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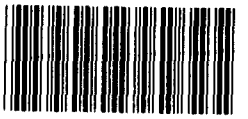

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Medicare: Further Changes Needed to Reduce Program Costs

Statement of
Charles A. Bowsher
Comptroller General of the United States

Before the
Subcommittee on Health
Committee on Ways and Means
House of Representatives

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss actions needed to control rising Medicare costs. Earlier this year I appeared before the full committee to discuss broad strategies to control national health care spending. Today, I will focus on specific steps to address Medicare's cost growth.

To underscore the importance of today's discussion, I would like to put the growth of health spending in the context of the federal budget problem. Since 1980, health spending has been the second fastest growing component of the federal budget, trailing only interest expense on the burgeoning national debt. As federal health outlays have risen, Medicare has increased its budgetary importance and is consuming larger portions of the federal health care dollar. Even after adjusting for increases in beneficiaries, Medicare costs are still growing faster than general inflation or the gross national product. Consequently, an important step in getting the federal budget under control is to get Medicare spending under control.

Therefore, I will be focusing today first on changes to Medicare payment methods that will reduce program spending and then on ways to improve program administration to help minimize program losses due to waste, fraud, and abuse. My comments and the report we are releasing today, Medicare: Further Changes Needed to Reduce Program and Beneficiary Costs (GAO/HRD-91-67),

draw on GAO's work identifying areas for over $1 billion in savings and include a recommendation on how to ensure better program administration.

OPPORTUNITIES TO REDUCE MEDICARE PAYMENTS TO PROVIDERS

Congressional actions over the last decade have resulted in major reforms in the way Medicare pays hospitals and physicians. The adoption of a prospective payment system (PPS) for hospitals and comprehensive physician payment reform were two bold steps providing Medicare with a framework for effective cost containment. Indeed, in our work looking at several other countries' health care systems, we have found that PPS is being considered as a model for their reform efforts. Yet, as the Subcommittee is aware, much remains to be done to ensure that these reforms realize their full potential.

Growth in Medicare spending has accelerated each year since 1986. In 1989, Medicare expenditures increased nearly 13 percent over spending in 1988--exceeding the 11-percent growth in the nation's total spending for health care. The Congressional Budget Office projects that over the next 5 years Medicare outlays will increase nearly 70 percent--from $105 to $177 billion.

Looking further into the future, the Medicare trustees project that the Hospital Insurance Trust Fund will be depleted in about 15 years. Further, the rapid growth in physician-related expenditures, if left unchecked, will place an increasing burden on both the federal budget and beneficiaries whose Medicare premiums are currently structured to offset 25 percent of these expenditures. Consequently, much of our work has been and will continue to be focused on identifying ways to reduce or refine Medicare payment amounts and methods. I will give a few examples of areas we have identified where action is needed.

One area of concern is continued overpayment for diagnostic services. We have found, for example, that Medicare payment rates for clinical diagnostic laboratory services remain excessive. Despite recent fee reductions, the five largest laboratories participating in the Medicare program had profits on Medicare business that were 11 percent higher than their overall profit rates. In effect, Medicare was subsidizing other laboratory customers. Reducing Medicare payments for clinical laboratory services by an amount that would eliminate this profit rate disparity could save Medicare about $150 million annually.

Another 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 driving health care cost inflation. 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. Medicare payment rates established for technology when it is new, however, are not systematically adjusted downward as the technology ages and unit costs decline. Failing to make such adjustments results in unnecessarily high Medicare payments and encourages an oversupply of the equipment because profits can be earned at inefficient levels of operation. We are developing a method that might be considered to make such adjustments.

The prospective payment system for hospitals is another area that requires continuing attention. For PPS to remain a factor in containing hospital cost growth, payment rates must be closely monitored to assure that they remain appropriate relative to hospitals' costs and that they provide incentives for efficient operations. Payments to teaching hospitals are one area where we believe payments have been and remain excessive.

Our work and that of others has shown that Medicare substantially overcompensates teaching hospitals for the indirect costs they incur as a result of their teaching programs. 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 these hospitals for Medicare's portion of their indirect teaching costs.

One of the problems of reducing the additional payments for teaching costs is the adverse effect it could have on certain hospitals, mainly large inner city hospitals that have high levels of charity care. The charity care problem will continue as long as a portion of our population lacks resources to pay for hospital care. We believe that, in the absence of universal health insurance coverage, concerns about charity care costs should be addressed through a direct and targeted approach, not through PPS's indirect teaching adjustment. These two concerns, Medicare overpayments and charity care problems, should be addressed in concert.

Lastly, implementing the recently adopted resource-based physician payment system provides opportunities to bring the most rapidly growing segment of Medicare costs under control. Between 1975 and 1990 Medicare benefit payments for physician services increased more than ninefold, from about $3 billion to $29 billion.

We believe that the key to control is effective implementation of the volume growth goals that in effect place an overall limit on expenditures for physician services. 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. Volume performance standards are the new reform's method to overcome this shortcoming. The Congress sought to provide a way to remove excess volume growth from Medicare, and we believe it chose a method with a high potential for success. In my earlier testimony before the full committee, I cited spending targets for major health care sectors as one of the methods used by other countries that have been most successful at cost containment. Consequently, we believe the implementation of the Medicare physician reforms is important not only to control Medicare costs but as a possible model for reforming physician payments overall.

BUDGET CUTS UNDERMINE ACTIVITIES TO PREVENT FRAUD, WASTE, AND ABUSE

Along with the changes in Medicare payments to control costs, program administration must be improved to assure that Medicare pays appropriately for services that beneficiaries receive. We have identified Medicare as a program that may be vulnerable to large losses to the taxpayer through mismanagement, waste, and abuse.

In a series of ongoing reviews, we are finding that program dollars are not being protected adequately. We believe that part

of this mismanagement may be attributable to budget cutbacks that have affected program administration. In short, spending too little on administration translates into spending too much on the program. The effect is to forgo hundreds of millions of dollars in savings that could otherwise be attained.

Many of Medicare's administrative activities are carried out by contractors. The Health Care Financing Administration (HCFA) contracts with insurance companies to process and pay Medicare claims as well as perform a broad range of safeguard activities. Generally speaking, contractors assure that provider payments are limited to claims for covered, medically necessary services as determined by Medicare rules. The contractors are also the main channel of communication between beneficiaries and providers for matters relating to claims and coverage issues.

Cutbacks in Safeguard Activities Result in Large Program Losses

Though Medicare's payment safeguard activities are cost-effective--returning nearly $14 for every dollar spent--contractor budgets to perform these functions have been cut each year since 1989. The administration requested $333 million for fiscal year 1992 for program safeguard activities, less than the amount spent in 1989, while projecting a 40-percent increase in the number of claims contractors will process. In 1990, HCFA

estimated total savings foregone as a result of the reduction in Medicare safeguard activities to be nearly $500 million.

Even now, funding reductions have caused contractors to cut back on medical and utilization reviews that are essential in detecting and preventing erroneous payments. Contractors also attribute inadequate funding as the reason for not pursuing hundreds of millions of dollars owed to Medicare by private insurers and for fewer audits of the billions of dollars of costs claimed by institutional providers.

Failure to recover money from private insurers who cover Medicare beneficiaries is one of the more costly and pervasive problems we found in each of our contractor reviews. For example, one contractor had over a 3,000-case backlog where Medicare mistakenly paid about $8.8 million for services to beneficiaries who may have had private insurance. Although the contractor had identified private insurers after paying the beneficiaries' claims, it did little to recover the payments because of staffing constraints. Not coincidentally, the contractor's budget for this activity was significantly reduced in fiscal year 1990 and was not fully restored in 1991.

The irony of this situation is that in 1989 the Congress significantly strengthened HCFA's ability to identify beneficiaries having other insurance by authorizing such actions

as Internal Revenue Service (IRS) data matches with Medicare records. The Congress anticipated additional Medicare savings of $1.6 billion over the next 3 fiscal years. Although tools such as the IRS data match have enhanced HCFA's potential to identify cases of mistaken Medicare payments, the anticipated program savings may never be realized if contractors are not given the necessary resources to recover the mistaken payments.

Another aspect of recovering payments involves collecting Medicare overpayments, or "credit balances," from hospitals. These credit balances, which represent monies due Medicare, often occur when both Medicare and another insurer pay for the same services. Here too we found significant problems with contractors' ability to identify and collect overpayments.

To illustrate the problem, we identified $545,000 in credit balances owed Medicare by two local hospitals. Although these amounts had been outstanding for an average of 15 months, the contractor did little to recover the money. In fact, even when other hospitals we reviewed notified their respective contractors of the credit balances, collection action was seldom initiated. Apparently, the contractors had placed little priority on this area because of resource constraints.

Proposals to Trim Beneficiary and Provider Services Can Be Costly

Proposed cutbacks in beneficiary and provider services are another area of contractor budgets that concerns us. Medicare beneficiaries are HCFA's first line of defense against provider fraud and abuse. Medicare contractors estimate that beneficiaries make about 90 percent of the fraud and abuse complaints referred for investigation. However, HCFA's fiscal year 1992 budget request reduces by nearly 60 percent the funding for contractor staff who respond to beneficiary inquiries. Such a significant reduction in the number of operators answering beneficiary telephone calls could result in contractors' losing over 900,000 fraud and abuse complaints a year.

HCFA's funding for contractor hearings and appeals activities is another area of beneficiary and provider services targeted for a 60-percent funding reduction. When beneficiaries or providers question a contractor's payment decisions, they are entitled by law to request that the contractor reconsider its initial payment decision. The resulting hearings and appeals activities help assure that beneficiaries and providers are not inappropriately denied payment.

Yet HCFA estimates that if its proposed cutbacks are authorized, nearly 70 percent of the hearings and reconsiderations

expected in 1992 will be delayed. This means that 7 million cases, most of which involve Medicare beneficiaries, could encounter delays of 250 or more days before contractors consider their cases. Encouraging contractors to be aggressive in identifying and denying questionable claims, while limiting their ability to provide beneficiaries and providers their rights to question contractor actions, is a formula for serious problems.

Contractor Budgets Should Be Increased

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 contractors' payment safeguard activities. We will also be issuing a series of reports on this issue starting later this year. HCFA likewise has concerns about the existing administrative structure and has undertaken a Medicare Contractor Reform Initiative to address these issues.

At least until 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.

The Budget Enforcement Act of 1990, however, imposed constraints on federal spending. This law provides, in general, that federal discretionary spending, which includes Medicare administrative expenditures, be subject to spending limits. The savings achieved are classified as mandatory, and so would not count as offsets to the increased spending for safeguard activities. This spending would, therefore, require cuts elsewhere in discretionary spending to remain within the established limits.

In recognition of a similar situation, the Budget Enforcement Act provided for discretionary spending increases for IRS compliance funding outside of the domestic discretionary funding caps. This permitted additional funding for IRS enforcement activities, without necessitating spending cuts elsewhere.

Because of the strong potential for a net reduction in federal spending, we recommend that the Congress establish a similar scorekeeping procedure so that increased expenditures to fund Medicare administrative costs for enforcement do not require offsetting reductions in domestic discretionary programs.

CONCLUSIONS

Medicare payment reforms can directly reduce program expenditures. The proposals set out above represent ways to

enhance the effect of the Medicare reforms already enacted and identify opportunities for further reform.

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Mr. Chairman, this concludes my statement. I would be happy to answer any questions that you or members of the Subcommittee may have.