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HEALTH INSURANCE

Medicare and Private Payers Are Vulnerable to Fraud and Abuse

Statement of Lawrence H. Thompson
Assistant Comptroller General
Human Resources Division

SUMMARY

Given the magnitude and growth of Medicare spending, ensuring that program funds are spent appropriately and are well protected from fraud and abuse is increasingly important. This responsibility rests with the Medicare program administrators--the Health Care Financing Administration (HCFA) and its contractors.

HCFA's weak oversight of contractors' operations underlies some of the waste and abuse problem within the Medicare program. HCFA relies on numerous contractors to process Medicare's claims and protect program funds through review activities called payment safeguards. HCFA's lack of vigilance over contractors' payment safeguard activities has left program funds inadequately protected from loss and waste.

Compounding the oversight problem is the fact that funding for payment safeguards has not kept pace with the growth in claims volume; thus, contractors' safeguard efforts have been adversely affected. In 1992 we reported that contractors failed to recover millions of dollars in mistaken payments that primary health insurers owed Medicare, in part, because funds for such recovery operations had not been budgeted.

Other factors contribute as well. Medicare payment policies permit excessive reimbursement rates for certain services, such as high cost new technology and laboratory services. Moreover, loose payment controls invite exploitation by unscrupulous providers.

GAO believes that HCFA needs to improve oversight of contractors' performance and strengthen payment safeguards. The Congress and HCFA also need to make the protection of Medicare funds a priority by providing adequate and consistent funding of contractors' safeguard activities. Finally, HCFA needs to modify its payment policies so that reimbursement rates do not result in excessive payments to certain providers and that payment controls are strengthened so that program funds can be more adequately protected.

GAO also believes that all health payers face common barriers to the effective detection and pursuit of health care fraud and abuse. Therefore, the weaknesses that beset the Medicare program cannot be addressed totally in isolation. Both public health programs and private health insurers are vulnerable to fraud and abuse but separately have been unable to combat them successfully. Despite the commonality of fraud and abuse problems, diverse and autonomous insurers have few established means of collaborating systematically to solve them. GAO continues to suggest that the Congress establish a national health insurance fraud commission to develop recommendations for resolving these problems.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the challenges that the Medicare program faces in minimizing losses to fraud, waste, and abuse. As you know, the Health Care Financing Administration (HCFA) contracts with insurance companies to process medical claims and pay Medicare beneficiaries. These contractors also perform review activities, known as payment safeguards, to protect Medicare from financial loss due to fraud, waste, and abuse. Despite the fact that both GAO and OIG has identified numerous areas needing improvement, Medicare is considered a leader in establishing payment safeguards.

Weaknesses in HCFA's oversight of contractor review activities, exacerbated by inadequate and inconsistent funding for payment safeguards, makes Medicare vulnerable to losses[1]. Overseeing Medicare's payment safeguard activities has been a challenge to HCFA because of the program's complex administrative structure. Medicare operates through numerous contractors that are responsible for establishing local criteria for medical-services reimbursement, processing claims in their service area, and ensuring the accuracy of payments.

Although this contractor network permits Medicare to recognize and accommodate local differences in medical practices, it can and has led to significant variations in payment policies and safeguard practices among geographic areas. Finding the appropriate level of national uniformity while permitting discretion to acknowledge local differences is a significant challenge to HCFA's efforts to address fraud, waste, and abuse.

Today I would like to address oversight and funding problems that Medicare faces in combatting fraud. I will also discuss our recent efforts to identify excessive Medicare payments and poor payment controls. My statement will conclude with an example from the report we are releasing today on how dishonest providers defrauded the Medicare program, were identified and prosecuted, yet allegedly continued fraudulent activities among private insurers.

This case highlights the common barriers that all health payers, to one degree or another, face in the effective detection and pursuit of health care fraud and abuse. Therefore, the weaknesses that beset Medicare program administration cannot be addressed totally in isolation. We believe that efforts to oversee and implement payment safeguards in the Medicare program should also be viewed within the larger health insurance industry.

STRONGER HCFA OVERSIGHT OF MEDICARE CONTRACTORS NEEDED

Limited HCFA oversight of Medicare contractors and reductions in funding for payment safeguards have contributed to a breakdown

in program protections. Our recent work has addressed the investigation and referral of beneficiary complaints, contractors' failure to recover millions of dollars in Medicare overpayments to hospitals, and the effect of funding reductions on the Medicare secondary payer recoveries.

HCFA provided virtually no program guidance to Medicare contractors regarding the investigation of beneficiary complaints--a primary source of fraud, waste, and abuse leads.[2] Contractors' failure to adequately investigate beneficiary complaints of provider fraud and abuse can result in missed opportunities to (1) identify billings for services not rendered, (2) recover overpayments, (3) impose penalties, and (4) send a message to the provider community that fraudulent or abusive behavior will not be tolerated. In one instance, a provider was initially pursued for billing irregularities because of beneficiary complaints. Upon further investigation, 100 apparently similar complaints surfaced, encompassing about 300 fraudulent claims. The provider involved agreed to refund over $2.5 million to the federal government.

In another study, we reported that HCFA was not giving adequate program guidance to Medicare contractors regarding the recovery of hospital overpayments.[3] The refundable amounts, referred to by hospitals as credit balances, typically occurred when both Medicare and other insurers mistakenly paid for the same service or when Medicare paid twice for the same service. Many of the hospitals' credit balances had been outstanding for several years, despite attempts by some to repay the money.

The contractors we visited were doing little to identify amounts owed Medicare or to ensure that refunds were promptly recovered. As a result of our work, HCFA instructed Medicare contractors to have hospitals report amounts owed and to recover the mistaken payments. Over 9,000 hospitals and other providers reported $171.7 million in Medicare overpayments, of which $84.2 million had been repaid as of March 1992. HCFA recently implemented a reporting and tracking system to monitor such overpayments and ensure that they are promptly recovered.

These problems may be partly related to budget cutbacks that have affected program administration. Although Medicare's payment safeguard activities are cost-effective--returning nearly $11 for every $1 spent in 1989--contractor budgets for these functions have not kept pace with the growth in claims volume. Specifically, claims volume rose by about 40 percent from 1989 to 1992; however, over the same period, contractors' funding for payment safeguards was cut by about $15 million, from $357.7 million to $342.9 million.

The magnitude of the potential losses incurred by Medicare as a result of these cutbacks is illustrated in our reports on Medicare's secondary payer program. In 1990 and 1991, we found a

large inventory of potential mistaken Medicare payments that were not being investigated. Contractors were doing little to recover these claims, at least in part, because their funding for these activities was significantly reduced in fiscal year 1990 and remained at that level in fiscal year 1991.

In response to our work, HCFA implemented a system in mid-1991 to track these mistaken payments. Contractors reported unrecovered payments amounting to over $1.1 billion. An additional large backlog of claims was discovered. These had not been investigated to determine what amounts Medicare paid that primary insurers should have paid. We estimate that an investigation of these additional claims will reveal another $1 billion in mistaken payments owed by primary insurers.[4]

In its fiscal year 1993 budget, the Department of Health and Human Services (HHS) proposed increased funding for Medicare's payment safeguard activities. The planned increase, if appropriated, will allow contractors to begin replacing staff lost to cutbacks in prior years and to accommodate the growing claims workload. Hiring and training the necessary staff and implementing expanded safeguard programs will take time. For this reason, stable safeguard funding is quite important; however, in today's difficult budget environment the stability of Medicare contractor funding levels will remain in question. Consequently, as recommended in 1991, we continue to believe that the Congress should consider modifying the budget process to better ensure adequate and stable Medicare contractor funding.*

To ensure that Medicare's administrative efforts are focused and money is well-spent, we are currently assessing the effects of medical policies on different carriers, of physician ownership on Medicare utilization in imaging centers, and of postpayment review and recovery efforts. We are also beginning a study of the basic contractor structure used to administer Medicare.

HIGH PAYMENT RATES ADD TO MEDICARE'S SPENDING

Medicare policies have also led to excessive program spending. We recently reported on three areas where Medicare's payment rates for certain services are excessive: payments for emerging technologies and payments for laboratory and anesthesiology

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*Under the Budget Enforcement Act of 1990, the Congress provided for increasing appropriations for Internal Revenue Service (IRS) compliance activities without necessitating spending cuts elsewhere. We suggested using IRS's method of funding compliance activities as a potential model. See Medicare: Further Changes Needed to Reduce Program and Beneficiary Costs (GAO/HRD-91-67, May 15, 1991).

services. Here we will discuss two of the areas: emerging technologies and laboratory services.

A primary factor influencing health care cost inflation has been the rapid development and increased use of new medical technologies. The diffusion of such 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, Medicare payment rates have not been lowered to reflect these decreased costs. This encourages the proliferation of high-cost, low-volume providers.

For example, Medicare payments for magnetic resonance imaging (MRI) services are based, in part, on the charges allowed by local Medicare contractors in the mid-1980s. The 1991 payment levels in some localities were more than twice as high as in others, reflecting wide geographic disparities in the historically allowed charges. We recently reported that, despite efforts to standardize Medicare's payment for MRI services, HCFA did not fully adjust such payments to reflect declining unit costs.[5]

Medicare payments for laboratory services are also excessive. In a recent report, we compared laboratories' profit rates from Medicare with their overall profit rates.[6] Comparable profit rates would mean that Medicare was carrying its own weight, and neither subsidizing nor being subsidized by other payers. We found, however, that profits from Medicare business substantially exceeded laboratories' overall profit rates, and concluded that Medicare's fee schedules were too high. Medicare payments for laboratory services could be reduced; this action would save Medicare approximately $150 million annually.

WEAK PAYMENT CONTROLS INVITE EXPLOITATION OF MEDICARE

One longstanding weakness within the Medicare program involves control over the issuance of billing identification numbers, known as provider numbers. Under the procedures of many contractors, providers applying for billing identification numbers receive little scrutiny of their qualifications or of their business and investment relationship to other medical facilities. For certain providers, contractors have difficulty identifying whether an applicant has been previously disciplined by the program, has outstanding Medicare debts, or has the financial wherewithal to maintain solvent business operations.

HHS's Office of the Inspector General reports that Medicare contractors often cannot identify or deactivate numbers for providers who have lost the legal authority to practice.[7] In addition, individual providers can obtain multiple numbers. This

allows providers to fragment their billings under various identities. As a result, contractors cannot easily discern billing irregularities or draw meaningful comparisons among providers' billing patterns.

To respond to ownership and provider number problems, HCFA has recently proposed regulations and guidance to improve contractor control over the acquisition of provider numbers. Proposals include explicitly requiring information on owners or individuals with management interests and requiring minimum standards that applicants must meet to qualify as equipment suppliers.

Today, we are releasing a report in which we conclude that limited controls over provider numbers were an integral part of a multimillion-dollar fraud scheme involving mobile physiology labs.[8] Although this elaborate fraud scheme initially involved Medicare, it expanded to private payers who proved even more vulnerable than Medicare. This report illustrates the common obstacles health care payers face in their efforts to combat health care fraud.

MEDICARE'S VULNERABILITY REFLECTS SYSTEMIC HEALTH INSURANCE PROBLEMS

Referred to as the "rolling labs" scheme, our report discusses how fraudulent billings for services at mobile physiology labs were masked behind at least 30 different corporate names and Medicare provider numbers. These multiple provider numbers greatly complicated contractors' efforts to detect suspiciously high volumes of tests. In 1987, Medicare successfully prosecuted laboratory operators involved in the scheme, and one owner was imprisoned. However, Medicare's efforts to recover overpayments to providers affiliated with the scheme have not been successful, and at least $5 million has not been recovered.

The fraud shifted to private payers who also found their attempts to recover overpayments stymied. The report underscores several observations regarding the effects of a single major scheme on the entire health insurance industry.

1. **Considerable losses to the health care system can occur as a result of even a single scheme**. The rolling lab operation is believed to have affected over 90 percent of the health plans in California and to have involved $1 billion in fraudulent billings.

2. **Providers can bill insurers with relative ease, because they are often not required to meet specific requirements**. The services provided by the rolling lab do not require licensure in many states, and many insurers do not have specific requirements for those who can bill for medical services. Because many of the rolling lab billing addresses were mail

drops, payers could not even identify the actual location of the labs.

3. The obstacles to prosecuting and recovering losses are daunting. The rolling lab operators were successfully prosecuted in 1987 by Medicare and in 1990 by private insurers. Private insurers expended $1 million in their investigation and prosecutorial efforts. Although they won a $18 million judgment, the private insurers have recovered virtually nothing.

   In the case of Medicare, the involved parties went out of business or changed their billing identity, and attempts to recover overpayments were unsuccessful. In the private insurers' case, the involved entities declared bankruptcy and the owners temporarily fled the country. Although as many as 200 other clinics and physicians were thought to be linked with the rolling lab, not one has lost its license or been prosecuted.

4. The replication of similar schemes in southern California suggests that the profitability of health insurance fraud may outweigh the risk of getting caught. At least six or more schemes having characteristics similar to the rolling lab are believed to be operating in California. Investigators believe schemes such as this are operating in other states.

   We have first-hand knowledge of one of these schemes because a telemarketer reached a GAO evaluator working on this assignment and offered her "free" medical exams. She was told that a specific medical group would perform, at no cost to her, a treadmill test, a urinalysis, an acuity test, a pap-smear, vascular ultra-sound tests, and a pancreas test. According to a Medicare contractor official, the fees for such a series of tests would have been about $700. The telemarketer withdrew the offer when our evaluator explained she was covered under an HMO-type plan rather than a fee-for-service arrangement.

We believe that both public health programs and private health insurers are vulnerable to fraud and abuse but separately have been unable to combat them successfully. Despite the commonality of fraud and abuse problems, diverse and autonomous insurers have few established means of collaborating systematically to solve them. In our view, if the efforts of independent payers, public payers, and state insurance and licensing agencies, as well as state and federal law enforcement agencies, were more coordinated, the attack on health care fraud and abuse would be more fruitful.

Previously, we have suggested that the Congress establish a national health insurance fraud commission.[9] Such a commission could be responsible for analyzing trade-offs and developing

recommendations to the Congress. Key issues would likely include (1) how insurers can standardize claims information and billing rules, (2) how insurers can coordinate case development and prosecution efforts, and (3) whether and how to regulate unlicensed medical facilities.

CONCLUSIONS

Health insurance fraud and abuse contribute to the health care cost spiral that confronts this nation. Only a fraction of the fraud and abuse committed against the health care system is identified and prosecuted, and that which has been detected has involved substantial sums. This waste is particularly alarming as the portion of the nation's resources spent on health care continues to increase. Certain actions should be taken to minimize these losses.

With respect to Medicare, we believe that HCFA needs to strengthen its oversight of contractor operations. To monitor and direct contractor actions, HCFA may need to develop better information systems, more focused performance measures, and stronger contractor guidance. Stable and adequate funding of Medicare's program administration is required as well. Contractors must be assured of the government's commitment to improve safeguard activities. Otherwise, contractors have little incentive to perform these resource-intensive activities--from investigating beneficiary complaints to reducing backlogs of identified overpayments. Consequently, we continue to support modifying the budget process to better enable appropriate funding for Medicare program safeguard activities.

With respect to the health insurance industry as a whole, added resources alone will not succeed in overcoming fraud and abuse. As we discussed earlier, we believe that the Congress should consider establishing a national health care fraud commission composed of private and public payers, providers, and law enforcement agencies. Such a commission could best consider the conflicting legal and administrative objectives involved in the industry's battle against fraud and abuse.

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I want to thank you for the opportunity to speak before you today. The Committee's oversight of Medicare is an important component in addressing the major challenges faced by the agency. Mr. Chairman, I would be pleased to answer any questions.

ENDNOTES

1. Medicare: Contractor Oversight and Funding Need Improvement (GAO/T-HRD-92-32, May 21, 1992).

2. Medicare: Improper Handling of Beneficiary Complaints of Provider Fraud and Abuse (GAO/HRD-92-1, Oct. 2, 1991). Testimony on same topic (GAO/T-HRD-92-2, Oct. 2, 1991).

3. Medicare: Millions of Dollars in Mistaken Payments Not Recovered (GAO/HRD-92-26, Oct. 21, 1991).

4. Medicare: Over $1 Billion Should Be Recovered From Primary Health Insurers (GAO/HRD-92-52, Feb. 21, 1992).

5. Medicare: Excessive Payments Support the Proliferation of Costly Technology (GAO/HRD-92-59, May 27, 1992).

6. Medicare: Payments for Clinical Laboratory Test Services Are Too High (GAO/HRD-91-59, June 10, 1991).

7. Carrier Maintenance of Medicare Provider Numbers, Department of Health and Human Services, Office of Inspector General (OEI-06-89-00870, May 1991).

8. Medicare: One Scheme Illustrates Vulnerabilities to Fraud (GAO/HRD-92-76, Aug. 26, 1992).

9. Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse (GAO/HRD-92-69, May 7, 1992). Testimony on same topic (GAO/T-HRD-92-29, May 7, 1992).