid claims—a cost-benefit ratio of about 1 to 11. Consequently, we believe that the Congress should ensure that future contractor budgets are sufficient for effective program administration.

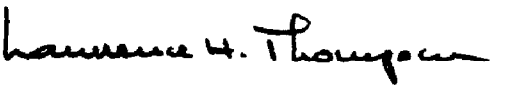
For several federal activities, the Congress has recognized that specific increased administrative expenditures are likely to result in overall savings; therefore, the Congress devised methods to facilitate the funding of such expenditures notwithstanding the constraints currently imposed on federal spending. We believe the Congress should consider a similar method to fund increased expenditures for Medicare safeguard activities. The result should be a net reduction in Medicare costs. (See p. 38.)

Conclusions

Medicare payment reforms can reduce program and beneficiary costs. The proposals set out above and summarized on the following page represent ways to enhance the effect of the Medicare reforms already enacted and identify opportunities for further reform. Ensuring that Medicare payments are not excessive or inadequate is especially important because the program serves as a national guide to other health care payers, who often follow Medicare's lead. Consequently, successful implementation of the Medicare reforms can significantly affect the nation's overall health care costs.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies to interested parties and will make copies available to others on request. This report was prepared under the direction of Janet L. Shikles, Director, Health Financing and Policy Issues, who can be reached (202) 275-5451. Other major contributors are listed in appendix IV.

Sincerely yours,



Lawrence H. Thompson
Assistant Comptroller General

Summary of Key Findings

Rural hospitals. Additional PPS payments are not an appropriate vehicle for resolving rural hospital problems. (See pp. 19-20.)

Teaching hospitals. PPS payments could be reduced by about a third; this change would save about $840 million annually. (See pp. 20-22.)

Variation in treatment costs within DRGs. HCFA should continue to refine DRGs to reduce wide variations in treatment costs. (See pp. 22-23.)

Physician payment reforms. Funding of Medicare administrative activities needs to be sufficient to assure the successful implementation of physician payment reform. (See pp. 24-26.)

Beneficiary costs for inpatient physician services. Beneficiary out-of-pocket costs can be reduced significantly for inpatient physician services, such as those provided by anesthesiologists, radiologists, and pathologists. (See pp. 26-27.)

Payment for anesthesia services. HCFA should eliminate the link between anesthesia time and payment levels; such a change could save Medicare about $50 million annually. (See p. 27.)

Payment for laboratory services. Medicare payments for laboratory services could be reduced; this action would save Medicare approximately $150 million annually. (See pp. 28-29.)

Payment for emerging technology. To reduce Medicare costs, HCFA should consider developing a procedure for redetermining payments as new technologies mature and associated costs fall. (See pp. 29-31.)

Payment for ambulatory surgery. Technical corrections to the payment calculation for ambulatory surgery performed in a hospital outpatient department would reduce Medicare payments and beneficiary out-of-pocket costs. (See pp. 31-32.)

Health maintenance organizations. Legislation and administrative changes are needed to correct problems in payment, monitoring quality of care, and compliance with federal regulations. (See pp. 33-38.)

Payment safeguards. Consideration should be given to modifying the budget process to more explicitly recognize that increasing spending for safeguard activities would reduce overall Medicare expenditures. (See pp. 38-44.)

Contents

Abbreviations

ADP	automated data processing
CT	computer tomography
DRG	diagnosis-related group
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	health maintenance organization
HMP	Humana Medical Plan
IMC	International Medical Centers, Inc.
IRS	Internal Revenue Service
MRI	magnetic resonance imaging
OMB	Office of Management and Budget
PPS	prospective payment system
PRO	Peer Review Organization
ProPAC	Prospective Payment Assessment Commission
RAP	radiology, anesthesiology, and pathology
VA	Department of Veterans Affairs

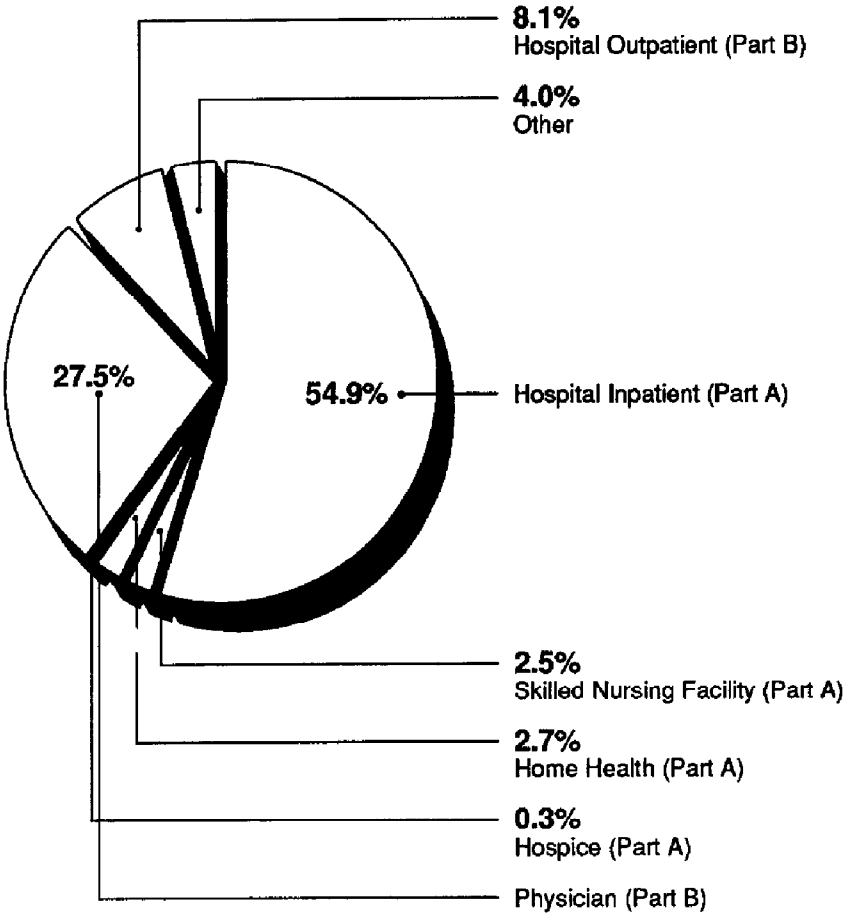
Medicare: Further Changes Needed to Reduce Program and Beneficiary Costs

Medicare is a health insurance program that covers most Americans aged 65 and over and certain individuals under 65 who are disabled or have chronic kidney disease. The program, authorized under title XVIII of the Social Security Act, is administered by the Health Care Financing Administration (HCFA) within the Department of Health and Human Services (HHS). Medicare provides coverage under two parts:

- Part A, Hospital Insurance, which is financed primarily by Social Security payroll taxes, covers inpatient hospital services, posthospital care in skilled nursing facilities, hospice care, and care provided in patients' homes. In fiscal year 1990, part A covered 31 million aged and 3 million disabled people, and benefit payments amounted to about $60.9 billion.
- Part B, Supplementary Medical Insurance, which is a voluntary program financed by enrollee premiums (set at 25 percent of program costs for elderly enrollees in 1990) and federal general revenues, covers physician services and a variety of other health care services, such as laboratory and outpatient hospital services. In fiscal year 1990, part B covered 29.9 million aged and 3 million disabled people, and benefit payments totaled about $44.5 billion.

The composition of Medicare benefit payments by service category is shown in figure I.1. Two service categories, inpatient hospital and physician services, accounted for about 82 percent of total Medicare outlays in fiscal year 1990.

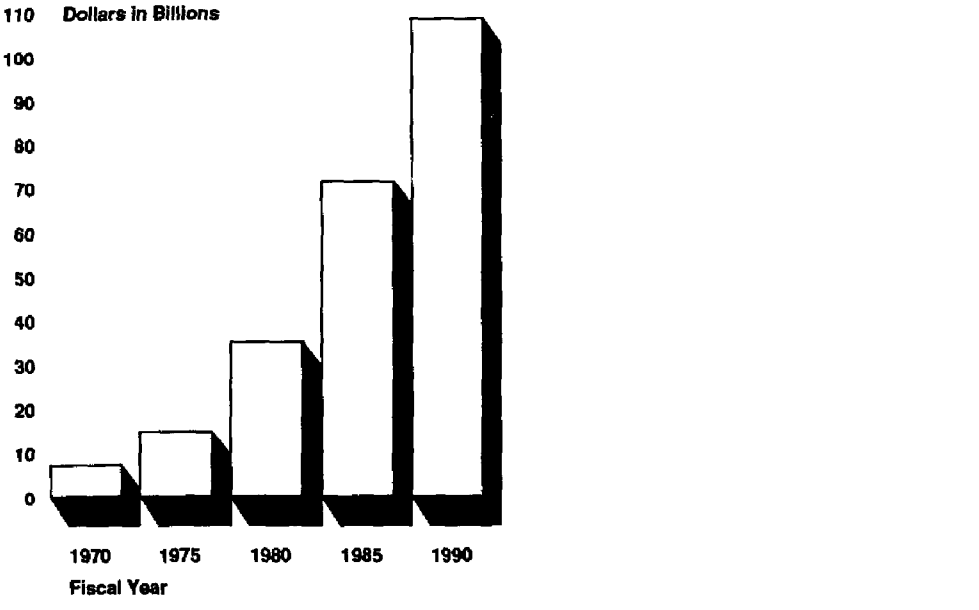
Figure I.1: Medicare Payments by Service Category (Fiscal Year 1990)



Note: Other includes payments for independent laboratory, group practice, rural health clinics, and a variety of other services.
Source: HCFA.

During Medicare's 25-year history, benefit costs have grown faster than either the general inflation rate or the gross national product, as have the nation's health expenses in general. Medicare outlays more than tripled from about $35 billion in fiscal year 1980 to about $106 billion in fiscal year 1990. The growth in Medicare outlays is shown in figure I.2.

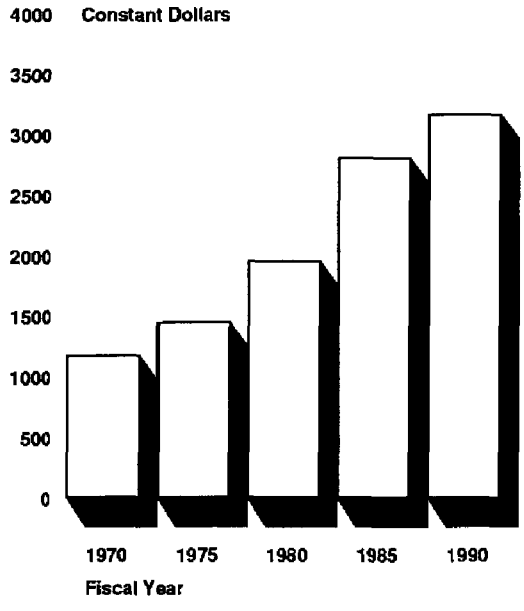
Figure I.2: Medicare Outlays
(Fiscal Years 1970-90)



Source: 1990 Annual Report of the Board of Trustees: Hospital Insurance Trust Fund and Supplementary Medical Insurance Trust Fund.

Some of the growth is due to an increasing number of beneficiaries. During the period 1980-90, the number of Medicare beneficiaries increased about 21 percent, from about 27.5 million to about 33.2 million for part A and from about 27.1 million to about 32.8 million for part B. A major reason for cost growth 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. The growth in Medicare spending per beneficiary, adjusted for economywide inflation, is shown in figure I.3 for the period 1970-90.

Figure I.3: Medicare Outlays Per Beneficiary, in 1990 Dollars
(Fiscal Years 1970-90)



Source: HCFA.

The Congress and HCFA have developed many strategies to contain Medicare costs. These strategies include major reforms in the way Medicare pays hospitals and physicians, as well as attempts to encourage beneficiaries to use alternative health care delivery systems, such as health maintenance organizations (HMOs). In combination these reforms provide a framework for controlling expenditures.

Objectives, Scope, and Methodology

The Chairman, Subcommittee on Health, House Committee on Ways and Means, asked for our views on Medicare issues involving program and beneficiary costs that warrant legislative or administrative attention. In preparing this report, we relied principally on the reports that we have issued in the past 5 years and on our ongoing work. We also reviewed reports and testimonies by HCFA, the Prospective Payment Assessment Commission (ProPAC), the Physician Payment Review Commission, the Congressional Research Service, and the Congressional Budget Office.

For purposes of analysis and presentation, we organized our report into five broad areas:

- Hospital prospective payment.
- Physician payment.
- Other part B payment.
- Health maintenance organizations.
- Program administration and payment safeguards.

Further Changes Needed to Medicare Prospective Hospital Payment System

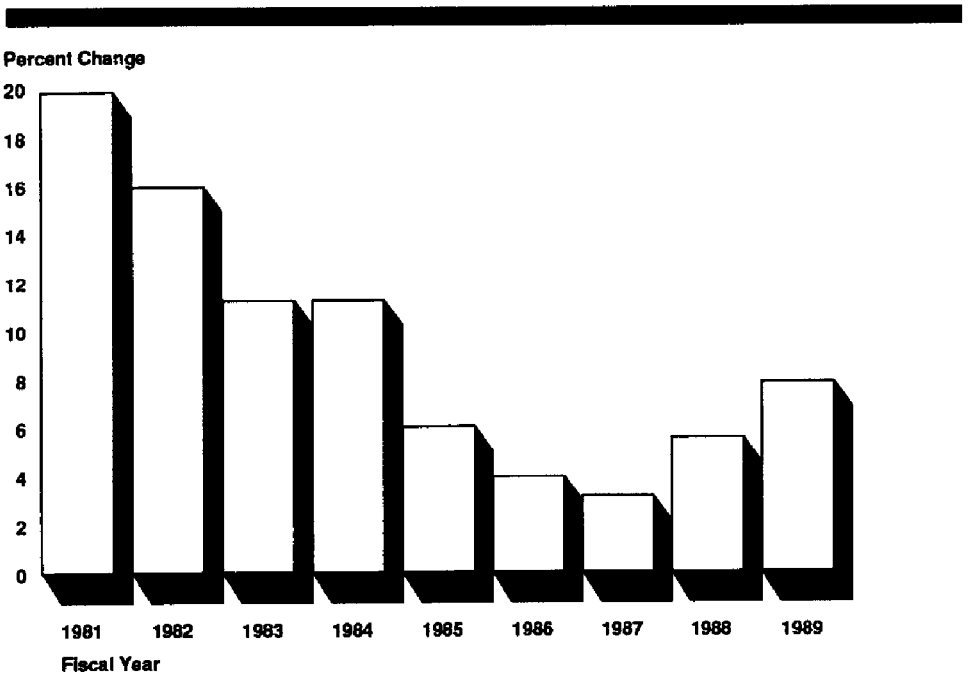
Out of concern over the continuing rapid increase in Medicare costs, in 1983 the Congress set into motion the implementation of fundamental payment reforms aimed at creating incentives for providers to be more cost conscious. The first of these reforms established a prospective payment system (PPS) for inpatient acute care hospitals. In contrast to the previous cost-based system, PPS established predetermined payment rates for hospital services.[1] This gave hospitals strong incentives for reducing inpatient care costs.

The system's foundation was a patient classification system called diagnosis-related groups (DRGs), which groups patients for payment purposes according to medical condition. Hospitals were no longer paid for the incurred costs of treating a Medicare patient but were paid a fixed price based on the patient's DRG. The new system was designed to increase predictability in Medicare expenditures and encourage cost-effective care by changing hospital incentives.

Without PPS, Medicare would have spent substantially more on inpatient care. Medicare growth in hospital payments averaged 15.7 percent annually in the 3 years before PPS but only 6.3 percent annually since. Even though the fiscal year 1989 growth rate for inpatient hospital payments reached 7.8 percent, its highest point since 1984, payments for inpatient hospital services had the lowest growth rate of all Medicare expenditures. The rate of growth in payments for Medicare-covered inpatient hospital services is shown in figure I.4.

[1] PPS covers hospital operating costs—routine, ancillary, and intensive care inpatient services. Capital costs, direct medical education costs, and outpatient costs are not covered.

Figure I.4: Annual Percentage Growth in Medicare Payments for Inpatient Hospital Services (Fiscal Years 1981-89)



Note: Changes in payments are based on incurred expenditures, rather than outlays.
Source: ProPAC based on HCFA data.

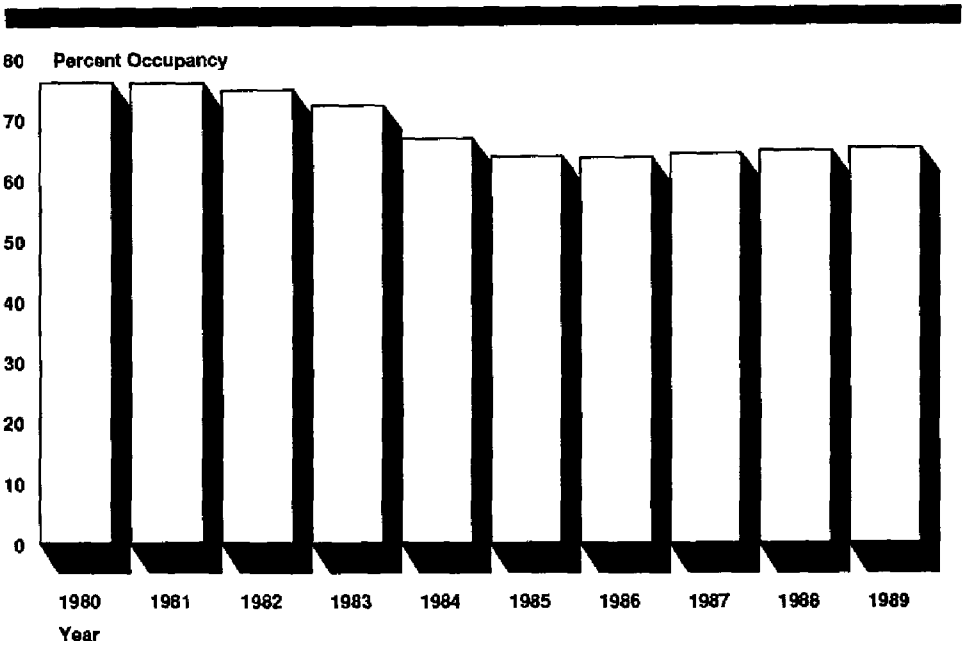
Some of the success of PPS in moderating inpatient outlays, however, is a result of the shifting of services elsewhere—especially to outpatient settings.[2] As the major payer, Medicare exerted a powerful influence on the hospital sector. Moreover, hospital responses to PPS incentives have had a far-reaching effect on other groups of institutions and individuals that provide and pay for health care. Use of home health, nursing home, and outpatient providers has grown appreciably; health care formerly provided on an inpatient basis is now increasingly provided in those settings. Other payers have also adopted cost-containment strategies, in part to avoid a potential shifting of hospital costs from Medicare patients to their own.

Partly in response to PPS, hospital care has undergone substantial change in recent years. The average length of stay for Medicare patients had been declining before the onset of PPS, but as hospitals came under the new payment system, the decline continued. This, combined with a decline in admissions for both Medicare and non-Medicare patients, has

[2]Medicare outpatient benefit outlays rose from $1.8 billion in fiscal year 1980 to $3.9 billion in 1985 and $8.6 billion in 1990.

resulted in a decline in hospital occupancy rates since PPS implementation. Figure I.5 illustrates changes in hospital occupancy rates from 1980 to 1989.

Figure I.5: Hospital Average Occupancy Rates (1980-89)



Source: ProPAC analysis of American Hospital Association data.

The number of inpatient beds has decreased somewhat (about 7 percent), but hospital occupancy rates remain low, leading to increased competition for patients among facilities. The decline in the volume of inpatient care and overall profitability has affected groups of hospitals differently. In general, small hospitals have been hardest hit by the increased competition for patients, declining profit margins, and lower patient volume.

As the hospital industry has faced financial strains, pressure to change PPS has mounted. Medicare cannot and should not be expected to prop up a hospital industry burdened by substantial overcapacity; however, its rates must be sufficient to assure access to high-quality care for Medicare beneficiaries. PPS, therefore, must be closely monitored to assure that its payments are accurate and equitable.

Over the past few years, our work examining PPS has focused on issues of payment accuracy and equity. Recent work has addressed three general

questions: (1) To what extent have PPS payments caused hospital closures, particularly rural closures? (2) Are special PPS payments to teaching hospitals reasonable? (3) Is PPS appropriately paying hospitals that treat more severely ill patients within specific DRGs?

PPS Not a Major Factor in Most Rural Hospital Closures

Many rural hospitals have closed since 1980, and others are at risk of closure. There has been widespread concern that such closures may jeopardize access to medical care, particularly for elderly and low-income residents, who may have difficulty traveling to more distant facilities. In an attempt to improve rural hospitals' financial viability, over the past several years the Congress has provided them special treatment under Medicare by increasing payment rates and creating new grant programs.[3]

We were asked to examine the extent to which Medicare inpatient payments, among other factors, contributed to the financial distress of rural hospitals. We reported that symptoms of financial distress preceded hospital closures and that Medicare losses were not a major factor underlying most closures.[4]

Medicare may have contributed disproportionately to the financial losses in about a third of small (under 50-bed) rural hospitals that closed. However, in the 3 years before closure, most hospitals made more or lost less on their Medicare patients than on other patients. Among the important predictive factors for hospitals that closed were

- small size and low occupancy rates,
- treatment of less complex medical conditions,
- for-profit ownership,
- weak local economies, and
- competition from other hospitals.

[3]Specifically, this has included phasing in higher PPS payment rates for rural hospitals by reducing the urban-rural payment rate differential, discharge weighing of DRGs which is more favorable to small hospitals (which are predominately rural), exempting certain groups of rural hospitals from reductions in Medicare payments for capital, and creating two grant programs to assist rural hospitals.

[4]Rural Hospitals: Factors That Affect Risk of Closure (GAO/HRD-90-134, June 19, 1990), Rural Hospitals: Federal Leadership and Targeted Programs Needed (GAO/HRD-90-67, June 12, 1990), and Rural Hospitals: Federal Efforts Should Target Areas Where Closures Would Threaten Access to Care (GAO/HRD-91-41, Feb. 15, 1991).

Rural hospitals as a group are more vulnerable to closure because they are more likely to exhibit several of the characteristics associated with a higher risk of closure. However, urban hospitals with the same characteristics are just as likely to close.[5]

Providing additional payment to rural hospitals through changes to PPS is not necessarily an appropriate vehicle for resolving their problems, nor does it guarantee their financial viability. In most cases, increased Medicare revenues would at best merely postpone closure if these hospitals' other problems continue. Moreover, not all rural hospitals are having financial difficulties or need special assistance. For these reasons, we believe federal efforts to assist rural hospitals should be targeted at hospitals that are deemed essential to maintaining access to care and whose viability is likely to be significantly improved by such assistance.

We believe HHS should take a more active role in developing and implementing a coordinated approach to identify and assist communities where hospitals provide essential services and are at risk. The issue today is not one of authority for or availability of resources to provide such assistance, because over the years the Congress has given HHS both. Rather, the issue should now center on how HHS uses its authority and resources to direct the right kinds of assistance to the right hospitals. HHS can do more with what it has to help assure rural areas continue to retain their access to essential health care services.

Further, if the Congress decides to take additional actions to assist rural hospitals, it should incorporate three principles into such actions. Funding should

- target at-risk, essential, and potentially viable hospitals;
- be sufficient to make a difference for these hospitals; and
- help a community strengthen access to alternative sources of care, if a hospital providing essential services is not likely to remain viable.

PPS Payments to Teaching Hospitals Can Be Reduced

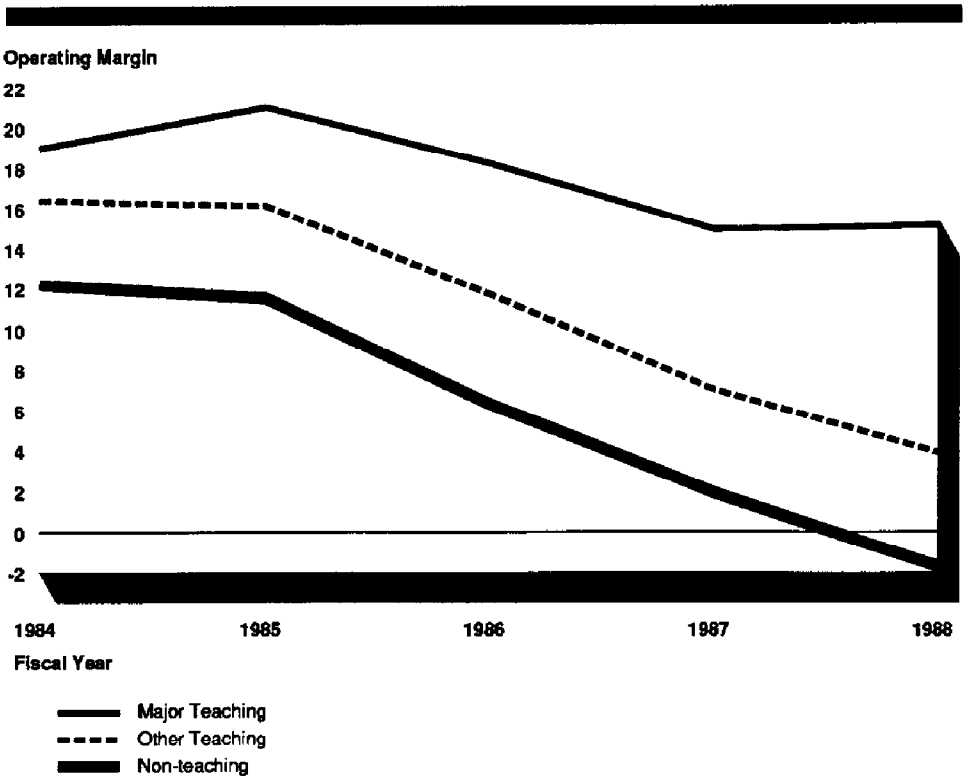
Another PPS payment issue is whether the indirect costs associated with medical education programs are recognized appropriately. Under PPS, Medicare pays teaching hospitals more than other hospitals for treating patients under the same DRG to reimburse them for the higher patient

[5]Only for-profit rural hospitals had a slightly higher risk of closure than urban hospitals. However, for-profit hospitals are a small share of all rural hospitals.

care costs associated with graduate medical education. In fiscal year 1990, Medicare paid teaching hospitals additional payments estimated at $2.5 billion for these indirect costs.

We and others have reported that these additional PPS payments to teaching hospitals are too high. Since the inception of PPS, teaching hospitals have experienced the highest Medicare profit margins of any group of hospitals. The 228 hospitals with large teaching programs, accounting for 60 percent of all Medicare indirect medical education payments, had average PPS operating margins of 15.1 percent in fiscal year 1988, the 5th year of PPS. The average for all hospitals that year was 2.6 percent. PPS operating margins for the first 5 years of PPS by hospital teaching status are shown in figure I.6.

Figure I.6: PPS Hospital Operating Margins, by Teaching Status
(Fiscal Years 1984-88)



Source: ProPAC analysis of Medicare Cost Report data from HCFA.

Our 1989 report on Medicare's payments to teaching hospitals presents a number of estimates of the indirect effect of medical education on hospital costs, all of which are lower than the adjustment factor currently

specified by law.[6] One of our estimates, which considers only those factors used in the current formula for calculating the adjustment but uses more accurate measures of them, is that the indirect teaching adjustment should be reduced from the current statutory level of 7.7 percent to 5.09 percent.[7] Estimated Medicare savings from the reduction of indirect payments range from $2.1 billion to $6 billion over 3 years, depending on which of our estimates is used.

We are not alone in proposing reductions in teaching hospital payments. A recent ProPAC report recommended that the indirect medical education adjustment to PPS payment levels be reduced to 7.0 percent for fiscal year 1992.[8] Although the study suggests that a 4.2-percent indirect medical education adjustment would be warranted, ProPAC has expressed concerns about the effects of a sudden reduction in the Medicare indirect teaching allowance on certain hospitals—mainly large inner city hospitals—that provide significant amounts of charity care. While these hospitals' Medicare profit margins remain high, their total profit margins are on average lower than those of other hospitals.

Though we share ProPAC's concerns about high charity teaching hospitals, we do not believe the indirect teaching adjustment under PPS is the appropriate vehicle for addressing hospitals' charity care burdens. All teaching hospitals benefit from the adjustment, not just those with high levels of charity care. Consequently, we believe any actions taken to address the broader issue of hospital charity care costs should be done through a direct and targeted approach, not through PPS's indirect teaching adjustment.

Excessive Variation of Treatment Costs Within DRGs Results in Payment Inequities

Another concern about PPS is that the DRG system may give hospitals financial incentives to seek low-cost and avoid high-cost patients within certain DRGs. For PPS to encourage hospitals to operate efficiently while providing quality care, it must group patients with similar resource needs.

Some variation in treatment costs among patients falling under a given DRG is expected. In theory, institutions would treat enough patients so

[6]Medicare: Indirect Medical Education Payments Are Too High (HRD-89-33, Jan. 5, 1989).

[7]Currently the indirect teaching adjustment is a 7.7-percent increase for each increment of 0.1 in the intern-to-bed ratio.

[8]Report and Recommendations to the Congress, March 1, 1991, Prospective Payment Assessment Commission.

that losses on higher cost patients would be offset by profits from lower cost patients. However, in 1988, we reported that (1) about one-third of the DRGs exhibited wide variation in treatment costs with respect to the discharges within a given DRG and (2) high and low expected treatment cost cases were not evenly distributed among hospitals.[9] Over 600 hospitals, primarily medium and large urban hospitals, consistently treated patients with diagnoses or procedures having higher than average resource requirements in these wide-variation DRGs. Over 2,000 hospitals, mainly small hospitals, both urban and rural, consistently treated patients with lower than average resource requirements in these DRGs.

Because patients in these wide-variation DRGs are not randomly distributed among hospitals, hospitals can profit or lose based on their mix of patients rather than their level of efficiency. To remove this inequity and prevent PPS from giving hospitals financial incentives to seek low-cost and avoid high-cost patients, the DRGs should be refined to reduce the wide variations in expected treatment costs.

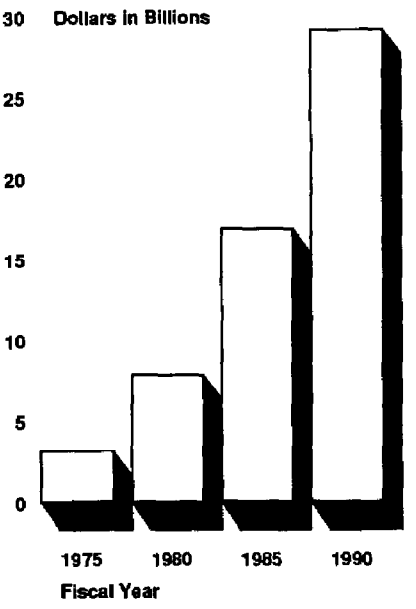
Since our report, HCFA has taken some action to adjust selected wide-variation DRGs. We continue to believe there is a need for a systematic approach to review and periodically adjust DRGs. We believe that this area will warrant continued attention as long as Medicare retains DRGs.

Concerns With Medicare Physician Payment

Part B is the most rapidly growing part of Medicare, and physician services are the largest component of part B. Between 1975 and 1990, Medicare benefit payments for physician services increased more than ninefold, from $3.1 billion to $29.1 billion. Medicare's annual payments for physician services are shown in figure I.7.

[9]Medicare: Refinement of Diagnosis Related Groups Needed to Insure Payment Equity (GAO/HRD-88-41, Apr. 22, 1988).

Figure I.7: Medicare Payments for Physician Services (Fiscal Years 1975-90)



Source: HCFA.

The proportion of total Medicare benefit payments accounted for by physician services rose from about 22 percent in 1975 to about 28 percent in 1990.

Controlling Volume of Services Key to Cost-Containment Success of New Physician Payment System

Many legislative actions have been taken to constrain Medicare physician expenditures throughout the 1980s, including a freeze on physicians' fees from mid-1984 through 1986. In addition, prices for selected procedures have been reduced starting in 1987. Despite these constraints, Medicare spending on physicians' services has continued to rise rapidly. The largest factor contributing to this has been growth in the volume and complexity of services per enrollee. These factors account for about 45 percent of Medicare part B expenditure growth during the period 1984-90.[10]

Medicare payments for physician services have been largely based on historical charge patterns. Concerned that this payment system, known

[10]Supplemental Medical Insurance Trustee Report, 1990.

as the reasonable charge method,[11] had locked in an inappropriate set of relative payment differentials, in 1989 the Congress adopted a new system for Medicare. The concern was that payment differentials among physicians were giving inappropriate market incentives leading to an urban/rural maldistribution of physicians, overproduction of specialists, and an overprovision of specialty services in expensive settings. The Congress was also concerned that utilization of physician services under the reasonable charge method was excessive and that this was driving the rapid increase in Medicare payments to physicians during the 1980s.

The Congress restructured the Medicare physician payment system by adopting a fee schedule, based on a resource-based relative value scale for pricing physician services. The fee schedule will be phased in over the 1992-96 period. Under this methodology, physicians will be paid an amount for each service, based on the average resources required to provide the service,[12] instead of their historical charges for the service.

Past efforts to control physician payments by limiting the fees paid have been largely unsuccessful because volume increases have offset the savings from constraining fees. To discourage physicians from increasing the volume of services to counteract fee constraints, the new payment methodology also establishes overall spending standards for physician services. Annual updates to Medicare's fees will be based on how expenditures related to prior years' standards. The underlying concept is to tie fee updates to how aggregate expenditure growth compares to a preestablished growth rate.

Because volume plays an important role in driving part B expenditure growth, the success of these physician payment reforms in achieving cost-containment goals hinges on HHS's effective implementation of the Medicare volume performance standards. Under the implementing legislation, HCFA and its contractors—the carriers that process and pay claims for part B services—are required to closely monitor utilization of services and identify possible sources of inappropriate utilization and the factors underlying these patterns. These requirements will expand carrier responsibilities. As we discuss more fully on page 38, however,

[11]Under this method, physicians are paid the lower of their actual, customary, or prevailing charges. The customary charge is the amount a physician normally charges for a service. The prevailing charge is an amount equal to the 75th percentile of physician charges for a service. Since the 1970s, increases in prevailing charge levels have been limited to the increase in an economic index that measures changes in wages and in physician office practice costs.

[12]The relative value of each service will be determined by estimates of average physician time and effort, practice expense, and the costs of professional liability insurance.

over the years carriers' budgets for such monitoring activities have not kept pace with either Medicare's expanding claims volume or the administrative demands of implementing new legislative requirements. Inadequate funding of carrier monitoring activities could compromise the successful implementation and refinement of the new physician payment system.

Lack of Beneficiary Choice Among Physicians Inflates Out-of-Pocket Costs

Another issue that merits congressional consideration involves the inability of hospitalized beneficiaries to avoid certain physicians' bills in excess of the amount approved by Medicare. In other settings, beneficiaries can avoid the extra costs by selecting a physician who accepts assignment.

For most part B services, beneficiaries are responsible for 20-percent coinsurance and can be liable for a higher amount. If a physician accepts assignment of the beneficiary's right to Medicare payment, the physician also agrees to accept the amount Medicare allows as payment in full. Therefore, on assigned claims a beneficiary's liability is limited to 20 percent of Medicare's allowed amount. However, if a physician does not accept assignment, the beneficiary is liable for the 20-percent coinsurance plus any charge above the Medicare-allowed charge up to an absolute limit prescribed by law (that is, 125 percent of the allowed charge in 1991, decreasing to 115 percent in 1993). The practice of collecting more than the allowed amount on unassigned claims is referred to as balance billing.

Many physicians (about 46 percent in December 1990) participate in Medicare, thereby agreeing to accept assignment in all cases. Moreover, many others accept assignment on a case-by-case basis. Overall, about 78 percent of Medicare claims were assigned in fiscal year 1990. This indicates that in many cases, by shopping for a physician, beneficiaries can avoid the additional out-of-pocket expenses resulting from balance billing. However, this is not always the case, particularly with certain hospital-based specialists. When Medicare patients are admitted to the hospital, they generally do not have the option of choosing, for example, their radiologist, anesthesiologist, or pathologist. Instead, these physicians have already been selected for them, frequently through an exclusive contract negotiated by the hospital.

In 1987, we reported that the market for radiology, anesthesiology, and pathology (RAP) services has several characteristics that limit the ability

of market forces to restrain fees.[13] Although hospitals negotiate exclusive contract provisions, they have little incentive to negotiate low rates for physician direct patient care services or the acceptance of assignment by those physicians. And few of the hospitals' contracts with RAP services that we reviewed explicitly provided for restraint on fees or acceptance of assignment. Anesthesiologists had the lowest assignment rate (57 percent) among major specialty groups in 1987. Radiologists and pathologists had higher assignment rates (76 and 78 percent, respectively).

While Medicare's recently enacted balance billing limits give beneficiaries increased financial protection, they do not address the special circumstances that exist when a hospitalized Medicare beneficiary receives physician services from a physician that he or she did not select. Consequently, the Congress may wish to consider either reducing the balance bill ceilings for such in-hospital part B services or mandating that physicians accept assignment in these circumstances.

Differences in Medicare Payments to Anesthesiologists Linked to Time

Another concern under part B is the appropriateness of Medicare payments for anesthesia services, which in fiscal year 1988 cost about $1.2 billion. Unlike other physicians, anesthesiologists are paid based on units of time.

During a study of payments for anesthesia services, we reviewed the anesthesia times reported on a sample of Medicare claims and their corresponding patient medical records.[14] For these claims, time accounted for about 60 percent of Medicare's total anesthesia payment; moreover, variations in anesthesia time were the primary reason payments differed markedly for identical anesthesia procedures.

Anesthesia time before the start of surgery (preoperative time) accounted for a considerable portion of a procedure's total time variation. We concluded that preoperative time was largely controlled by the anesthesiologist and that justification for the wide variations was questionable. In fact, the time-based payment system rewarded and may have promoted inefficiencies. Further, we identified a serious internal

[13]Medicare: Payment to Radiologists, Anesthesiologists, and Pathologists (GAO/HRD-87-114BR, July 20, 1987).

[14]Medicare: Variation in Payments to Anesthesiologists Linked to Anesthesia Time (GAO/HRD-91-43, Apr. 30, 1991). Also see Medicare: Need for Consistent National Policy for Special Anesthesia Services (GAO-HRD-91-23, Mar. 13, 1991).

control weakness that precluded validating the reported anesthesia times that Medicare used as the basis for payment.

We recommended that HHS break the direct link between anesthesia time and payment amount when it implements the resource-based relative value scale for physicians' services. This would make payments for the same anesthesia services more uniform and eliminate the internal control weakness. HHS agreed with this recommendation but is still considering the specific method for computing future amounts. One approach we evaluated would base payment amounts on a procedure's median anesthesia time. If implemented, this method could reduce Medicare payments by over $50 million annually.

Other Part B Payment Concerns

In addition to physician services, we have identified three areas where we have concerns about the part B portion of Medicare. These include the pricing of diagnostic laboratory services; excessive payments for new technology, such as magnetic resonance imaging; and excessive payments for ambulatory surgery in hospital outpatient departments.

Prices for Diagnostic Laboratory Services Should Be Reduced

Expenditure growth for clinical diagnostic laboratory services is a part B area that has received significant legislative attention in recent years. In 1984, a laboratory fee schedule was enacted to standardize payments for similar services provided by different types of laboratories and to save money for both Medicare and beneficiaries. In our 1987 report, we noted that while the fee schedules saved the beneficiaries substantial amounts of money with no appreciable effect on access or quality, Medicare costs increased.[15]

Although Medicare payment rates for independent laboratories were reduced in 1988 and later years, results from our ongoing work indicate that payments for their test services remain too high.[16] Independent laboratories generally have two price lists: discounts are offered to physicians and other providers, but not to Medicare and other retail customers.

[15]Medicare: Laboratory Fee Schedules Produced Large Beneficiary Savings but No Program Savings (GAO/HRD-88-32, Dec. 22, 1987).

[16]Medicare: Payments for Clinical Laboratory Test Services Are Too High (GAO/HRD-91-59, forthcoming).

In reviewing five large laboratories that accounted for about 40 percent of Medicare's payments to independent laboratories, we found that their profit rates from Medicare were significantly higher than their overall profit rates. Medicare fee schedule payments produced average profits of 32 percent of sales for these companies, while their overall profit rates average 15 percent. After factoring in the 1990 and 1991 fee reductions, Medicare profit rates would have been 11 percent higher than these laboratories' overall profit rates. This pattern holds but is less pronounced in the smaller laboratories we reviewed.

We believe that Medicare's contribution to laboratories' profits should not exceed their overall profit rates. We estimate that reducing payment rates to a level that would equalize profit rates for Medicare and total laboratory operations could save Medicare about $150 million annually in laboratory service expenditures.

Payments for Emerging Technologies Can Be Reduced

Another area of concern involves how Medicare pays for emerging technology. It is widely acknowledged that one of the primary factors influencing health care cost inflation has been the rapid development and use of new medical technologies. In the United States, the diffusion of new medical technology is relatively unrestrained once it is declared eligible for Medicare reimbursement. As the new technology matures, reductions in equipment costs, improvements in its efficiency, and increased utilization can decrease unit costs. In some cases, however, these cost reductions have not been accounted for in adjustments to Medicare payment rates. This results in excessive Medicare payments and creates an incentive for the proliferation of high-cost, low-volume providers.

The rapid diffusion and high cost of new technology is apparent in diagnostic imaging, particularly computer tomography (CT) scan and magnetic resonance imaging (MRI) technology. Some CT scans became eligible for Medicare payment beginning in the mid 1970s. In 1988, part-B-allowed charges for CT scans totaled over $591 million. Medicare first approved coverage for MRI services in 1985, and by 1988 part B payments amounted to about $152 million. The continuing evolution in MRI technology illustrates trends in technology diffusion, changes in cost and utilization, and problems adjusting Medicare payment rates to reflect those changes.

In 1985 fewer than 100 MRI units were in operation. At that time HCFA developed Medicare guidance for its carriers to use in paying MRI claims. For imaging services, Medicare sets separate payment rates for taking

the image itself, referred to as the technical component, and for a physician's interpretation of the image, called the professional component. For technical component costs, HCFA's guidance provided an estimated cost per scan of $474. It based this estimate on assumed MRI capital costs of about $2 million per machine and a utilization rate of 2,000 scans per year.

Today there are an estimated 2,200 MRI units in operation nationwide, and sales of MRI equipment are expected to grow by 59 percent between 1989 and 1994. Advances in MRI and computer technology are making MRIs useful for more diagnostic procedures, improving image quality, and decreasing scan time. There is also a broader range in equipment costs, with some units priced as low as $300,000. Meanwhile, utilization rates have increased dramatically, with some imaging centers reporting over 4,000 scans per MRI unit per year. These factors have resulted in significant reductions in providers' costs per scan. The Physician Payment Review Commission recently estimated that per scan costs range from $297 (for lower cost MRI equipment performing 2,500 scans per year) to $402 (for higher cost MRI equipment performing 2,500 scans per year). These costs are considerably lower than Medicare's average payment of about $458.

Medicare payment rates for MRI scans have not been systematically adjusted to reflect changes in the unit costs as the technology has evolved. For a high-cost technology that is continuing to evolve, such as MRI services, we believe it is necessary periodically to adjust payments to take into account changes in provider costs. Failing to do this can result in overcompensating providers and encourage an oversupply of the equipment because profits can be earned even at inefficient levels of operation. We are continuing to study this issue. Another concern that has been expressed about the emerging technologies involves physician ownership of the equipment. Physicians who own equipment, either in their offices or in separate facilities, have an economic incentive to order services to maximize their return on investment. Work by us[17] and by the HHS Inspector General has indicated that physician owners of independent laboratories order more tests and more expensive tests than do other physicians. Also, a recent study shows that physicians

[17]Medicare: Referring Physicians' Ownership of Laboratories and Imaging Centers (GAO/T-HRD-89-26, June 8, 1989).

who have X-ray equipment in their offices order many more X-rays.[18] The Congress has directed HHS to gather data comparing use rates for certain services at physician-owned and other entities. We have been directed to analyze the data when they become available and report to the Congress.

Payments for Ambulatory Surgery in Hospital Outpatient Departments Can Be Reduced

Medicare's methods of paying for ambulatory surgery in hospital outpatient departments is another area of concern. Since the implementation of PPS, hospitals have provided more medical services in outpatient settings. Medicare pays hospitals for such services under part B.

From 1983 to 1985, Medicare expenditures on ambulatory surgery to hospital outpatient departments grew more than tenfold.[19] In response, the Congress has legislated various reforms aimed at slowing this growth rate. The current payment system, however, is fragmented and still provides few incentives to control costs. In an attempt to provide a more uniform Medicare payment system for hospitals and to help reduce outpatient surgical costs, the Congress is exploring more fundamental payment reforms.

In 1986, the Congress directed that HHS develop recommendations for a prospective payment system for hospital outpatient surgery by April 1989, and for other hospital outpatient services by January 1991. In November 1990, the Congress again directed HHS to develop a proposal, this time by September 1991, to replace the current payment system for hospital outpatient services. Because of the complexities of specifying and implementing such reforms, they may not be in place for some time. Consequently, we believe the Congress should consider actions to decrease beneficiary and program costs.

Medicare has two main payment systems for outpatient surgery—ambulatory surgery centers are paid under a prospective payment system, and hospital outpatient departments are paid using a blend of their costs and the ambulatory surgery payment rate. This is called the blended payment. The dual payment system results in large payment differences

[18]B. Hillman and others, "Frequency and Costs of Diagnostic Imaging in Office Practice—A Comparison of Self-Referring and Radiologist-Referring Physicians," The New England Journal of Medicine, Vol. 323, Dec. 6, 1990, pp. 1604-8.

[19]Shelah Leader and Marilyn Moon, "Medicare Trends in Ambulatory Surgery," Health Affairs, Spring 1989, 8:1, p. 165.

for similar procedures in the two settings. For example, for cataract surgery, Medicare pays some hospitals almost twice what it pays free-standing facilities.[20]

Based on our analyses of Medicare's payment system for ambulatory surgery done in hospital outpatient departments,[21] we found two distinct problems associated with the beneficiary coinsurance amount and its application in the computation process of the blended payment. First, the beneficiary's coinsurance amount is based on charges, while Medicare's payment is based on Medicare-allowable costs.[22] As a result, the beneficiary's portion of the hospital payment is usually higher than the 20-percent share generally applicable to other part B services. Moreover, because outpatient charges differ across hospitals, beneficiary payments can vary significantly, depending upon where the surgery is performed. The second problem is associated with the method that Medicare uses to calculate the blended payment amount. This calculation does not use beneficiary coinsurance to reduce Medicare's portion of the hospital payment as much as it might. Thus, Medicare may be paying more than necessary for hospital outpatient surgery.

Our April 1990 report provided two alternatives for correcting these technical problems. One alternative would correct both problems and could result in substantially lower beneficiary coinsurance amounts and modest savings to the Medicare program. The other alternative would correct the way in which Medicare calculates its blended payment and could result in significant Medicare savings but no savings to beneficiaries.

Because the hospital outpatient prospective payment system or other reforms may not be implemented soon, we believe that the Congress should consider requiring HCFA to implement one of these alternatives to correct the shortcomings of the current ambulatory surgery payment methodology.

[20]Based on a GAO analysis of 1987-88 Medicare cost data.

[21]Medicare: Alternatives for Computing Payments for Hospital Outpatient Surgery (GAO/HRD-90-78, Apr. 3, 1990).

[22]Simply put, the beneficiary's coinsurance is figured from a higher base (charges) than that used in the calculation of Medicare's blended payment (allowed costs).

Health Maintenance Organizations: Problems in Payments, Quality Assurance, and Oversight

In addition to health services financing mechanisms, another fundamental concern in Medicare is how health services are delivered. There have long been concerns that fee-for-service health delivery, the way most Medicare beneficiaries receive care, can lead to the overprovision of services and unnecessary Medicare costs. Since 1972, Medicare has had mechanisms for paying alternative delivery systems—primarily health maintenance organizations paid on a prospective capitation basis. This payment method gives HMOs financial incentives to control costs and utilization because they receive a fixed amount per enrolled beneficiary regardless of the services provided. From the Medicare beneficiaries' perspective, HMOs can offer a more comprehensive package of services than regular Medicare at lower cost than the beneficiaries might incur if they purchased such coverage through supplementary insurance.

Throughout the 1980s, the executive branch has advocated policies designed to increase the number of Medicare beneficiaries enrolled in HMOs as a way to control costs. In fiscal year 1990, about 1.2 million Medicare beneficiaries were enrolled in HMOs at a cost to Medicare of about $4.2 billion. Proposals to further encourage managed care have been a cornerstone of the administration's recent proposals to reform Medicare payment and delivery systems. Although managed care strategies have cost-control appeal and offer potential advantages to beneficiaries, a series of reports we have issued over the past 5 years has highlighted persistent problems with payment methods and program oversight. (See pp. 61-63.) Specifically, we have found that HCFA is

- paying more than it should for enrolled beneficiaries,
- not adequately monitoring the quality of care delivered to Medicare beneficiaries within HMOs, and
- ineffective at dealing with HMOs having recurrent problems complying with Medicare requirements.

HMO Payment Rates Likely to Increase Medicare Costs

Our first concern regarding HMOs is that the payment rates are too high. The Congress established that participating HMOs were to be paid 95 percent of the average cost that would have been borne under fee-for-service care. However, we believe that not only does Medicare not achieve

the 5-percent savings intended through its HMO risk contract program,[23] but actually incurs losses from overly high payments it makes to HMOs.

HCFA's rate-setting procedures do not adjust sufficiently for the ability of risk-contract HMOs to select enrollees who are less costly to serve than beneficiaries remaining in the fee-for-service sector. Studies have estimated that "favorable selection" by HMOs has resulted in payments to HMOs of between 15 and 33 percent more than Medicare's costs would have been if the enrollees had remained in the fee-for-service sector.[24]

Although the evidence is strong that Medicare on average overpays HMOs, developing a more precise payment methodology is difficult. In general, Medicare's method of paying HMOs assumes that HMOs will enroll beneficiaries who will on average have costs similar to costs of beneficiaries remaining in the regular Medicare fee-for-service program. As discussed above, however, there is little assurance that this is the case. Consequently, ensuring equitable HMO payment rates would require that HCFA develop better ways of adjusting payments to estimate more accurately the costs that enrollees would incur if they remained in the regular Medicare program.

HCFA's current method of adjusting for cost differences of individual enrollees (based on such factors as age, sex, and disability status) explains less than 1 percent of the differences in costs among Medicare beneficiaries.[25] The Congress has directed the Secretary of HHS to submit a proposal for a more reliable method of paying HMOs to the Congress by January 1, 1992. Identifying better predictors of costs alone, however, is not likely to resolve the problems encountered when HMOs enroll disproportionately high or low users of care. At best, better predictors could be developed to explain only 20 percent of differences in costs among Medicare beneficiaries, HCFA-sponsored research indicates.[26]

[23]Under risk contracts, HMOs agree to provide all the Medicare-covered services beneficiaries need for a fixed amount (or capitation rate) and incur a profit or loss depending on their ability to provide covered services for less than the fixed payment.

[24]Mathematica Policy Research, Inc., The Impact of the Medicare Demonstrations on the Use and Cost of Services, Final Report, January 31, 1989.

[25]J. Lubitz, J. Beebe, and G. Riley, "Improving the Medicare HMO Payment Formula," Advances in Health Economics and Health Services Research, Vol. 6, R. M. Scheffler and I. F. Rossiter (eds.). JAI Press, 1985.

[26]Joseph P. Newhouse and others, "Adjusting Capitation Rates Using Objective Health Measures and Prior Utilization," Health Care Financing Review, Spring 1989, Vol. 10, No. 1, pp. 41-54.

We believe that program changes should also be considered to minimize HMOs' "favorable selection" of enrollees. One such change would modify the way in which HMOs are permitted to market their Medicare health plans. Currently, HMOs can selectively market their plans to avoid high-cost beneficiaries. Such marketing strategies are subtle and hard to detect, yet studies by us and others suggest that selective marketing may be occurring.[27] Further, HMO compliance with Medicare marketing requirements has created problems in certain HMO market areas, as we discuss on page 37.

Consequently, the Congress may wish to consider directing HCFA to test and assess alternative ways to market HMOs that serve Medicare beneficiaries. Specifically, the Congress could direct that HCFA conduct demonstrations to test-market HMOs through independent third-party organizations operating under HCFA's direction.[28] One model that could be considered would be the one used by the Federal Employees Health Benefits Program. Under this model, each market area has a single open enrollment period and a uniform marketing brochure that compares the coverage and prices of all participating plans. This approach would assure that all beneficiaries in a market area would have (1) an equal opportunity to enroll in an HMO, (2) more complete and uniform information on which to base their decisions, and (3) greater protection from abusive marketing practices.

Another alternative that could be explored is the establishment of a minimum enrollment period before beneficiaries would be allowed to disenroll from an HMO. Presently, Medicare beneficiaries can disenroll from HMOs at any time. HMOs' utilization control mechanisms, whether intentional or not, can encourage higher users to disenroll and return to the fee-for-service system. In fact, HCFA-sponsored research indicates that this occurs. HMO disenrollees, on average, tend to be higher-than-

[27]Medicare: Issues Raised by Florida Health Maintenance Organization Demonstrations (GAO/HRD-86-97, July 16, 1986), pp. 56-86. Also see Mathematica Policy Research, Inc., Biased Selection in the Medicare Competitive Demonstrations, Mar. 1988.

[28]HCFA has attempted a marketing demonstration in the past, as we reported in Medicare: Issues Concerning the HealthChoice Demonstration Project (GAO/HRD-88-69, July 20, 1988). HCFA's implementation of the project was flawed, however, because, among other things, it merely assisted HMOs by distributing promotional and educational material without reimbursement from the HMOs. What we would envision is a demonstration that would be paid for by the HMOs and would involve an independent third-party organization conducting all phases of the HMOs' marketing to Medicare beneficiaries. That is, under HCFA's guidance and regulations, the organization would publish marketing material covering all plans offered in the selected markets, and enroll and disenroll the Medicare beneficiaries who reside in those markets.

average-cost Medicare beneficiaries.[29] This effect could be mitigated by requiring a minimum enrollment period, as is common with most other insurance plans, such as the Federal Employees Program. We would not recommend this action, however, until HCFA has demonstrated that it has adequate mechanisms in place for assuring HMO quality of care and overseeing HMOs' compliance with federal requirements.

Insufficient Monitoring of Quality Within HMOs

Our second concern regarding HMOs is that the government has little assurance that Medicare beneficiaries are receiving high-quality medical care. The same financial incentives that encourage HMOs to reduce overutilization of medical services may also encourage an inappropriate reduction of necessary services.

We reported in August 1988 that HCFA had relatively limited data with which to monitor an HMO's quality of care, and HCFA's staffing for compliance monitoring had not kept pace with HMO growth.[30] We also noted that HCFA was in the first year of contracting with Peer Review Organizations (PROs) to evaluate the quality of health care provided to Medicare HMO enrollees. We stated that the PRO review of HMO medical records offered the potential to augment and enhance HCFA's ability to oversee its HMO contractor activities.

Our recent evaluation of the new program shows that the PRO review program has not fulfilled its potential.[31] First, HCFA has not taken advantage of the medical expertise available through the PROs to obtain a thorough evaluation of HMOs' quality assurance programs. Second, record-keeping inadequacies at most risk HMOs have jeopardized the PRO external review of HMO quality of care from the start. The PROs have not had access to complete data on all Medicare enrollee encounters from which to select their review samples and, thus, have yet to conduct enough inpatient or ambulatory reviews to make a valid assessment of the quality of care at risk HMOs.

PROs need accurate data on HMO enrollees' care to function. Although HMOs are required to cooperate with the PROs by providing the necessary

[29]Mathematica Policy Research, Inc., Enrollment and Disenrollment in Medicare Competition Demonstration Plans: A Descriptive Analysis, September 15, 1986.

[30]Medicare: Experience Shows Ways to Improve Oversight of Health Maintenance Organizations (GAO/HRD-88-73, Aug. 17, 1988).

[31]Medicare: PRO Review Does Not Assure Quality of Care Provided by Risk HMOs (GAO/HRD-91-48, Mar. 13, 1991).

data, many HMOs do not comply with these requirements. Problems in this area have been long-standing, and HCFA's attempts to correct them have failed.

The only punitive action available to HCFA when HMOs do not comply with PRO review requirements is contract termination. HCFA is unlikely to invoke this alternative. Consequently, we believe the Congress should consider broadening HCFA's sanction authority, for example by authorizing civil monetary penalties, when HMOs do not comply with PRO review requirements.

Resolving HMO Compliance Problems Remains an Issue

Our remaining concern with HCFA's management and oversight of the HMO program involves its ability and willingness to enforce Medicare and other federal standards when HMOs are found to be out of compliance with Medicare standards. Broadly, these enrollee protection standards relate to quality assurance systems, the availability and accessibility of health services, marketing practices, enrollment and disenrollment, complaint handling and grievance procedures, and payment of enrollees' bills for covered services.

In our 1988 report we found that most HMOs having compliance problems identified by HCFA were responsive and reasonably timely in initiating corrective actions.[32] This was not the case for a few HMOs, however. These HMOs had recurring compliance problems or were unresponsive or untimely in taking HCFA-requested corrective actions. HCFA tried to resolve these HMOs' compliance problems, but the practical effect was often little more than to document the history of the problems.

The most notable case involved the long-standing compliance problems at International Medical Centers, Inc. (IMC)—a south Florida HMO that became insolvent and was placed in receivership by the state in May 1987. This HMO had continuing problems meeting federal requirements from the time it first entered into a contract to serve Medicare beneficiaries in 1981. As IMC's compliance problems mounted, so too did its enrollment of Medicare beneficiaries—from about 5,000 in 1981 to 135,000 in 1986. HCFA never resolved the HMO's compliance problems, and the HMO became insolvent and in 1987 was sold to Humana, Inc., becoming the Humana Medical Plan (HMP).

[32]GAO/HRD-88-73.

Although HCFA's oversight mechanisms have improved in recent years, a situation that has developed with HMP suggests that further improvements are needed. Though HMP corrected many of the problems of its predecessor, HCFA has found HMP out of compliance with numerous federal requirements. These relate to marketing, timely disenrollment of Medicare beneficiaries who wish to return to the regular Medicare program, the adequacy of its internal quality assurance systems, prompt payment of claims, and other issues related to the HMO's overall management of its health care network.

As we reported in 1988, HCFA has limited authority to suspend an HMO's enrollment of Medicare beneficiaries. Under several circumstances specified in the enabling legislation, HCFA can suspend an HMO's enrollment or impose civil monetary penalties. We suggested that the Congress broaden HCFA's authority to deal with HMOs out of compliance with requirements. With broadened authority HCFA could more easily apply sanctions. This would also make HCFA more accountable if it chooses not to apply a sanction against an out-of-compliance HMO. Specifically, in our earlier report, we recommended that HCFA be given greater discretion to suspend Medicare enrollments in HMOs that fail to respond to notices of noncompliance in a timely manner or, among other things, have recurring compliance problems. We continue to believe that the Congress should grant HCFA such authority.

Budget Cuts Reduce Program and Payment Safeguard Activities

Our final set of concerns addresses the administration and control functions of the Medicare program, specifically the degree to which it is vulnerable to waste, abuse, and mismanagement. The federal government contracts with insurance companies to process and pay Medicare claims. Currently, there are 48 "intermediaries" that process part A claims and 34 "carriers" that process part B claims.

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 requirements.[33] The contractors are also the main channel of communication between beneficiaries and providers about matters relating to claims and coverage issues.

[33]Specifically, the contractors' responsibilities include ensuring that (1) beneficiaries were eligible at the time of service; (2) rendered medical services are medically necessary, covered benefits (except in the case of inpatient hospital services, where PROs have this function); (3) applicable cost reports are submitted and accurate; (4) the submitted claims met HCFA's billing standards; and (5) the claims are processed and paid accurately and in a timely fashion.

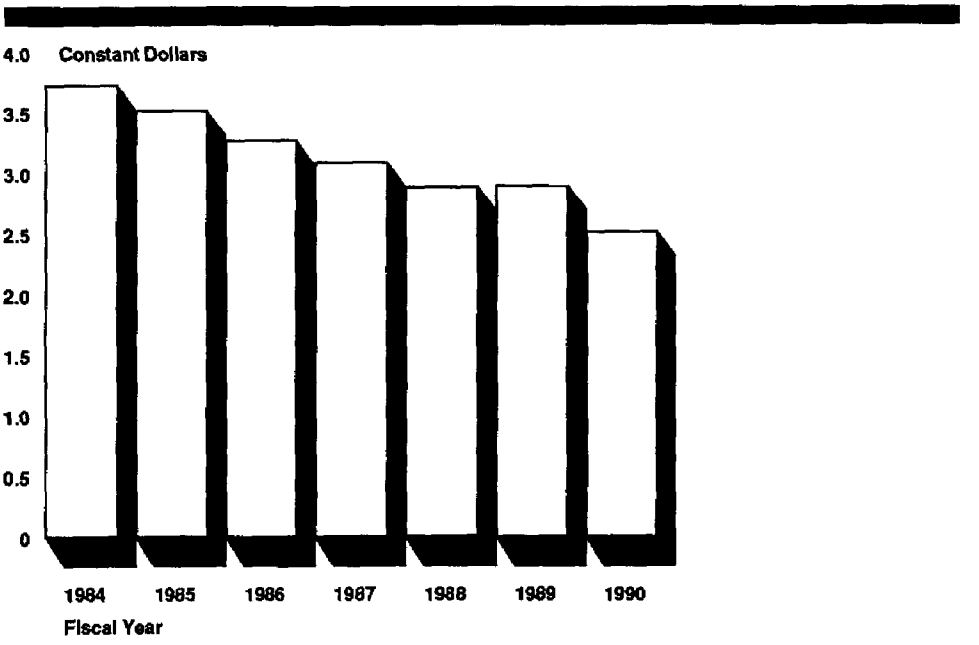
The demands placed on the Medicare contractors are substantial because of the number of providers and program beneficiaries and the volume of claims. During fiscal year 1990, the contractors processed about 537 million Medicare claims. The complex, dynamic nature of the Medicare payment policies has also increased the demands on these claims-processing contractors. In recent years, however, the administrative funds available to pay contractors has not kept pace with program growth. As a result, the contractors' ability to employ effective payment safeguards and ensure the proper expenditures of Medicare funds has diminished.

Contractor Budget Has Not Kept Pace With Program Growth

From 1984 through 1990 the total amount paid to the Medicare contractors increased from $817 million to about $1.35 billion. At first glance, this 65-percent increase appears to be significant. However, a closer look at these figures, in the context of other changes to the Medicare program during the same period, suggests otherwise.

Medicare's claims volume has increased at an annual rate of over 11 percent, while numerous legislative and programmatic changes have significantly increased the costs and demands placed on contractor operations. When the total contractor budget is viewed on a cost-per-claim basis and adjusted for inflation, the amount paid, in 1990 dollars, to the contractors actually decreased—from about $3.72 per claim in fiscal year 1984 to about $2.51 per claim in fiscal year 1990, an average annual decrease of about 6 percent. The trend in Medicare contractor outlays per claim in 1990 dollars is illustrated in figure I.8.

Figure I.8: Medicare Contractor Outlays Per Claim, in 1990 Dollars (Fiscal Years 1984-90)



Source: HCFA.

Underfunded Payment Safeguard Activities Result in Higher Medicare Expenditures

Most contractor funding is allocated for claims processing, that is, paying the bills submitted by the providers accurately. A large part of the remaining money received by the contractors is for payment safeguard activities. We are concerned that the contractors' ability to ensure the accuracy of program payments has been and remains underfinanced.[34] These payment safeguards are central to protecting the program from unnecessary expenditures.

Contractor payment safeguard activities are an integral part of normal claims-processing activities and comprise three activities: (1) reviewing all submitted claims to determine whether the services furnished were medically necessary and appropriate;[35] (2) auditing cost reports submitted by providers, such as home health agencies and hospitals providing outpatient services, that are reimbursed for services on a cost

[34]Medicare: Existing Contract Authority Can Provide for Effective Program Administration (GAO/HRD-86-48, Apr. 22, 1986). Medicare: Cutting Payment Safeguards Will Increase Program Costs (GAO/T-HRD-89-6, Feb. 28, 1989), testimony before the Subcommittee on Labor, Health and Human Services, and Education, Senate Committee on Appropriations. Medicare: Effects of Budget Reductions on Contractor Program Safeguard Activities (GAO/T-HRD-90-42, June 14, 1990), testimony before the Subcommittee on Health, House Committee on Ways and Means.

[35]Intermediaries do not review inpatient hospital claims for medical necessity or appropriateness. This function is performed by PROs.

basis; and (3) assuring that Medicare pays beneficiaries' claims only after other responsible insurers had paid (referred to as the Medicare Secondary Payer program).[36]

Though payment safeguard activities are cost-effective—returning $11 for every $1 spent in 1989—contractor budgets to perform these functions have been cut. For example, payment safeguard funds were cut from about $358 million in 1989 to $345 million in 1990, a decrease of $13 million. The impact of the reduction was acknowledged in the associated savings projections. The administration's 1990 budget estimated that medical and utilization review savings would drop by $37 million, provider audit savings by $120 million, and part B secondary payer savings by $335 million.

The fiscal year 1991 current estimate for payment safeguard activities has decreased to $335 million, while the fiscal year 1992 budget request declined slightly to $333.1 million. Largely because of funding shortfalls, contractors are

- reducing medical and utilization reviews of claims that are essential for detecting and preventing erroneous payments and
- curtailing efforts to recover hundreds of millions of dollars in claims that should have been paid by private insurance companies but were mistakenly paid by Medicare.

The magnitude of the potential losses incurred by Medicare as a result of these cutbacks is illustrated by our recent report on the Medicare secondary payer recovery efforts of one contractor, Blue Cross and Blue Shield of Maryland.[37] During our review, we found a large inventory of potential mistaken Medicare payments that were not being recovered. Specifically, we identified over 3,000 cases for which Medicare paid about $8.8 million during the period 1983-89. The contractor was doing little to recover on these claims, at least in part because its funding for these activities was significantly reduced in fiscal year 1990. Because of our work at this contractor, HCFA provided it additional funding to begin

[36]Medicare: Millions in Potential Recoveries Not Being Sought by Contractors (GAO/T-HRD-91-8, Feb. 26, 1991), testimony before the Subcommittee on Oversight, House Committee on Ways and Means.

[37]Medicare: Millions in Potential Recoveries Not Being Sought by Maryland Contractor (GAO/HRD-91-32, Jan. 25, 1991). Blue Cross and Blue Shield of Maryland is the Medicare contractor for part A services in Maryland and the District of Columbia and for part B services in most of Maryland.

collecting the mistaken Medicare payments. Consequently, as of February 15, 1992, about $2.3 million had been repaid to Medicare, according to contractor officials.

While contractor budgets have not kept pace with the growth in their workloads, the contractor funding situation has become even more troubled because not all budgeted funds are made available to contractors. In recent years, an increasing part of contractor budgets has been set aside in a contingency fund to cover unanticipated administrative costs.

HCFA monitors contractor expenditures and workload throughout the year and can request the release of contingency funds if needed. Such requests go though HHS and must ultimately be approved by the Office of Management and Budget (OMB). Unused contingency funds are not carried over from year to year.

The contingency fund, as a line item in the budget, has grown from 2 percent of the fiscal year 1985 Medicare contractor budget ($20 million) to 6.4 percent of the fiscal year 1992 budget ($100 million). Although the fund has grown rapidly, release of the money has not been assured. HCFA's 1989 request for the release of over $90 million was denied by OMB. In 1990, only $6 million of the approximately $99 million contingency funds was released.

The problems created by taking funds from the mainstream of the contractors' budgets and placing it in the contingency fund is illustrated by HCFA's recent dilemma. Two months into fiscal year 1991, HCFA had already requested $101.3 million in contingency funds to address increased workloads and higher claims volume. During February 1991, OMB released $75 million of the contingency funds. While this will alleviate problems, it will not resolve them.

Adequate Funding for Safeguard Activities Should Be Assured

We believe that there is room for improvement in the efficiency and effectiveness of Medicare contractor operations. Over the years we have reviewed and addressed shortcomings in the efficiency of contractors' claims processing[38] and the effectiveness of their payment safeguard

[38]Medicare: Internal Controls Over Electronic Claims for Anesthesia Services Are Inadequate (GAO/HRD-90-49, Dec. 18, 1989). Medicare: Simplified Processing of Deceased Beneficiaries' Claims to Be Implemented (GAO/HRD-88-99, June 21, 1988). Medicare: Performance of Blue Shield of Massachusetts Under the Tri-State Contract (GAO/HRD-88-81BR, Mar. 31, 1988).

activities.[39] HCFA also has concerns about the existing administrative structure and has undertaken a Medicare Contractor Reform Initiative to address these issues.

Until the other reforms are effectively implemented, funding cutbacks in such key areas as program safeguards are likely to cost much more than they save. Consequently, we believe that the more immediate solution to the problem lies in adequate funding of these important contractor functions. Increasing funding for payment safeguard activities, and thereby preventing inappropriate program payments, could help lessen the need for the difficult across-the-board cuts to all providers that the Congress is faced with annually. Consequently, we believe the Congress should consider appropriating additional funds for contractor safeguard activities.

Recently, the Congress recognized that specific increases in administrative expenditures in several circumstances have the potential to reduce federal costs overall; therefore, the Congress devised methods to facilitate the funding of these increased expenditures, notwithstanding current constraints on federal spending. For example, as we advised in a 1990 report,[40] the Congress recently established a mechanism enabling the Department of Veterans Affairs (VA) to keep a portion of amounts recovered from insurers for care provided to certain insured veterans and use the funds to offset the expense of pursuing additional recoveries. Such a mechanism ensures that funds for VA's recovery efforts are forthcoming even in today's constrained fiscal environment.

The same law that established a suitable funding mechanism related to VA, the Budget Enforcement Act of 1990, imposed additional constraints, however, on federal spending. The act provides, in general, that federal discretionary spending, which includes Medicare administrative expenditures, be subject to spending limits. Increasing spending for safeguard activities would, therefore, currently require cuts elsewhere in discretionary spending to remain within the established limits.

Savings resulting from administrative actions are not counted as reductions in spending for purposes of the act. Consequently, savings

[39]Medicare: More Hospital Costs Should Be Paid by Other Insurers (GAO/HRD-87-43, Jan. 29, 1987). Medicare: Incentives Needed to Assure Private Insurers Pay Before Medicare (GAO/HRD-89-19, Nov. 29, 1988). Internal Controls: Need to Strengthen Controls Over Payments by Medicare Intermediaries (GAO/HRD-89-8, Nov. 14, 1988).

[40]VA Health Care: Better Procedures Needed to Maximize Collections From Health Insurers (GAO/HRD-90-64, Apr. 6, 1990).

achieved as a result of increased expenditures for Medicare safeguard activities would not be counted as reductions.

Also, in the act, in recognition of a similar situation, the Congress arranged for the discretionary spending limits to be increased if additional appropriations were made for Internal Revenue Service compliance funding. This permitted additional funding for IRS enforcement activities, without necessitating spending cuts elsewhere.

Consistent with the Budget Enforcement Act, the anticipated net effect of the IRS budgeting mechanism is to authorize increased expenditures to fund specific federal activities likely to produce a net reduction in federal spending. Because of the strong potential for a net reduction in federal spending, we believe that the Congress should consider establishing a similar means of facilitating increased expenditures to fund Medicare administrative costs.

GAO Products Relating to Issues Affecting the Medicare Program, Published From January 1986 Through March 1991

The following is a list of GAO reports and testimonies relating to nine issues affecting the Medicare program. See appendix III for an annotated list. Orders for copies of the reports should be sent to the following address:

U.S. General Accounting Office
P.O. Box 6015
Gaithersburg, MD 20877

Orders may also be placed by calling (202) 275-6241.

I. Hospital Payment Issues

Rural Hospitals: Federal Efforts Should Target Areas Where Closures Would Threaten Access to Care (GAO/HRD-91-41, Feb. 1991).

Rural Hospitals: Factors That Affect Risk of Closure (GAO/HRD-90-134, June 1990).

Medicare: Comparative Analyses of Payments for Selected Hospital Services (GAO/HRD-90-108, July 1990).

Nonprofit Hospitals: Better Standards Needed for Tax Exemption (GAO/HRD-90-84, May 1990).

Medicare: Alternatives for Computing Payments for Hospital Outpatient Surgery (GAO/HRD-90-78, Apr. 1990).

Rural Hospitals: Federal Leadership and Targeted Programs Needed (GAO/HRD-90-67, June 1990).

Medicare: Indirect Medical Education Payments Are Too High (GAO/HRD-89-33, Jan. 1989).

Medicare: Indirect Medical Education Payments Are Too High (GAO/T-HRD-89-14, Apr. 11, 1989). Testimony before the Subcommittee on Health, House Committee on Ways and Means.

Medicare: GAO Views on the Payment System for Outpatient Cataract Surgery (GAO/T-HRD-89-16, Apr. 10, 1989). Testimony before the Subcommittee on Health, House Committee on Ways and Means.

Medicare: Number of Rural Hospitals Terminating Participation Since the Program Began (GAO/HRD-88-46, Jan. 1988).

Medicare: Share of Hospitals' Inpatient Use and Revenue (GAO/HRD-88-44BR, Jan. 1988).

Medicare: Refinement of Diagnosis Related Groups Needed to Insure Payment Equity (GAO/HRD-88-41, Apr. 1988).

Medicare: Alternatives for Paying Hospital Capital Costs (GAO/HRD-86-93, Aug. 1986).

Medicare: Past Overuse of Intensive Care Services Inflates Hospital Payments (GAO/HRD-86-25, Mar. 1986).

II. Physician and Other Part B Payment Issues

Medicare: Need for Consistent National Payment Policy for Special Anesthesia Services (GAO/HRD-91-23, Mar. 1991).

Screening Mammography: Low-Cost Services Do Not Compromise Quality (GAO/HRD-90-32, Jan. 1990).

Medicare: Withdrawing Eyeglass Coverage Recommended Following Cataract Surgery (GAO/HRD-90-31, Feb. 1990).

Medicare: Impact of State Mandatory Assignment Programs on Beneficiaries (GAO/HRD-89-128, Sept. 1989).

Medicare: Referring Physicians' Ownership of Laboratories and Imaging Centers (GAO/T-HRD-89-26, June 8, 1989). Testimony before the Subcommittee on Health and the Environment, House Committee on Energy and Commerce.

Medicare: Payments to Radiologists, Anesthesiologists, and Pathologists (GAO/HRD-87-114BR, July 1987).

Medicare: Physician Income by Specialty and Place of Service (GAO/HRD-86-90BR, July 1986).

Medicare: Documenting Teaching Physician Services Still a Problem (GAO/HRD-86-36, Jan. 1986).

III. Managed Care Issues

Medicare: Second Status Report on Medicare Insured Group Demonstration Projects (GAO/HRD-90-117, June 1990).

Medicare: Increase in HMO Reimbursement Would Eliminate Potential Savings (GAO/HRD-90-38, Nov. 1989).

Medicare: Status Report on Medicare Insured Group Demonstration Projects (GAO/HRD-89-64, June 1989).

Medicare: Reasonableness of Health Maintenance Organization Payments Not Assured (GAO/HRD-89-41, Mar. 1989).

Medicare: Physician Incentive Payments by Prepaid Health Plans Could Lower Quality of Care (GAO/HRD-89-29, Dec. 1988).

Medicare: Health Maintenance Organization Rate-Setting Issues (GAO/HRD-89-46, Jan. 1989).

Medicare: Experience Shows Ways to Improve Oversight of Health Maintenance Organizations (GAO/HRD-88-73, Aug. 1988).

Medicare: Issues Concerning the HealthChoice Demonstration Project (GAO/HRD-88-69, July 1988).

Medicare: Uncertainties Surround Proposal to Expand Prepaid Health Plan Contracting (GAO/HRD-88-14, Nov. 1987).

Medicare: Issues Raised by Florida Health Maintenance Organization Demonstrations (GAO/HRD-86-97, July 1986).

IV. Long-Term Care

Long-Term Care Insurance: Risks to Consumers Should Be Reduced (GAO/T-HRD-91-14). Testimony before the Subcommittee on Health, House Committee on Ways and Means.

Medicare: Comparison of Two Methods of Computing Home Health Care Cost Limits (GAO/HRD-90-167, Sept. 1990).

Nursing Homes: Admission Problems for Medicaid Recipients and Attempts to Solve Them (GAO/HRD-90-135, Sept. 1990).

In-Home Services for the Elderly: Cost Sharing Expands Range of Services Provided and Population Served (GAO/HRD-90-19, Oct. 1989).

Medicare: Increased Denials of Home Health Claims During 1986 and 1987 (GAO/HRD-90-14BR, Jan. 1990).

Medicare: Assuring the Quality of Home Health Services (GAO/HRD-90-7, Oct. 1989).

Medicare: Program Provisions and Payments Discourage Hospice Participation (GAO/HRD-89-111, Sept. 1989).

Long-Term Care Insurance: State Regulatory Requirements Provide Inconsistent Consumer Protection (GAO/HRD-89-67, Apr. 1989).

Board and Care: Insufficient Assurances That Residents' Needs Are Identified and Met (GAO/HRD-89-50, Feb. 1989).

Long-Term Care for the Elderly: Issues of Need, Access, and Cost (GAO/HRD-89-4, Nov. 1988).

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

Medicare and Medicaid: Stronger Enforcement of Nursing Home Requirements Needed (GAO/HRD-87-113, July 1987).

Long-Term Care Insurance: Coverage Varies Widely in a Developing Market (GAO/HRD-87-80, May 1987).

Posthospital Care: Discharge Planners Report Increasing Difficulty in Placing Medicare Patients (GAO/PEMD-87-5BR, Jan. 1987).

Medicare: Need to Strengthen Home Health Care Payment Controls and Address Unmet Needs (GAO/HRD-87-9, Dec. 1986).

Post-Hospital Care: Efforts to Evaluate Medicare Prospective Payment Effects Are Insufficient (GAO/PEMD-86-10, June 1986).

V. Administrative Issues

Medicare Claims Processing: HCFA Can Reduce the Disruptions Caused by Replacing Contractors (GAO-HRD-91-44, Apr. 1991).

Medicare: Millions in Disabled Beneficiary Expenditures Shifted to Employers (GAO/HRD-91-24, Apr. 1991).

Medicare: Millions in Potential Recoveries Not Being Sought by Contractors (GAO/T-HRD-91-8, Feb. 1991). Testimony before the Subcommittee on Oversight, House Committee on Ways and Means.

Medicare: Millions in Potential Recoveries Not Being Sought by Maryland Contractor (GAO/HRD-91-32, Jan. 1991).

Budget Issues: Effects of the Fiscal Year 1990 Sequester on the Department of Health and Human Services (GAO/HRD-90-156FS, Aug. 1990).

Medicare: HCFA Can Reduce Paperwork Burden for Physicians and Their Patients (GAO/HRD-90-86, June 1990).

ADP Budget: Analysis of HCFA's Fiscal Year 1991 ADP Budget Request (GAO/IMTEC-90-67, Sept. 1990).

Management of HHS: Using the Office of the Secretary to Enhance Departmental Effectiveness (GAO/HRD-90-54, Feb. 1990).

Medicare: Internal Controls Over Electronic Claims for Anesthesia Services Are Inadequate (GAO/HRD-90-49, Dec. 1989).

Medicare: Effects of Budget Reductions on Contractor Program Safeguard Activities (GAO/T-HRD-90-42, June 14, 1990). Testimony before the Subcommittee on Health, House Committee on Ways and Means.

Medicare Part A Reimbursements: Processing of Appeals Is Slow (GAO/HRD-90-23BR, Feb. 1990).

Medicare: Statistics on the Part B Administrative Law Judge Hearings Process (GAO/HRD-90-18, Nov. 1989).

Information Technology: Health Care Financing Administration's Budget Process Needs Improvement (GAO/IMTEC-89-31, Aug. 1989).

Medicare: Incentives Needed to Assure Private Insurers Pay Before Medicare (GAO/HRD-89-19, Nov. 1988).

Internal Controls: Need to Strengthen Controls Over Payments by Medicare Intermediaries (GAO/HRD-89-8, Nov. 1988).

Medicare: Cutting Payment Safeguards Will Increase Program Costs (GAO/T-HRD-89-6, Feb. 28, 1989). Testimony before the Subcommittee on

Labor, Health and Human Services, and Education, Senate Committee on Appropriations.

Medicare: Contractor Services to Beneficiaries and Providers (GAO/HRD-88-76BR, Mar. 1988).

Financial Management: Continued Top Management Support Needed to Improve HHS' Accounting Systems (GAO/AFMD-88-37, Sept. 1988).

HCFA Research: Agency Practices and Other Factors Threaten Quality of Mandated Studies (GAO/PEMD-88-9, June 1988).

Medicare: Rehabilitation Service Claims Paid Without Adequate Information (GAO/HRD-87-91, July 1987).

Medicare: More Hospital Costs Should Be Paid by Other Insurers (GAO/HRD-87-43, Jan. 1987).

Medicare: Simplified Processing of Deceased Beneficiaries' Claims to Be Implemented (GAO/HRD-88-99, June 1988).

Medicare Claims: HCFA Proposal to Establish Administrative Law Judge Unit (GAO/HRD-88-84BR, Apr. 1988).

Medicare: Performance of Blue Shield of Massachusetts Under the Tri-State Contract (GAO/HRD-88-81BR, Mar. 1988).

Medicare: Existing Contract Authority Can Provide for Effective Program Administration (GAO/HRD-86-48, Apr. 1986).

VI. Quality Assurance Activities

Medicare: PRO Review Does Not Assure Quality of Care Provided by Risk HMOs (GAO/HRD-91-48, Mar. 1991).

Medicare: PRO Review Does Not Assure Quality of Care Provided by Risk HMOs (GAO/T-HRD-91-12, Mar. 1991). Testimony before the Senate Special Committee on Aging.

Health Care: Criteria Used to Evaluate Hospital Accreditation Process Need Reevaluation (GAO/HRD-90-89, June 1990).

Information System: National Health Practitioner Data Bank Has Not Been Well Managed (GAO/IMTEC-90-68, Aug. 1990).

Health Care: Limited State Efforts to Assure Quality of Care Outside Hospitals (GAO/HRD-90-53, Jan. 1990).

Medicare and Medicaid: More Information Exchange Could Improve Detection of Substandard Care (GAO/HRD-90-29, Mar. 1990).

Basic Elements of an Infection Control Program (GAO/HRD-90-25, Jan. 1990).

Quality Assurance: A Comprehensive National Strategy for Health Care Is Needed (GAO/PEMD-90-14BR, Feb. 1990).

Medicare: Improvements Needed in the Identification of Inappropriate Hospital Care (GAO/PEMD-90-7, Dec. 1989).

Laboratory Accreditation: Requirements Vary Throughout the Federal Government (GAO/RCED-89-102, Mar. 1989).

Medicare: Statutory Modifications Needed for the Peer Review Program Monetary Penalty (GAO/HRD-89-18, Mar. 1989).

Medicare: An Assessment of HCFA's 1988 Hospital Mortality Analyses (GAO/PEMD-89-11BR, Dec. 1988).

Medicare PROs: Extreme Variation in Organizational Structure and Activities (GAO/PEMD-89-7FS, Nov. 1988).

Medicare: Physician-Sponsored Organizations Receive Priority for Peer Review Contracts (GAO/HRD-88-43, Jan. 1988).

Medicare: Improved Patient Outcome Analyses Could Enhance Quality Assessment (GAO/PEMD-88-23, June 1988).

Medicare: Better Controls Needed for Peer Review Organizations' Evaluations (GAO/HRD-88-13, Oct. 1987).

Medicare: Improving Quality of Care Assessment and Assurance (GAO/PEMD-88-10, May 1988).

Health Facilities: Problems at Harlem Hospital in Complying With Medicare Standards (GAO/HRD-87-58, Feb. 1987).

Medicare: Preliminary Strategies for Assessing Quality of Care (GAO/PEMD-87-15BR, July 1987).

Medicare: Reviews of Quality of Care at Participating Hospitals (GAO/HRD-86-139, Sept. 1986).

VII. Health Insurance and Coverage Issues

Medigap Insurance: Better Consumer Protection Should Result From 1990 Change to Baucus Amendment (GAO/HRD-91-49, Mar. 1991).

Health Insurance Coverage: A Profile of the Uninsured in Selected States (GAO/HRD-91-31FS, Feb. 1991).

Health Insurance: A Profile of the Uninsured in Michigan and the United States (GAO/HRD-90-97, May 1990).

Employee Benefits: Extent of Companies' Retiree Health Coverage (GAO/HRD-90-92, Mar. 1990).

Medicare: Employer Insurance Primary Payer for 11 Percent of Disabled Beneficiaries (GAO/HRD-90-79, May 1990).

Health Insurance: Cost Increases Lead to Coverage Limitations and Cost Shifting (GAO/HRD-90-68, May 1990).

Medicare Catastrophic Act: Estimated Effects of Repeal on Medigap Premiums and Medicaid Costs (GAO/HRD-90-48FS, Nov. 1989).

Medigap Insurance: Proposals for Regulatory Changes and 1988 Loss Ratio Data (GAO/T-HRD-90-35, June 7, 1990). Testimony before the Subcommittee on Health and the Environment, House Committee on Energy and Commerce.

Health Insurance: Availability and Adequacy for Small Businesses (GAO/T-HRD-90-33, June 5, 1990). Testimony before the Subcommittee on Antitrust, Monopolies and Business Rights, Senate Committee on the Judiciary.

Medigap Insurance: Premiums and Regulatory Changes After Repeal of the Medicare Catastrophic Coverage Act and 1988 Loss Ratio Data (GAO/T-HRD-90-16, Mar. 13, 1990). Testimony before the Subcommittee on Health, House Committee on Ways and Means.

Medicare Catastrophic Act: Options for Changing Financing Benefits (GAO/HRD-89-156, Sept. 1989).

U.S. Employees Health Benefits: Rebate for Duplicate Medicare Coverage (GAO/HRD-89-58, Mar. 1989).

Employee Benefits: Companies' Retiree Health Liabilities Large, Advance Funding Costly (GAO/HRD-89-51, June 1989).

Health Insurance: An Overview of the Working Uninsured (GAO/HRD-89-45, Feb. 1989).

Employee Benefits: Company Actions to Limit Retiree Health Costs (GAO/HRD-89-31BR, Feb. 1989).

Health Insurance: Bibliography of Studies on Health Benefits for the Uninsured (GAO/HRD-89-27FS, Feb. 1989).

Medigap Insurance: Effects of the Catastrophic Coverage Act of 1988 on Future Benefits (GAO/T-HRD-89-22, June 1, 1989). Testimony before the Senate Committee on Finance.

Medigap Insurance: Effects of the Catastrophic Coverage Act of 1988 on Benefits and Premiums (GAO/T-HRD-89-13, Apr. 6, 1989). Testimony before the Subcommittee on Commerce, Consumer Protection, and Competitiveness, House Committee on Energy and Commerce.

Health Insurance: Hospital Indemnity and Specified Disease Policies Are of Limited Value (GAO/HRD-88-93, July 1988).

Health Insurance: A Profile of the Uninsured in Ohio and the Nation (GAO/HRD-88-83, Aug. 1988).

Health Insurance: Risk Pools for the Medically Uninsurable (GAO/HRD-88-66BR, Apr. 1988).

Medicare: Comparison of Catastrophic Health Insurance Proposals—An Update (GAO/HRD-88-19BR, Oct. 1987).

Medicare: Comparison of Catastrophic Health Insurance Proposals (GAO/HRD-87-92BR, June 1987).

Medicare: Catastrophic Illness Insurance (GAO/PEMD-87-21BR, July 1987).

Medigap Insurance: Law Has Increased Protection Against Substandard and Overpriced Policies (GAO/HRD-87-8, Oct. 1986).

VIII. Medical Malpractice

Medical Malpractice: Few Claims Resolved Through Michigan's Voluntary Arbitration Program (GAO/HRD-91-38, Dec. 1990).

Medical Malpractice: A Continuing Problem with Far-Reaching Implications (GAO/T-HRD-90-24, Apr. 26, 1990). Testimony before the Subcommittee on Health, House Committee on Ways and Means.

Medical Malpractice: A Framework for Action (GAO/HRD-87-73, May 1987).

Medical Malpractice: Characteristics of Claims Closed in 1984 (GAO/HRD-87-55, Apr. 1987).

Medical Malpractice: Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms (GAO/HRD-87-21, Dec. 1986). The following separate documents prepared as supplements to this report discuss GAO's work in each state:

(1) Medical Malpractice: Case Study on Arkansas (GAO/HRD-87-21S-1, Dec. 1986).

(2) Medical Malpractice: Case Study on California (GAO/HRD-87-21S-2, Dec. 1986).

(3) Medical Malpractice: Case Study on Florida (GAO/HRD-87-21S-3, Dec. 1986).

(4) Medical Malpractice: Case Study on Indiana (GAO/HRD-87-21S-4, Dec. 1986).

(5) Medical Malpractice: Case Study on New York (GAO/HRD-87-21S-5, Dec. 1986).

(6) Medical Malpractice: Case Study on North Carolina (GAO/HRD-87-21S-6, Dec. 1986).

Medical Malpractice: Insurance Costs Increased but Varied Among Physicians and Hospitals (GAO/HRD-86-112, Sept. 1986).

Medical Malpractice: No Agreement on the Problems or Solutions (GAO/HRD-86-50, Feb. 1986).

IX. Other Medicare Issues

Medicare: Options to Provide Home Dialysis Aides (GAO/HRD-90-153, Aug. 1990).

Medicare: Payments for Home Dialysis Much Higher Under Reasonable Charge Method (GAO/HRD-90-37, Oct. 1989).

Medicare and Medicaid: Updated Effects of Recent Legislation on Program and Beneficiary Costs (GAO/HRD-88-85, July 1988).

Medicare: Change in Contingency Reserve Funding Held Down Increase in Part B Premium (GAO/HRD-88-40BR, Nov. 1987).

Medicare: Laboratory Fee Schedules Produced Large Beneficiary Savings but No Program Savings (GAO/HRD-88-32, Dec. 1987).

Medicare: Legislative Amendment Would Avoid Adverse Effects on Disabled Beneficiaries (GAO/HRD-87-135, Sept. 1987).

Medicare and Medicaid: Effects of Recent Legislation on Program and Beneficiary Costs (GAO/HRD-87-53, Apr. 1987).

Medicare: Prescription Drug Issues (GAO/PEMD-87-20, July 1987).

Medicare and Medicaid: Budget Issues (GAO/T-HRD-87-1, Jan. 1987). Testimony before the Subcommittee on Health, Senate Committee on Finance.

An Aging Society: Meeting the Needs of the Elderly While Responding to Rising Federal Costs (GAO/HRD-86-135, Sept. 1986).

Medicare: Comments on HHS Proposal to Revise End Stage Renal Disease Facility Payment Rates (GAO/HRD-86-126BR, July 1986).

Annotation of GAO Products Relating to Issues Affecting the Medicare Program, Published From January 1986 Through March 1991

The following are brief descriptions of GAO reports and testimonies relating to nine issues affecting the Medicare program.

I. Hospital Payment Issues

Rural Hospitals: Federal Efforts Should Target Areas Where Closures Would Threaten Access to Care (GAO/HRD-91-41, Feb. 1991).

GAO investigated the causes and consequences of rural hospital closure. The report identifies the major factors associated with a higher risk of closure, assesses the impact of hospital closure on rural communities and health care costs, and reviews the role of Medicare's prospective payment system in closure.

Rural Hospitals: Factors That Affect Risk of Closure (GAO/HRD-90-134, June 1990).

GAO addresses the factors making rural hospitals vulnerable to closure. GAO (1) determined the financial characteristics associated with rural hospital closures, (2) determined the role of Medicare payment in rural closures, and (3) identified the operating and environmental characteristics associated with financial distress and a high risk of closure.

Medicare: Comparative Analyses of Payments for Selected Hospital Services (GAO/HRD-90-108, July 1990).

To analyze the adequacy of Medicare payment rates, GAO compared Medicare payment rates for selected inpatient hospital services with Medicaid payments for these same services in California, New York, and Ohio. GAO also analyzed differences among these states in Medicare payments and costs for similar inpatient hospital services.

Nonprofit Hospitals: Better Standards Needed for Tax Exemption (GAO/HRD-90-84, May 1990).

Nonprofit hospitals are exempt from federal taxation if they meet certain tests established by the Internal Revenue Service. GAO (1) analyzed the distribution of the costs of charity care and bad debt, uncompensated care, in five states to analyze the role of nonprofit hospitals in providing such care; (2) conducted case studies in five communities; and (3) surveyed a nationwide sample of hospitals regarding the types of community services offered.

Medicare: Alternatives for Computing Payments for Hospital Outpatient Surgery (GAO/HRD-90-78, Apr. 1990).

GAO developed and assessed alternative reimbursement methods for hospital outpatient surgeries. Due to technical issues affecting the payment calculation, Medicare may be paying more than necessary for hospital outpatient surgery. These problems also inflate the beneficiary coinsurance amount. The report discusses alternatives to the existing payment methodology that the Congress may wish to consider.

Rural Hospitals: Federal Leadership and Targeted Programs Needed (GAO/HRD-90-67, June 1990).

GAO identified and reviewed programs targeted at assisting rural hospitals. This report provides information on federal, state, and hospital programs that address problems for rural hospitals.

Medicare: Indirect Medical Education Payments Are Too High (GAO/HRD-89-33, Jan. 1989).

As required by statute, GAO examined the variation in Medicare costs and payments (1) among hospitals with different size teaching programs and (2) between teaching and nonteaching hospitals. The report analyzed the factors explaining the cost differences and estimated the size of the adjustment needed to compensate teaching hospitals for the indirect cost of medical education.

Medicare: Indirect Medical Education Payments Are Too High (GAO/T-HRD-89-14, Apr. 11, 1989). Testimony before the Subcommittee on Health, House Committee on Ways and Means.

The testimony summarized the report cited previously (GAO/HRD-89-33).

Medicare: GAO Views on the Payment System for Outpatient Cataract Surgery (GAO/T-HRD-89-16, Apr. 10, 1989). Testimony before the Subcommittee on Health, House Committee on Ways and Means.

GAO reviewed Medicare payments for cataract surgery, the most frequently performed outpatient surgery, and supported revising Medicare's cost-based payment system for outpatient hospital surgery. In addition to reimbursement issues, utilization safeguards, including documentation of medical necessity, were also discussed.

Medicare: Number of Rural Hospitals Terminating Participation Since the Program Began (GAO/HRD-88-46, Jan. 1988).

This report provides data on the number of rural hospitals that have ceased participation in Medicare for time periods before and after the implementation of that program's inpatient hospital PPS. GAO also determined, to the extent possible, from Medicare hospital participation data whether other hospitals were available to Medicare beneficiaries in the areas formerly served by the closed hospitals.

Medicare: Share of Hospitals' Inpatient Use and Revenue (GAO/HRD-88-44BR, Jan. 1988).

In response to concerns about the effects of Medicare's prospective payment system on the financial status of rural hospitals, GAO provided data on Medicare's share of inpatient use and revenues for rural and urban hospitals.

Medicare: Refinement of Diagnosis Related Groups Needed to Insure Payment Equity (GAO/HRD-88-41, Apr. 1988).

Because of the importance of diagnosis related groups to the Medicare prospective payment system, GAO evaluated the DRG case classification system as a means of grouping patients for payment purposes. Specifically, GAO (1) analyzed the variation in costs in cases within certain DRGs, (2) determined if hospitals receive an equal mix of high- and low-cost patients in DRGs where a wide variation in resource requirements exists, and (3) determined if hospital characteristics, such as bed size and rural or urban location, are systematically related to whether a hospital receives patients with higher- or lower-than-average treatment costs within the DRGs.

Medicare: Alternatives for Paying Hospital Capital Costs (GAO/HRD-86-93, Aug. 1986).

This report presents alternative methods for paying hospital capital costs that would lessen the immediate effects of a prospective capital payment system on hospitals.

Medicare: Past Overuse of Intensive Care Services Inflates Hospital Payments (GAO/HRD-86-25, Mar. 1986).

Information is provided on (1) the extent that, prior to PPS, Medicare patients received intensive care unit services when less costly routine care would have been a feasible option; (2) whether hospital practices regarding the use of intensive care service changed after PPS; and (3) the effectiveness of HCFA's program for assuring that utilization changes are reflected in Medicare payment rates.

II. Physician and Other Part B Payment Issues

Medicare: Need for Consistent National Payment Policy for Special Anesthesia Services (GAO/HRD-91-23, Mar. 1991).

GAO examined the effect of a HCFA policy change eliminating the use of modifier units when paying for anesthesia services. Before 1989, the Medicare anesthesia payment system allowed such units to be used to account for such factors as a patient's age, physical status, or unusual risk circumstances.

Screening Mammography: Low-Cost Services Do Not Compromise Quality (GAO/HRD-90-32, Jan. 1990).

The Medicare Catastrophic Coverage Act of 1988 required GAO to review the quality of screening mammography provided in a variety of settings. GAO collected and analyzed data across settings on the provision of screening mammography, charges for services, and quality assurance mechanisms. GAO surveyed 1,485 facilities in four states—California, Florida, Idaho, and Michigan.

Medicare: Withdrawing Eyeglass Coverage Recommended Following Cataract Surgery (GAO/HRD-90-31, Feb. 1990).

This report analyzed the disparity between the Medicare policy of paying for conventional eyeglasses for beneficiaries who have undergone cataract surgery and those who have not.

Medicare: Impact of State Mandatory Assignment Programs on Beneficiaries (GAO/HRD-89-128, Sept. 1989).

Information is provided on the impact of mandatory assignment laws on beneficiary out-of-pocket costs, use of physician services, and access to

care in Connecticut, Massachusetts, Rhode Island, and Vermont, the four states that have enacted such laws.

Medicare: Referring Physicians' Ownership of Laboratories and Imaging Centers (GAO/T-HRD-89-26, June 8, 1989). Testimony before the Subcommittee on Health and the Environment, House Committee on Energy and Commerce.

GAO provided information on the patterns of physician referrals to clinical diagnostic laboratories and diagnostic imaging centers in Pennsylvania and Maryland. The analysis examined (1) the extent of physician ownership of the two types of facilities, (2) whether physician ownership measurably influenced utilization rates for referral services, and (3) the terms of the investment opportunities and their investment return.

Medicare: Payments to Radiologists, Anesthesiologists, and Pathologists (GAO/HRD-87-114BR, July 1987).

This report analyzed the Medicare contractual arrangements for radiologists, anesthesiologists, and pathologists at 16 hospitals in four geographic areas (Maine; Rhode Island; Queens County, New York; and Dade County, Florida). We also examined (1) the level of physicians' net incomes and percentage return on the cost of medical training, (2) the Medicare service volume on a per beneficiary basis, (3) Medicare controls on the volume of these physicians' services, and (4) the geographic variation in payment rates for their services.

Medicare: Physician Income by Specialty and Place of Service (GAO/HRD-86-90BR, July 1986).

GAO presented information on (1) gross and net incomes of office-based physicians by specialty, (2) the portion of gross income derived from Medicare, (3) Medicare income by place of service, and (4) the extent to which Medicare income involved assigned and unassigned claims.

Medicare: Documenting Teaching Physician Services Still a Problem (GAO/HRD-86-36, Jan. 1986).

As required by the Deficit Reduction Act of 1984, this report reviews Medicare payments to teaching physicians at 10 hospitals. The focus was on the requirement that the teaching physicians provide a personal

and identifiable service to the Medicare patient in order to qualify for Medicare payments for teaching physician services.

III. Managed Care Issues

Medicare: Second Status Report on Medicare Insured Group Demonstration Projects (GAO/HRD-90-117, June 1990).

As required by statute, GAO (1) monitored the status of HCFA's implementation of the Medicare Insured Group demonstration project and the status of any projects awarded and (2) reviewed the potential effects of the payment limitations and beneficiary safeguards as specified by section 4015(a) of the Omnibus Budget Reconciliation Act of 1987.

Medicare: Increase in HMO Reimbursement Would Eliminate Potential Savings (GAO/HRD-90-38, Nov. 1989).

GAO reviewed the legislative history of setting Medicare's payment of health maintenance organizations at 95 percent of the fee-for-service sector's payment level and evaluated the proposed increase in light of the legislative history.

Medicare: Status Report on Medicare Insured Group Demonstration Projects (GAO/HRD-89-64, June 1989).

The Secretary of HHS is authorized to conduct demonstrations of contracting on a prepaid capitation basis with Medicare Insured Groups to provide Medicare benefits to retirees. As required by the Omnibus Budget Reconciliation Act of 1987, this report reviews the status of the projects and the effect on them of the act's requirements for the demonstration.

Medicare: Reasonableness of Health Maintenance Organization Payments Not Assured (GAO/HRD-89-41, Mar. 1989).

GAO's review of the "adjusted community rate" process, which is part of the payment-setting methodology for risk contract HMOs, is discussed.

Medicare: Physician Incentive Payments by Prepaid Health Plans Could Lower Quality of Care (GAO/HRD-89-29, Dec. 1988).

This report discusses financial incentives to control medical costs offered to physicians by HMOs, including plan characteristics that could jeopardize the care provided to Medicare patients.

Medicare: Health Maintenance Organization Rate-Setting Issues (GAO/HRD-89-46, Jan. 1989).

The Omnibus Budget Reconciliation Act of 1987 required GAO to analyze and assess the data and methods used to compute the monthly capitation payments made to HMOs for Medicare beneficiaries who enroll in them. The report provides an overview to three broad topics of concern relating to current rate-setting methodology. These issues are the (1) accuracy of the forecasted adjusted average-per-capita cost rates; (2) appropriateness of tying HMO payment levels to county fee-for-service Medicare cost levels; and (3) potential of the current capitation payment system to adversely affect Medicare, its beneficiaries, and HMOs.

Medicare: Experience Shows Ways to Improve Oversight of Health Maintenance Organizations (GAO/HRD-88-73, Aug. 1988).

This report discusses problems with HCFA's ability to deal decisively with HMOs having compliance problems that they are either unwilling or unable to resolve in a timely manner.

Medicare: Issues Concerning the HealthChoice Demonstration Project (GAO/HRD-88-69, July 1988).

GAO reviewed a demonstration project involving HealthChoice, Inc., a nonprofit company under contract with Medicare to determine (1) the appropriateness of HCFA to fund such a project, (2) whether HMOs were promoted equally in the project, and (3) whether names and addresses of Medicare beneficiaries, given by HCFA to HealthChoice for HMO promotional materials, were properly safeguarded.

Medicare: Uncertainties Surround Proposal to Expand Prepaid Health Plan Contracting (GAO/HRD-88-14, Nov. 1987).

This report analyzes an HHS proposal to seek legislative authority to contract on a prepaid basis with employer-based health plans to provide Medicare benefits to the employers' retirees under a Medicare Insured Group project.

Medicare: Issues Raised by Florida Health Maintenance Organization Demonstrations (GAO/HRD-86-97, July 1986).

GAO reviewed four components of Medicare's health maintenance organization program: (1) the oversight activities of federal and state HMO

agencies, (2) HMOs' contractual arrangements with their subcontractors, (3) the reasonableness of Medicare payments, and (4) HMOs' grievance procedures and marketing practices. The work focused on four HMOs in Florida.

IV. Long-Term Care

Medicare: Comparison of Two Methods of Computing Home Health Care Cost Limits (GAO/HRD-90-167, Sept. 1990).

As required by the Omnibus Budget Reconciliation Act of 1986, GAO provides information on the potential effect of applying home health cost limits by type of service on Medicare costs and beneficiaries. GAO also reviewed the appropriateness of the percentage-of-mean cost limits in the law.

Nursing Homes: Admission Problems for Medicaid Recipients and Attempts to Solve Them (GAO/HRD-90-135, Sept. 1990).

Problems that Medicaid recipients face when trying to gain admission to nursing homes are discussed. Information is presented on the types of reforms that have been implemented in various states and factors that influence states' willingness to improve access for Medicaid recipients.

In-Home Services for the Elderly: Cost Sharing Expands Range of Services Provided and Population Served (GAO/HRD-90-19, Oct. 1989).

Regulations implementing the Older Americans Act prohibit state agencies from establishing mandatory fees for services financed under the act, though fees may be charged for state-funded services. GAO surveyed state agencies and area agencies on aging to examine (1) the extent to which states currently use cost sharing, (2) the types of services being cost shared, (3) the benefits and disadvantages of cost sharing, (4) the types of fee schedules used, and (5) the characteristics of clients participating in cost-sharing programs.

Medicare: Increased Denials of Home Health Claims During 1986 and 1987 (GAO/HRD-90-14BR, Jan. 1990).

This report analyzes a number of issues related to the increased denials of Medicare home health care claims during 1986 and 1987. In addition, it determined the administrative and legislative changes that have decreased denials since 1987.

Medicare: Assuring the Quality of Home Health Services (GAO/HRD-90-7, Oct. 1989).

This report addresses HCFA's process for certifying home health agencies for participation in the Medicare program, specifically (1) HCFA's guidance to state survey agencies and (2) the adequacy of state surveys of home health agencies.

Medicare: Program Provisions and Payments Discourage Hospice Participation (GAO/HRD-89-111, Sept. 1989).

Why hospices are not participating in Medicare, the reasonableness of hospice payment rates, and hospice quality requirements are addressed.

Long-Term Care Insurance: State Regulatory Requirements Provide Inconsistent Consumer Protection (GAO/HRD-89-67, Apr. 1989).

This report on state regulation of private long-term care insurance provides information on the states' efforts to regulate the content of such policies and the insurers and their agents who market and sell them.

Board and Care: Insufficient Assurances That Residents' Needs Are Identified and Met (GAO/HRD-89-50, Feb. 1989).

Board and care encompasses a wide variety of nonmedical community-based residential facilities—group homes, foster homes, adult homes, domiciliary homes, personal care homes, and rest homes. This report provides information on (1) the size of the board and care industry, (2) characteristics and needs of board and care home residents, (3) the way that states monitor and regulate board and care homes, and (4) the oversight role of HHS. Fieldwork was done in California, Florida, New Jersey, Ohio, Texas, and Virginia to address ways in which states are monitoring and regulating board and care homes.

Long-Term Care for the Elderly: Issues of Need, Access, and Cost (GAO/HRD-89-4, Nov. 1988).

Information on the number of elderly who need long-term care, their access to this care, and the financing and delivery of long-term care in the United States is provided.

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

This report assesses the impact of shifting most payments for home health care from Medicare's Hospital Insurance Program, Part A, to its Supplementary Medical Insurance Program, Part B.

Medicare and Medicaid: Stronger Enforcement of Nursing Home Requirements Needed (GAO/HRD-87-113, July 1987).

GAO analyzed the extent and the potential effect of repeated noncompliance with Medicare and Medicaid nursing home requirements as well as the adequacy of enforcement actions taken by state and federal agencies when deficiencies were identified.

Long-Term Care Insurance: Coverage Varies Widely in a Developing Market (GAO/HRD-87-80, May 1987).

This report examines: (1) which companies market long-term care insurance policies, (2) the range of benefits and costs of policies being sold and availability of coverage for different age groups, (3) whether policies contain clauses that restrict eligibility for benefits, (4) what loss experience data (the expected percentage of benefits paid compared to premiums earned) are available for companies that have sold policies, (5) whether marketing abuses have been identified and the potential for marketing abuse, and (6) what federal laws provide protection to individuals who purchase long-term care insurance.

Posthospital Care: Discharge Planners Report Increasing Difficulty in Placing Medicare Patients (GAO/PEMD-87-5BR, Jan. 1987).

GAO surveyed a stratified random sample of 985 Medicare-certified hospitals to obtain information on the perceived difficulty in the posthospital placement of Medicare patients.

Medicare: Need to Strengthen Home Health Care Payment Controls and Address Unmet Needs (GAO/HRD-87-9, Dec. 1986).

GAO evaluated HCFA's efforts to strengthen internal controls over Medicare payments for home health services, specifically its prepayment utilization review program, its postpayment utilization program, and its evaluation of intermediary performance. This report also evaluated

HCFA's selection of 10 fiscal intermediaries. GAO also assessed the characteristics of Medicare home health beneficiaries, and estimated the number of chronically ill elderly whose home health care needs are not met by Medicare or other caregivers.

Post-Hospital Care: Efforts to Evaluate Medicare Prospective Payment Effects Are Insufficient (GAO/PEMD-86-10, June 1986).

GAO assessed the adequacy of HHS efforts to evaluate the impact of Medicare's prospective payment system on posthospital care. Specifically, the report (1) identified the range of issues regarding PPS's likely impact on Medicare skilled nursing facility and home health care services among other long-term care services; (2) developed criteria to determine the priority of federal evaluation efforts; (3) assessed the availability of important data and developed an evaluation plan; and (4) compared those plan specifications with HHS's proposed evaluation plan and data collection efforts.

V. Administrative Issues

Medicare Claims Processing: HCFA Can Reduce the Disruptions Caused by Replacing Contractors (GAO-HRD-91-44, Apr. 1991).

In December 1989, HCFA changed its claims-processing contractor in Georgia and its data-processing contractor in Florida. GAO determined the impact of these changes on beneficiaries and providers and identified actions that HCFA should take to reduce the impact of any future changes.

Medicare: Millions in Disabled Beneficiary Expenditures Shifted to Employers (GAO/HRD-91-24, Apr. 1991).

The Omnibus Budget Reconciliation Act of 1986 made Medicare the secondary payer for medical expenses of certain disabled beneficiaries covered by large-group health plans. In this report GAO estimates the resulting annual cost savings to Medicare and the effect on employment and employment-based health coverage of disabled beneficiaries and their families.

Medicare: Millions in Potential Recoveries Not Being Sought by Contractors (GAO/T-HRD-91-8, Feb. 1991). Testimony before the Subcommittee on Oversight, House Committee on Ways and Means.

GAO discussed the effectiveness of the Medicare Secondary Payer provisions.

Medicare: Millions in Potential Recoveries Not Being Sought by Maryland Contractor (GAO/HRD-91-32, Jan. 1991).

GAO described a situation in which (1) a Maryland Medicare claims-processing contractor paid at least $8.8 million in claims for which other health insurers may have primary payment responsibilities and (2) the contractor had done little to pursue recovery of the related payments.

Budget Issues: Effects of the Fiscal Year 1990 Sequester on the Department of Health and Human Services (GAO/HRD-90-156FS, Aug. 1990).

GAO identified (1) how resources were reduced in HHS by the fiscal year 1990 sequester and (2) what impact the sequester had on the Department's ability to fulfill its mission and on the people served by its programs. This report described the impact of the sequester on HCFA program management and Medicare benefits.

Medicare: HCFA Can Reduce Paperwork Burden for Physicians and Their Patients (GAO/HRD-90-86, June 1990).

The paperwork required in the Medicare part B claims process is reviewed to assess whether (1) opportunities exist to help providers submit complete claims, (2) notices to beneficiaries explain claims decisions clearly, and (3) electronic services, such as electronic mail, could reduce paperwork.

ADP Budget: Analysis of HCFA's Fiscal Year 1991 ADP Budget Request (GAO/IMTEC-90-67, Sept. 1990).

This report reviews HCFA's justification for $12.2 million requested for three major system enhancement automated data processing (ADP) projects to obtain more ADP and communications equipment, new software development, and related commercial services.

Management of HHS: Using the Office of the Secretary to Enhance Departmental Effectiveness (GAO/HRD-90-54, Feb. 1990).

GAO assessed the Office of the Secretary's role and effectiveness in managing the Department and made specific recommendations to the Secretary for improving management of the Department and helping it prepare for the future.

Medicare: Internal Controls Over Electronic Claims for Anesthesia Services Are Inadequate (GAO/HRD-90-49, Dec. 1989).

This report discusses the inadequacy of internal controls for claims for anesthesia services submitted by electronic media, such as magnetic tape or disk.

Medicare: Effects of Budget Reductions on Contractor Program Safeguard Activities (GAO/T-HRD-90-42, June 14, 1990). Testimony before the Subcommittee on Health, House Committee on Ways and Means.

GAO discussed the adequacy of Medicare contractor budgets in areas relating to program safeguards.

Medicare Part A Reimbursements: Processing of Appeals Is Slow (GAO/HRD-90-23BR, Feb. 1990).

In response to a directive in Senate Report No. 100-399, GAO reviewed the adequacy of staffing levels at the Provider Reimbursement Review Board, a five-member, quasijudicial body that was established under the hospital insurance portion (part A) of the Medicare program.

Medicare: Statistics on the Part B Administrative Law Judge Hearings Process (GAO/HRD-90-18, Nov. 1989).

Statistical information on various aspects of the Medicare part B appeals process is provided. Included are the number of administrative law judge cases filed and their status, the outcome of cases by type of hearing sought, and the time required to complete the hearing process.

Information Technology: Health Care Financing Administration's Budget Process Needs Improvement (GAO/IMTEC-89-31, Aug. 1989).

HCFA's fiscal year 1990 budget request for Information Technology Systems is reviewed to determine if supporting documentation exists for its

data processing needs. GAO also reviewed actions taken by HCFA to reduce the costs of automated data processing operations of insurance companies under contract to HCFA.

Medicare: Incentives Needed to Assure Private Insurers Pay Before Medicare (GAO/HRD-89-19, Nov. 1988).

Contractor activities and other actions that are needed to help assure that the Medicare program does not pay medical bills that other insurers should cover are analyzed.

Internal Controls: Need to Strengthen Controls Over Payments by Medicare Intermediaries (GAO/HRD-89-8, Nov. 1988).

This report discusses (1) HCFA's internal control problems with the resolution of claims processing errors related to Medicare's payments to institutions and (2) the need for incorporating results from external reviews in managing the program.

Medicare: Cutting Payment Safeguards Will Increase Program Costs (GAO/T-HRD-89-6, Feb. 28, 1989). Testimony before the Subcommittee on Labor, Health and Human Services, and Education, Senate Committee on Appropriations.

HCFA's fiscal year 1990 budget request envisioned a 4-percent decrease in the amount allocated per claim for claims processing activities and a one-third reduction in the payment safeguard function. This testimony assesses the impact of such reductions.

Medicare: Contractor Services to Beneficiaries and Providers (GAO/HRD-88-76BR, Mar. 1988).

This report on contractors' performance in fiscal years 1983-87 includes data relating to (1) Medicare claims processing times and accuracy; (2) review of appealed claims cases; (3) processing of hearings related to appealed claims; (4) written, telephone, and walk-in inquiries by beneficiaries and providers; and (5) education of beneficiaries and providers about Medicare coverage and requirements.

Financial Management: Continued Top Management Support Needed to Improve HHS' Accounting Systems (GAO/AFMD-88-37, Sept. 1988).

GAO's objectives were to (1) identify and describe HHS' financial management systems, (2) determine if these systems effectively account for and control departmental funds and other resources, (3) determine if the systems provide accurate and reliable information on the results of financial operations, (4) identify any major system weaknesses, and (5) examine HHS' actions to correct system weaknesses.

HCFA Research: Agency Practices and Other Factors Threaten Quality of Mandated Studies (GAO/PEMD-88-9, June 1988).

This report assesses the quality of research and evaluation at HCFA. It examines three major elements of quality: the relevance of HCFA research to congressional requests, the timeliness of products, and the technical adequacy of the work. GAO examined each of these elements at each of the three stages of the research and evaluation process—planning, project execution, and report review.

Medicare: Rehabilitation Service Claims Paid Without Adequate Information (GAO/HRD-87-91, July 1987).

GAO determined the appropriateness of Medicare payments made by intermediaries to rehabilitation agencies and Comprehensive Outpatient Rehabilitation Facilities for rehabilitation services under the Medicare program.

Medicare: More Hospital Costs Should Be Paid by Other Insurers (GAO/HRD-87-43, Jan. 1987).

GAO reviewed HHS implementation of legislative requirements that other insurers covering Medicare beneficiaries pay medical claims ahead of Medicare. The report identifies barriers to a more effective system for identifying and billing primary insurers.

Medicare: Simplified Processing of Deceased Beneficiaries' Claims to Be Implemented (GAO/HRD-88-99, June 1988).

This report concerns the timeliness of processing deceased beneficiary claims under the Medicare program.

Medicare Claims: HCFA Proposal to Establish Administrative Law Judge Unit (GAO/HRD-88-84BR, Apr. 1988).

HCFA's proposal to establish its own hearings and appeals unit to handle Medicare hearings and appeals is assessed.

Medicare: Performance of Blue Shield of Massachusetts Under the Tri-State Contract (GAO/HRD-88-81BR, Mar. 1988).

The performance of Blue Shield of Massachusetts as the Medicare Part B carrier for New Hampshire, Vermont, and Maine is reviewed. The areas of concern included claims payment timeliness and accuracy, telephone service, reviews of denied claims, responses to written inquiries, and requests for information already provided.

Medicare: Existing Contract Authority Can Provide for Effective Program Administration (GAO/HRD-86-48, Apr. 1986).

As required by the Deficit Reduction Act of 1984, this report assesses whether (1) the advantages of fixed-price competition justify broader use of this method of contracting in the Medicare program and (2) HHS's current authority is sufficient to achieve increased administrative efficiency without a change in contracting methods.

VI. Quality Assurance Activities

Medicare: PRO Review Does Not Assure Quality of Care Provided by Risk HMOs (GAO/HRD-91-48, Mar. 1991).

GAO examined the extent to which the PRO review program provides reasonable assurance that Medicare beneficiaries enrolled in risk HMOs are receiving quality health care. The report contains an analysis of the effectiveness of the PRO review of the (1) internal quality assurance programs at risk HMOs and (2) health care provided by these HMOs.

Medicare: PRO Review Does Not Assure Quality of Care Provided by Risk HMOs (GAO/T-HRD-91-12, Mar. 1991). Testimony before the Senate Special Committee on Aging.

The testimony summarized the report cited previously (GAO/HRD-91-48).

Health Care: Criteria Used to Evaluate Hospital Accreditation Process Need Reevaluation (GAO/HRD-90-89, June 1990).

This report discusses (1) the number of HCFA hospital validation surveys conducted from fiscal years 1980 to 1987, (2) how often HCFA compares its survey findings with Joint Commission survey findings, and (3) how effective HCFA surveys are in determining whether problems identified by the Joint Commission have been corrected. GAO described the problems encountered by HCFA in comparing its survey results with those of the Joint Commission.

Information System: National Health Practitioner Data Bank Has Not Been Well Managed (GAO/IMTEC-90-68, Aug. 1990).

GAO reviewed and assessed the Health Resources and Services Administration's development of the National Practitioner Data Bank.

Health Care: Limited State Efforts to Assure Quality of Care Outside Hospitals (GAO/HRD-90-53, Jan. 1990).

Information on the state requirements relating to quality assurance for health care delivered by both freestanding providers and HMOs is presented. It includes information on state quality assurance activities concerning (1) licensing, inspection, and enforcement for 16 types of freestanding providers and (2) inspection and enforcement activities for HMOs.

Medicare and Medicaid: More Information Exchange Could Improve Detection of Substandard Care (GAO/HRD-90-29, Mar. 1990).

GAO determined (1) whether peer review organizations, Medicare carriers, and state Medicaid agencies reviewed services provided by the same physicians, (2) whether these review entities regularly exchanged information on such physicians who were found to provide unnecessary or poor-quality care, and (3) whether legal restrictions on such exchanges existed.

Basic Elements of an Infection Control Program (GAO/HRD-90-25, Jan. 1990).

The Centers for Disease Control estimates that about 5 percent of all hospital patients contract at least one infection during their stay. Working with health care organizations like the American Hospital

Association and the Centers for Disease Control, GAO prepared a list of 56 elements that experts say are necessary for effective infection control programs in hospitals.

Quality Assurance: A Comprehensive National Strategy for Health Care Is Needed (GAO/PEMD-90-14BR, Feb. 1990).

GAO addressed the following four elements viewed essential to a comprehensive national strategy: (1) national practice guidelines and standards of care; (2) enhanced data to support quality assurance activities; (3) improved approaches to quality assessment and assurance at the local level; and (4) a national focus for developing, implementing, and monitoring a national system.

Medicare: Improvements Needed in the Identification of Inappropriate Hospital Care (GAO/PEMD-90-7, Dec. 1989).

This report (1) examined available information on the extent of inappropriate care in the Medicare program, (2) described the current approaches used by Medicare and the private sector to review the appropriateness of hospital care, and (3) suggested approaches that might reduce the level of inappropriate care in the Medicare program.

Laboratory Accreditation: Requirements Vary Throughout the Federal Government (GAO/RCED-89-102, Mar. 1989).

GAO examined laboratory accreditation requirements of the various federal government programs and determined which, if any, had overlapping requirements that could be streamlined. This report also includes information on other issues associated with laboratory accreditation, such as the potential for more universal charging of user fees and possible focusing of accreditation at the national level in the interest of U.S. competitiveness.

Medicare: Statutory Modifications Needed for the Peer Review Program Monetary Penalty (GAO/HRD-89-18, Mar. 1989).

This report evaluated HHS's Office of Inspector General policy and procedures for responding to peer review organizations' recommendations for monetary penalties against hospitals and physicians who have delivered improper or unnecessary care.

Medicare: An Assessment of HCFA's 1988 Hospital Mortality Analyses (GAO/PEMD-89-11BR, Dec. 1988).

GAO examined the analytical approach that HCFA employed in its 1988 analyses of Medicare hospital mortality. This report also assessed the extent to which HCFA resolved the issues previously raised by GAO concerning the 1987 hospital mortality analyses.

Medicare PROs: Extreme Variation in Organizational Structure and Activities (GAO/PEMD-89-7FS, Nov. 1988).

In this report, GAO described four aspects of the operations of peer review organizations: (1) organizational characteristics, (2) review activities, (3) PRO objectives and interventions, and (4) relationships with other health and consumer groups in the state in which the PRO is located.

Medicare: Physician-Sponsored Organizations Receive Priority for Peer Review Contracts (GAO/HRD-88-43, Jan. 1988).

GAO assessed whether HCFA had complied with the requirement that physician-sponsored organizations be given preference in the award of Medicare's PRO contracts.

Medicare: Improved Patient Outcome Analyses Could Enhance Quality Assessment (GAO/PEMD-88-23, June 1988).

GAO (1) examined HCFA's analyses and uses of existing administrative data to monitor patient outcomes under Medicare, (2) compared HCFA's approaches to those developed by HCFA contractors and independent researchers, and (3) examined the feasibility of using Medicare administrative data to assess the effects of Medicare's prospective payment system on patient outcomes.

Medicare: Better Controls Needed for Peer Review Organizations' Evaluations (GAO/HRD-88-13, Oct. 1987).

HCFA's evaluation of the PROs' performance during the 1984-86 contract period is discussed. The report also discusses HCFA's process for determining program funding for the 1986-88 contract period.

Medicare: Improving Quality of Care Assessment and Assurance (GAO/PEMD-88-10, May 1988).

GAO's findings on systems for measuring and monitoring the quality of care provided to Medicare beneficiaries are summarized in this report. GAO assessed the need for systematic evaluation of quality review methods, better coordination among the quality-related activities of Medicare contractors, and improvements to data systems reporting the incidence and distribution of quality of care problems. GAO also reviewed quality assurance research and evaluation activities with HHS and assessed the need for longer term changes.

Health Facilities: Problems at Harlem Hospital in Complying With Medicare Standards (GAO/HRD-87-58, Feb. 1987).

GAO obtained information on (1) Harlem Hospital Center's compliance with Medicare's program standards and (2) actions taken by the New York State Department of Health and HCFA to address deficiencies at the hospital.

Medicare: Preliminary Strategies for Assessing Quality of Care (GAO/PEMD-87-15BR, July 1987).

GAO reviewed activities of HHS to measure and monitor the quality of care received by Medicare beneficiaries. This report examined the options for short-term improvements in the measurement of quality of care and developed recommendations for a long-term effort with regard to measuring and monitoring quality of care.

Medicare: Reviews of Quality of Care at Participating Hospitals (GAO/HRD-86-139, Sept. 1986).

GAO examined (1) HCFA's peer review organization monitoring processes and its internal control of those processes at the Atlanta and San Francisco regional offices and at HCFA's headquarters in Baltimore, (2) HCFA's scope of work for the 1984-86 and 1986-88 PRO contract periods, and (3) processes used by the PROs for California, Florida, and Georgia to implement the initial scope-of-work requirements.

VII. Health Insurance and Coverage Issues

Medigap Insurance: Better Consumer Protection Should Result From 1990 Change to Baucus Amendment (GAO/HRD-91-49, Mar. 1991).

GAO reviewed state efforts to regulate Medigap insurance and to educate consumers about these kinds of policies. Four specific questions were addressed: (1) What have been the results of state activities to identify and prevent abusive sales practices? (2) How do states monitor Medigap advertising to prevent use of deceptive materials? (3) How effective have state efforts been to educate the elderly about Medigap policies? (4) What percentage of premium dollars are returned as benefits to Medigap policyholders?

Health Insurance Coverage: A Profile of the Uninsured in Selected States (GAO/HRD-91-31FS, Feb. 1991).

This report presents income, employment, and demographic characteristics of under age 65 uninsured populations in the United States and the 15 states that had the largest numbers of uninsured during 1988. GAO used the Bureau of the Census' March 1989 Current Population Survey for its analysis of the data in this report.

Health Insurance: A Profile of the Uninsured in Michigan and the United States (GAO/HRD-90-97, May 1990).

GAO developed data on income, employment, and demographic characteristics of under age 65 uninsured populations in the United States and Michigan during 1987 using the Bureau of the Census' March 1988 Current Population Survey for 1987.

Employee Benefits: Extent of Companies' Retiree Health Coverage (GAO/HRD-90-92, Mar. 1990).

This report provides information on the extent to which companies provide retiree health benefits, including (1) the percentage of companies with retiree health plans, (2) the number of workers enrolled in company health plans that extend coverage to retirees, (3) the number of retirees enrolled in company health plans, and (4) the percentage of companies that have terminated retiree health plans since 1984. Surveys were sent to a stratified, random sample of 5,550 companies.

Medicare: Employer Insurance Primary Payer for 11 Percent of Disabled Beneficiaries (GAO/HRD-90-79, May 1990).

As required by statute, GAO estimated the number of disabled Medicare beneficiaries for whom Medicare became the secondary payer because they were insured through their own or a family member's employment.

Health Insurance: Cost Increases Lead to Coverage Limitations and Cost Shifting (GAO/HRD-90-68, May 1990).

GAO examined the impacts resulting from private sector cost-containment efforts, specifically: (1) private sector cost-cutting initiatives that affect employee costs and access to health insurance, (2) changes in the nature and structure of health benefits plans, and (3) special problems facing employees of small firms.

Medicare Catastrophic Act: Estimated Effects of Repeal on Medigap Premiums and Medicaid Costs (GAO/HRD-90-48FS, Nov. 1989).

GAO surveyed 29 commercial Medicare supplemental insurance companies and 50 state Medicaid agencies (37 of which could provide data) to obtain estimates of impact of the repeal of the Medicare Catastrophic Coverage Act of 1988 on Medigap premiums and Medicaid budgets.

Medigap Insurance: Proposals for Regulatory Changes and 1988 Loss Ratio Data (GAO/T-HRD-90-35, June 7, 1990). Testimony before the Subcommittee on Health and the Environment, House Committee on Energy and Commerce.

GAO discussed the impact of proposed legislation on the marketing and performance of Medicare supplemental insurance.

Health Insurance: Availability and Adequacy for Small Businesses (GAO/T-HRD-90-33, June 5, 1990). Testimony before the Subcommittee on Antitrust, Monopolies and Business Rights, Senate Committee on the Judiciary.

GAO discussed the problems small businesses have in providing health insurance to their employees.

Medigap Insurance: Premiums and Regulatory Changes After Repeal of the Medicare Catastrophic Coverage Act and 1988 Loss Ratio Data (GAO/T-HRD-90-16, Mar. 13, 1990). Testimony before the Subcommittee on Health, House Committee on Ways and Means.

GAO discussed the survey results regarding 1990 Medigap premiums of 29 commercial insurers. GAO also discussed the percentage of premiums paid out as benefits (the loss ratios) in 1988 and recent changes in federal and state regulatory requirements for Medigap policies.

Medicare Catastrophic Act: Options for Changing Financing Benefits (GAO/HRD-89-156, Sept. 1989).

The Medicare Catastrophic Coverage Act of 1988 is reviewed, including a summary of the options available to either (1) revise the benefits and financing under the act or (2) phase out the program.

U.S. Employees Health Benefits: Rebate for Duplicate Medicare Coverage (GAO/HRD-89-58, Mar. 1989).

The report provides information on duplication of benefits provided under the Federal Employees Health Benefits Program and the Medicare Catastrophic Coverage Act of 1988. The report also assessed whether the program's rebate amount for duplicate coverage was set at an appropriate amount for 1989.

Employee Benefits: Companies' Retiree Health Liabilities Large, Advance Funding Costly (GAO/HRD-89-51, June 1989).

GAO estimated the present value of future liabilities for U.S. companies' retiree health benefits. The report also discussed funding alternatives for these liabilities.

Health Insurance: An Overview of the Working Uninsured (GAO/HRD-89-45, Feb. 1989).

GAO compiled information on the working uninsured and, where appropriate, identified gaps and limitations in the available data.

Employee Benefits: Company Actions to Limit Retiree Health Costs (GAO/HRD-89-31BR, Feb. 1989).

GAO provided information on (1) companies' flexibility to change their health plans to cope with rising retiree benefit costs, (2) how companies have used this flexibility to make changes, and (3) additional changes that might be forthcoming.

Health Insurance: Bibliography of Studies on Health Benefits for the Uninsured (GAO/HRD-89-27FS, Feb. 1989).

An annotated bibliography of studies concerning health benefits for the uninsured is provided in this report.

Medigap Insurance: Effects of the Catastrophic Coverage Act of 1988 on Future Benefits (GAO/T-HRD-89-22, June 1, 1989). Testimony before the Senate Committee on Finance.

GAO discussed changes in Medicare benefits under the Medicare Catastrophic Coverage Act of 1988, the effect of such changes on Medigap policies, and the percentage of Medigap premiums returned as benefits (loss ratios).

Medigap Insurance: Effects of the Catastrophic Coverage Act of 1988 on Benefits and Premiums (GAO/T-HRD-89-13, Apr. 6, 1989). Testimony before the Subcommittee on Commerce, Consumer Protection, and Competitiveness, House Committee on Energy and Commerce.

GAO discussed changes in Medicare benefits under the Medicare Catastrophic Coverage Act of 1988, how such changes affect Medigap policies, and the percentage of Medigap premiums returned as benefits (loss ratios).

Health Insurance: Hospital Indemnity and Specified Disease Policies Are of Limited Value (GAO/HRD-88-93, July 1988).

GAO analyzed (1) the effectiveness of state regulation of policies and practices for hospital indemnity and specified disease insurance, (2) the types of coverage provided under those policies, (3) the premiums earned and benefits paid on hospital indemnity and specified disease policies from 1982 through 1986, and (4) the percentage of premiums returned to policyholders as benefits.

Health Insurance: A Profile of the Uninsured in Ohio and the Nation (GAO/HRD-88-83, Aug. 1988).

Information is provided on the (1) growth of the uninsured population between 1982 and 1985, (2) characteristics of the uninsured population in the nation and Ohio, (3) health insurance costs and affordability in Ohio, and (4) federal, state, and local programs in Ohio that assist the uninsured with their health care needs.

Health Insurance: Risk Pools for the Medically Uninsurable (GAO/HRD-88-66BR, Apr. 1988).

GAO assessed state-administered health insurance risk pool programs to determine their program characteristics, operation, enrollment, financial experience, characteristics of the insured persons, and success in meeting expectations.

Medicare: Comparison of Catastrophic Health Insurance Proposals—An Update (GAO/HRD-88-19BR, Oct. 1987).

GAO updated information on the potential effects of alternative legislative proposals for providing catastrophic illness insurance on Medicare beneficiary out-of-pocket costs.

Medicare: Comparison of Catastrophic Health Insurance Proposals (GAO/HRD-87-92BR, June 1987).

GAO analyzed and compared the potential effects of alternative legislative proposals for providing catastrophic illness insurance on Medicare beneficiaries' out-of-pocket costs.

Medicare: Catastrophic Illness Insurance (GAO/PEMD-87-21BR, July 1987).

This report assessed alternative legislative proposals for providing insurance against the expenses of catastrophic illness by reviewing the associated changes in enrollee benefits, enrollee costs, and Medicare financing mechanisms. GAO established a context for the assessment by identifying important, unresolved, and controversial issues and by discussing the structure, cost, and administration of five state-financed catastrophic insurance programs.

Medigap Insurance: Law Has Increased Protection Against Substandard and Overpriced Policies (GAO/HRD-87-8, Oct. 1986).

GAO reviewed compliance with federal standards regarding Medicare supplemental insurance policies sold by the private sector to the elderly. Information on legal sanctions imposed for abusive sales practices was also analyzed.

VIII. Medical Malpractice

Medical Malpractice: Few Claims Resolved Through Michigan's Voluntary Arbitration Program (GAO/HRD-91-38, Dec. 1990).

An arbitration program established by Michigan's Medical Malpractice Arbitration Act of 1975, which resolves claims through a voluntary binding arbitration process, rather than through a court trial, is reviewed in this report. GAO assessed the Michigan program to determine (1) the extent of hospital, health care provider, and patient participation, (2) the arbitration alternative's effect on medical malpractice claims resolution, and (3) whether arbitration contributed to reducing medical malpractice insurance costs.

Medical Malpractice: A Continuing Problem With Far-Reaching Implications (GAO/T-HRD-90-24, Apr. 26, 1990). Testimony before the Subcommittee on Health, House Committee on Ways and Means.

The cost of medical malpractice and limits to legislative reform are discussed in this testimony. In GAO's view, fundamental issues that should be addressed include how to (1) reduce the incidence of negligent care, (2) fairly compensate individuals injured through medical negligence, and (3) deal with the complexities involved in efforts to enhance overall quality of care provided in this country.

Medical Malpractice: A Framework for Action (GAO/HRD-87-73, May 1987).

The purpose of this report, the final one in a series of five reports, is to suggest actions that appear to GAO to be appropriate beginnings to address medical malpractice problems.

Medical Malpractice: Characteristics of Claims Closed in 1984 (GAO/HRD-87-55, Apr. 1987).

Information on the characteristics of a sample of malpractice claims closed in 1984 is presented in this report. From a universe of 102 insurers, GAO randomly selected 25. The report includes information about awards/settlements, the nature of patient injuries, the length of time for claims processing and resolution, and the health care providers involved in claims.

Medical Malpractice: Six State Case Studies Show Claims and Insurance Costs Still Rise Despite Reforms (GAO/HRD-87-21, Dec. 1986).

This report contains information on the medical malpractice insurance situation, problems, and reforms in six states (Arkansas, California,

Florida, Indiana, New York, and North Carolina). GAO obtained views of organizations representing physicians, hospitals, insurers, and lawyers in the six states on perceived malpractice problems, actions taken to deal with the problems, the results of these actions (including the effects of state tort reforms), and the need for federal involvement. GAO also surveyed the nonfederal hospitals in each state about the sources, coverage limits, and costs of their malpractice insurance. GAO requested leading insurers in each state to provide data for physicians and hospitals regarding the cost of malpractice insurance, the frequency of claims, the average amount paid per claim, and the cost to investigate and defend against malpractice claims. The following separate documents prepared as supplements to this report discuss GAO's work in each state:

(1) Medical Malpractice: Case Study on Arkansas (GAO/HRD-87-21S-1, Dec. 1986).

(2) Medical Malpractice: Case Study on California (GAO/HRD-87-21S-2, Dec. 1986).

(3) Medical Malpractice: Case Study on Florida (GAO/HRD-87-21S-3, Dec. 1986).

(4) Medical Malpractice: Case Study on Indiana (GAO/HRD-87-21S-4, Dec. 1986).

(5) Medical Malpractice: Case Study on New York (GAO/HRD-87-21S-5, Dec. 1986).

(6) Medical Malpractice: Case Study on North Carolina (GAO/HRD-87-21S-6, Dec. 1986).

Medical Malpractice: Insurance Costs Increased but Varied Among Physicians and Hospitals (GAO/HRD-86-112, Sept. 1986).

Information on the cost of medical malpractice insurance for physicians and hospitals is presented. The physicians' data are reported by physician specialty, geographic location, and as a percentage of practice costs. GAO analyzed the hospital data in terms of cost per inpatient day, a commonly used measure for hospitals. This information is presented by hospital size and region.

Medical Malpractice: No Agreement on the Problems or Solutions (GAO/HRD-86-50, Feb. 1986).

This report presents the views of 37 nationally based organizations representing medical, legal, and consumer interests on the medical malpractice issue and what to do about it. The report also discusses the advantages and tradeoffs of a number of alternatives to the current system for resolving malpractice claims.

IX. Other Medicare Issues

Medicare: Options to Provide Home Dialysis Aides (GAO/HRD-90-153, Aug. 1990).

When Home Intensive Care, Inc., stopped providing home dialysis aides to patients in February 1990, alternative dialysis sources had to be found for many of its dialysis patients. GAO assessed the circumstances under which it might be cost effective to authorize Medicare payments for an aide under the end renal stage disease program.

Medicare: Payments for Home Dialysis Much Higher Under Reasonable Charge Method (GAO/HRD-90-37, Oct. 1989).

GAO reviewed Medicare's payment calculation for Home Intensive Care, Inc., dialysis services. This firm received twice as much per home patient for furnishing dialysis supplies and equipment as a facility would have received for serving the same patient at home.

Medicare and Medicaid: Updated Effects of Recent Legislation on Program and Beneficiary Costs (GAO/HRD-88-85, July 1988).

The effects of legislation since 1980 on Medicare and Medicaid program costs and on beneficiary out-of-pocket costs are discussed.

Medicare: Change in Contingency Reserve Funding Held Down Increase in Part B Premium (GAO/HRD-88-40BR, Nov. 1987).

GAO describes HCFA's changes in the way it computed the amount in the 1988 Part B premium of Medicare necessary to ensure an adequate reserve to cover contingencies.

Medicare: Laboratory Fee Schedules Produced Large Beneficiary Savings but No Program Savings (GAO/HRD-88-32, Dec. 1987).

As required by the Deficit Reduction Act of 1984, GAO examined (1) the effect on beneficiary and program costs of fee schedules for Medicare-covered clinical diagnostic laboratory services furnished by physicians, independent laboratories, and hospitals on an outpatient basis, (2) the effect of the fee schedules on the volume and quality of clinical laboratory services, and (3) the potential effects of adopting a national fee schedule.

Medicare: Legislative Amendment Would Avoid Adverse Effects on Disabled Beneficiaries (GAO/HRD-87-135, Sept. 1987).

As required by statute, GAO evaluated the impact of the Medicare secondary payer provisions, specifically: (1) the number of disabled beneficiaries for whom Medicare became the secondary payer, (2) the resulting annual savings, and (3) the effect on employment and health insurance coverage of disabled individuals and their family members.

Medicare and Medicaid: Effects of Recent Legislation on Program and Beneficiary Costs (GAO/HRD-87-53, Apr. 1987).

GAO analyzed the effects of major legislative changes from 1980 onward on Medicare and Medicaid program costs and the out-of-pocket costs to the programs' beneficiaries.

Medicare: Prescription Drug Issues (GAO/PEMD-87-20, July 1987).

GAO determined (1) the usage and cost of prescription drugs for the elderly, (2) prescription drug benefits covered under Medicare, (3) prescription drug benefits covered by Medicaid, (4) which states have separate programs to provide assistance to the elderly for prescription drugs, what kind of assistance these programs provide, and who benefits from them, and (5) what provisions of H.R. 2470 and S. 1127 cover prescription drug benefits and the extent of coverage for the elderly.

Medicare and Medicaid: Budget Issues (GAO/T-HRD-87-1, Jan. 1987). Testimony before the Subcommittee on Health, Senate Committee on Finance.

GAO presented information on the impact of legislated changes and discussed areas where additional changes could be warranted.

An Aging Society: Meeting the Needs of the Elderly While Responding to Rising Federal Costs (GAO/HRD-86-135, Sept. 1986).

GAO analyzed the (1) demographic changes in the elderly population, (2) relationship of these changes to the elderly's retirement income status and to their need for, use of, and expenditures for acute health care and long-term care services, and (3) extent to which potential changes to federal health and retirement programs could affect the current and future needs of the elderly.

Medicare: Comments on HHS Proposal to Revise End Stage Renal Disease Facility Payment Rates (GAO/HRD-86-126BR, July 1986).

HHS's proposed revisions to Medicare's payment rates for facilities participating in the End Stage Renal Disease Program are evaluated. GAO also reviewed a critique of the proposal and a sample of other public comments submitted to HHS on the proposal.

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