United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Health and Environment, Committee on Commerce, House of Representatives

For Release on Delivery
Expected at 10:00 a.m.
Wednesday, June 28, 1995

MEDICARE

Rapid Spending Growth Calls for More Prudent Purchasing

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063951/154584

GAO/T-HEHS-95-193

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the ways in which the Medicare program could be improved to avoid excessive or unnecessary spending. Last fiscal year, federal spending for the Medicare program totaled $162 billion, over $440 million a day. In March 1995, the Congressional Budget Office estimated that these expenditures would approach $350 billion by 2002. In 2005--10 years from now--they could exceed $460 billion unless changes are made. Today we will examine the program's areas of rapid spending growth and ways to conserve program dollars--mainly by revising certain reimbursement policies and better controlling unwarranted use of services. Our findings derive from numerous studies we have done on the Medicare program in recent years as well as our ongoing work. (See app. I for a list of the related GAO products.)

The broad-based payment system reforms of the 1980s slowed the escalation of aggregate spending, at least temporarily, yet Medicare expenditures are now growing by more than 11 percent a year. And while the need for further reforms is widely recognized, the nature of such reforms is the subject of much debate. What is less disputed, however, is the need for immediate steps directed at correcting the practices whereby Medicare pays too much for certain services and supplies. Fiscal pressures have increasingly led private and state-government payers to negotiate discounts with providers and to manage the form and volume of care, but for many services Medicare has not exercised its potential market power in similar fashion.

The program's pricing methods and utilization controls are consistent with the health care financing and delivery system of 15 or even 30 years ago, not with today's financing and delivery systems. To some extent, the predicament inherent in public programs--the uncertain line between adequate managerial control and excessive government intervention--helps explain the divergence in the ways Medicare and private health insurers administer their respective "plans."

We believe that a viable strategy for restraining the unmanaged components of the Medicare program involves adapting the health care management approach of private payers to Medicare's public payer role. Such a strategy would entail (1) more competitively determined payment rates, (2) more powerful checks on overutilization, and (3) more rigorous criteria for granting authorization to bill the program.

BACKGROUND

The Medicare program provides health insurance coverage for about 37 million elderly and disabled individuals, almost 90

percent of them over 65. Its coverage is quite extensive, including physician, hospital, skilled nursing facility (SNF), home health, and various other services. About 90 percent of Medicare beneficiaries obtain services on an unrestricted fee-for-service basis; that is, patients choose their own physician or other health care provider, with charges sent to the program for payment. This setup mirrors the nation's private health insurance indemnity plans that prevailed until the 1980s.

Since then, revolutionary changes have taken place in the financing and delivery of health care. Greater competition among hospitals and other providers has enabled health care buyers to be more cost-conscious. Private payers, including large employers, increasingly use aggressive cost-management strategies to control health care costs. The Health Care Financing Administration (HCFA), within the Department of Health and Human Services (HHS), is Medicare's health care buyer. HCFA's pricing methods and utilization controls are carefully prescribed by statute, regulation, or agency policy. Consequently, HCFA often finds it impossible, or at least impractical, to use the cost-management strategies commonly used by private payers.

HCFA contracts with private companies--such as Blue Cross and Aetna--to review and pay claims and to audit providers. About 77 commercial contractors handle claims screening and processing, and each is required to work with its own medical community to set coverage policies and payment controls. As a result, payment policies and practices are established, for the most part, at the contractor level. This arrangement was prompted when the program was established in the mid-1960s by concerns that the federal government, which lacked extensive claims processing expertise and experience, would prove incapable of providing service comparable to that of private insurers.

MANY MEDICARE SERVICES GROWING AT DOUBLE-DIGIT RATES

Program spending growth has remained high despite major cost-containment reforms for two reasons: first, inpatient hospital spending and physician spending have continued to grow substantially faster than the gross domestic product. Second, spending for other service categories has grown in recent years at double-digit rates. (See table 1.)

Table 1: Medicare Spending Growth Rates

Category	Average annual growth rate (percent)	
	1990-94	1993-94
Inpatient hospital and physician	8	9
SNF, home health, and outpatient services	24	19
Overall program expenditures	11	11

Data source: Medicare and the American Health Care System: Report to the Congress, Prospective Payment Assessment Commission, June 1995.

To deal with spending pressures in the two largest Medicare service categories, the Congress enacted two major payment reforms. The first was the prospective payment system (PPS) for inpatient hospital services. By paying hospitals a standardized amount per case based on diagnosis, PPS helped bring aggregate spending growth for inpatient hospital services down from about 15 percent in the early 1980s to about 7.5 percent a year today. The second major reform was a fee schedule, the resource-based relative value scale (RBRVS). RBRVS helped reduce aggregate physician payment growth from double-digit rates in the late 1980s to 3 percent in 1992. Whether the cost-containment effects of RBRVS will persist is unclear, however. From 1993 to 1994, physician payments rose by almost 12 percent.

Together, the inpatient hospital and physician spending categories amount to $120 billion--about 73 percent of total Medicare spending. The sheer size of these spending categories means that each percentage point of growth represents hundreds of millions of dollars. This helps account for the projected spending of $350 billion by 2002--more than double current expenditures.

These two major reforms did not address other, smaller categories of services that have displayed rapid growth throughout the 1990s (see fig. 1).

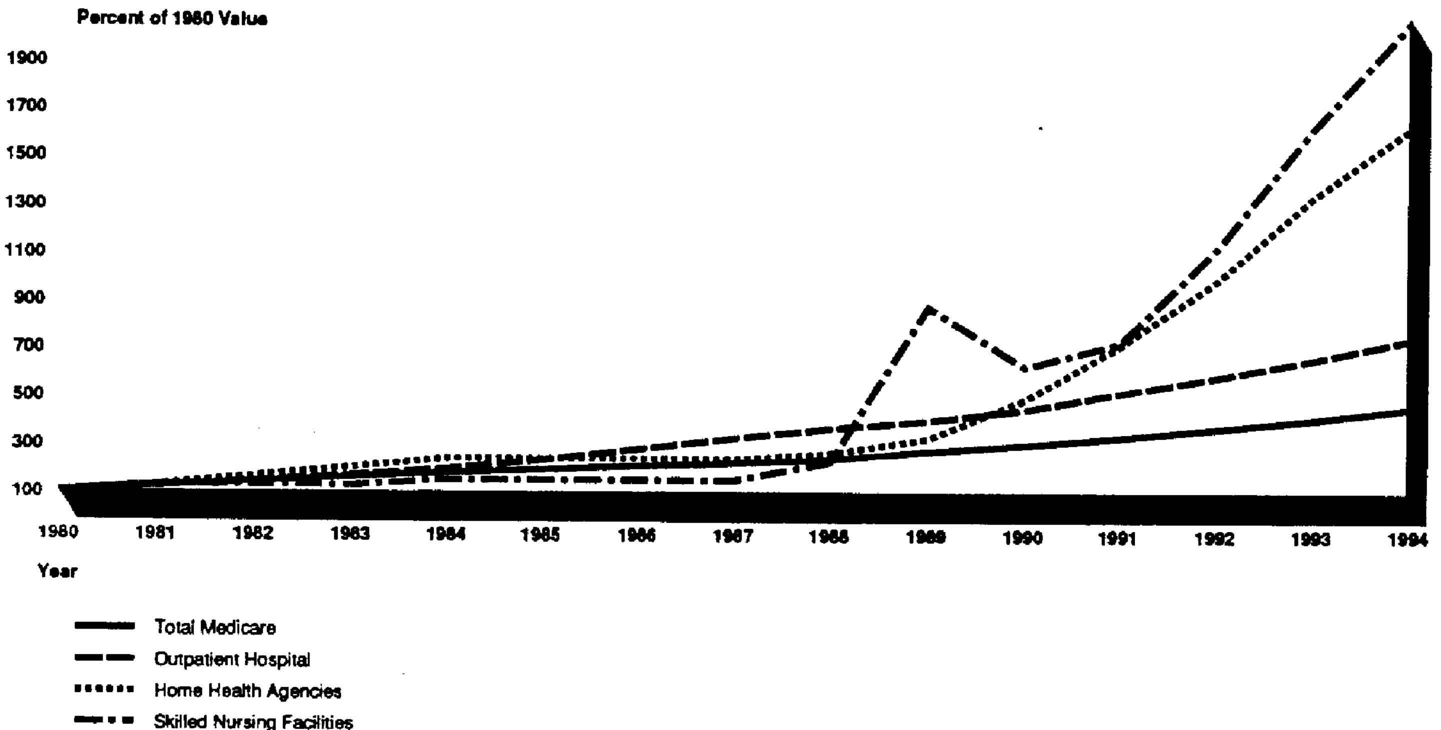
-- Skilled nursing facilities. According to a recent report by the Prospective Payment Assessment Commission (PROPAC), since 1990, benefit payments for SNF residents have increased at an average annual rate of 35 percent to more

than $8 billion in 1994.[1] The report suggests, and GAO's findings confirm, that this is due to the provision of more ancillary services, such as therapy, for which the facilities are paid unlimited costs in addition to a limited payment for routine services.

-- Home health agencies. Payments for home health services grew at a 35-percent annual rate since 1990 and have nearly tripled as a share of total Medicare payments in the last decade, from 2.7 percent in 1985 to 7.8 percent ($13 billion) in 1994.

-- Outpatient services. Spending growth for outpatient services, though less dramatic than for other categories, has exceeded 13 percent annually since 1990, costing Medicare over $14 billion in 1994.

Figure 1: Growth in Medicare Payments and Fastest Growing Services



[1] Medicare and the American Health Care System: Report to the Congress, PROPAC, Washington D.C.: June 1995.

Ironically, spending growth for these three categories stemmed in part from the cost-containment success of PPS, which prompted providers to shift the delivery of procedures such as cataract surgery to outpatient settings. In addition, reduced hospital stays may have increased the demand for services provided by home health agencies and SNFs. Home health and nursing home spending, the program's fastest growing components, have expanded also as the result of external pressure to interpret Medicare's coverage rules for these services more liberally. This pressure, in the form of successful legal actions against the program, was precipitated by Medicare's attempts following the introduction of PPS to scrutinize the appropriateness of home health and skilled nursing home claims.

MEDICARE'S SPENDING CONTROL STRATEGIES OUT OF SYNC WITH CONTEMPORARY HEALTH CARE MARKET

Faced with similar spending pressures in the past decade, private insurers and employer purchasers have sought to stem health cost escalation by shifting from their role as passive payers to become more prudent managers of health care costs. In so doing, some 90 percent of health plans--from managed indemnity to health maintenance organizations--actively manage care, regardless of whether they reimburse through fee-for-service or prepay through capitation. Specifically:

-- Employers purchase health care by assessing the market options; for example, Walt Disney World in Orlando, Proctor and Gamble in Cincinnati, and LTV Steel in Cleveland have organized health care coalitions to help them make better purchasing decisions. They collect information on provider costs and performance to obtain the best value for their health care dollars.

-- Insurers use state-of-the-art computer software to detect coding manipulation and computerized systems to monitor utilization; almost 200 private insurers now use commercial systems to detect code manipulation, including 13 of the 20 largest.

-- Health plans use preferred provider networks and other contractual arrangements to help control costs; plans select providers that perform favorably in terms of quality and use of services. Even such managed indemnity plans as Blue Cross and Blue Shield use provider networks.

Medicare's pricing methods and utilization controls, on the other hand, are not well-aligned with the revolutionary changes in today's health care market. Instead, Medicare's day-to-day operations have been shaped by three principles on which the

program was founded in 1965: the government must not interfere in medical practice; patients should be free to choose their own health care providers; and attempts to alter public programs require public comment and discussion, making changes difficult to obtain without consensus. These are sensible principles with wide appeal, but they have not been adapted to the contemporary health care marketplace and today's demands for fiscal discipline in public programs. As a result, HCFA is generally unable to

- -- negotiate with providers for discounts, promptly change prices to match those available in the market, or competitively bid prices for widely used items such as pacemakers, intraocular lenses, and wheelchairs. This has resulted in Medicare paying higher prices than other large payers.[2]

- -- differentiate between providers who meet utilization, price, and quality standards and those who do not. In addition, HCFA cannot provide incentives to encourage beneficiaries to use the preferred providers, thus hampering Medicare's ability to encourage beneficiaries to use providers meeting Medicare's standards.

- -- use preadmission review or other utilization control practices to curb the excessive or unnecessary provision of expensive procedures or use case management to coordinate and monitor high-cost patients' multiple services and specialist care. This has limited Medicare's ability to emphasize cost efficiency in its dealings with those suppliers, physicians, and institutions that habitually provide excessive services.

IN SEVERAL REGARDS, MEDICARE IS NOT A PRUDENT PURCHASER

The consequence of these constraints on HCFA is that Medicare remains too often a bill payer rather than a prudent buyer of health care services. Unlike the most successful private payers, Medicare pays higher than market rates for some services, lacks state-of-the-art technology for checking payments, and has not introduced effective approaches to screen providers for their business or professional credibility.

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[2]For further discussion of competitive bidding and negotiation strategies, see Medicare Managed Care: Program Growth Highlights Need to Fix HMO Payment Problems (GAO/T-HEHS-95-174, May 24, 1995).

Medicare Often Pays Higher Than Market Rates

Medicare pays substantially higher than market rates for many services. For example:

- The HHS Office of Inspector General reported in 1992 that Medicare paid $144 to $211 each for home blood glucose monitors when drug stores across the country sold them for under $50 (or offered them for free as a marketing ploy).[3] HCFA took nearly 3 years to reduce the price to $59.

- For one type of gauze pad, the lowest suggested retail price is currently 36 cents. The Department of Veterans Affairs (VA) pays only 4 cents. Medicare, however, pays 86 cents for this pad. Indeed, Medicare pays more than the lowest suggested retail price for more than 40 other types of surgical dressings. Medicare pays more than VA for each of the nine types of dressing purchased by both VA and Medicare. For all practical purposes, HCFA is prohibited from adjusting the prices for these and similar supplies.[4]

- Medicare was billed $8,415 for therapy to one nursing home resident. Over one-half the amount--$4,580--was for charges added by the billing service for submitting the claim. This bill-padding is permissible because, for institutional providers, Medicare allows almost any patient-related costs that can be documented.

- Anesthesia payments, unlike payments to other physicians, are based on units of time, thus providing a financial incentive to prolong anesthesia service delivery. Our studies have shown that reported times for the same

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[3]Home blood glucose monitors enable individuals to determine the adequacy of their blood glucose levels. The manufacturers have an incentive to promote the sale of their brand of monitor to ensure future sale of related test strips. According to HCFA, the income generated in 1 month by the sale of test strips can exceed the total income generated from the sale of the monitors.

[4]Under 42 U.S.C. 1395m(i), HCFA is required to establish a fee schedule for surgical dressings based on average historical charges. However, because the benefit was expanded, HCFA does not have such data. Instead, it uses a gap-filling process based on the median price in supply catalogs. This is necessarily higher than the lowest price (given any variation at all). HCFA cannot change the methodology for determining the fee schedule, nor can it adjust the schedule if retail prices decrease. While HCFA is authorized to increase payments annually based on the consumer price index, it lacks authority to reduce such payments.

anesthesia service vary widely for no apparent reason and that basing fees on a procedure's median anesthesia time could reduce Medicare payments by over $50 million a year.

Further, our work has shown that HCFA's failure to systematically review payment rates as technologies mature and become more widely used and as providers' costs per service decline can support the proliferation of costly technology and encourage an oversupply of services. Magnetic resonance imaging (MRI) equipment is a case in point, as we reported in 1992.[5] In the absence of systematic adjustment, the Congress has had to act several times, specifically reducing rates for various procedures and services, such as overpriced surgeries, selected durable medical equipment items, intraocular lenses, MRIs, and CT scans.

Medicare Underutilizes Advanced Technology to Check Claims

Medicare's claims processing contractors employ a number of automated controls to prevent or remedy inappropriate payments.[6] Although these measures are effective in some instances, abusive claims costing billions of dollars escape detection.

Our work shows that improbable charges or unlikely payments often escape the controls and go unquestioned. For example, none of the contractors that process claims for medical equipment and supplies automatically reviews high-dollar claims for newly covered surgical dressings.[7] As a consequence, one such contractor paid $23,000 when the appropriate payment was $1,650. Similarly, Medicare paid a psychiatrist over a prolonged period for claims that represented, on average, nearly 24 hours a day of services. Neither of these overpayment cases came to light through a systematic examination of claims data.

In congressional testimony earlier this year, we reported the results of our study on private sector computer software controls

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

[6]Some controls are designed to stop processing when claims do not meet certain conditions for payment. For example, one control flags claims that exceed the allowed threshold of 12 chiropractic manipulations a year per beneficiary. Another kind of control, postpayment review of data, is intended to enable Medicare to spot patterns and trends of unusually high spending.

[7]In March 1994, Medicare's surgical dressing benefit was greatly expanded to include various types and sizes of gauze pads not previously covered and to extend the duration of coverage to whatever is considered medically necessary.

used to detect certain billing abuses.[8] We compared what Medicare actually paid providers against what would have been paid by four commercial firms that market computerized systems to detect miscoded claims.[9] We invited each firm to reprocess 200,000 statistically selected claims that Medicare paid in 1993. On the basis of this sample, we estimated that if Medicare had used this commercial software the government would have saved $3 billion over 5 years by detecting these billing abuses.

Medicare Does Not Adequately Screen Providers for Credibility

Our studies and those of the HHS Inspector General have found that for some providers there are so few requirements that must be met in order to obtain authorization to bill Medicare that their credibility cannot be assumed. The result is that too often Medicare loses large sums to providers and suppliers that never should have been authorized to serve program beneficiaries. This problem has become more acute as providers that are less scrutinized or more transient than doctors and hospitals use elaborate, multilayered corporations to bill Medicare.

The following examples show instances in which such providers obtained Medicare provider numbers and billed the program extensively over the past several years:

-- Five clinical labs (to which Medicare paid over $15 million in 1992) have been under investigation since early 1993 for the alleged submission of false claims. The labs' mode of operation was to bill Medicare large sums over 6 to 9 months; whenever a lab received inquiries from Medicare, it went out of business.

-- A wheelchair van service obtained a Medicare provider number as an ambulance service. The provider was not

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[8]See Medicare Claims Billing Abuse: Commercial Software Could Save Hundreds of Millions Annually (GAO/T-AIMD-95-133) and Medicare Claims: Commercial Technology Could Save Billions Lost to Billing Abuse (GAO/AIMD-95-135), both issued May 5, 1995.

[9]Providers bill their charges to Medicare according to an official book of procedure codes. By manipulating these codes, a provider can charge Medicare more than the appropriate code would permit. For example, a comprehensive code covers the fee for removing a ruptured appendix, which includes making the incision to reach the appendix and closing the wound. A physician could miscode the claim by including three separate codes: one for making the incision, one for closing the wound, and the correct one--the comprehensive code covering removal of the appendix.

licensed by the state as an ambulance service, nor did the provider have the equipment required by Medicare to qualify as an ambulance service. Over 16 months, on behalf of just one beneficiary, the van service billed Medicare $62,000 for 240 ambulance trips--about 1 trip every 2 days at nearly $260 per trip.

-- A therapy company added $170,000 to its Medicare reimbursements over a 6-month period, while providing no additional services, by creating a "paper organization" with no space or employees. The company simply reorganized its nursing home and therapy businesses so that a large portion of its total administrative costs could be allocated to Medicare.

-- A medical supply company serving nursing facility patients obtained more than 20 different Medicare provider numbers for companies that it controlled. The companies, all in the same state, were nothing more than shells that allowed the supplier to spread its billings over numerous provider numbers to avoid detection of its overbillings.

CONCLUSIONS

In conclusion, Medicare is an expensive program that is growing fast. Because of its vast size and the aging of the population, broad-based reforms will be required to keep Medicare from consuming ever-larger shares of the national income. Reforms have moderated spending growth for inpatient hospital and aggregate physician services, but the lower growth still increases Medicare spending in multibillion dollar increments.

In addition, HCFA's capabilities to manage Medicare are misaligned with the current methods used for health care delivery and financing.

-- Despite the competitive health care market, Medicare often pays more than the market price for medical services and supplies.

-- Although payment of claims for services provided constitutes the program's chief administrative function, Medicare does not use the best available computer technology to screen claims for overcharging or overutilization.

-- Despite the increase in nonmedical providers billing for services and supplies, Medicare does little to scrutinize the qualifications of such providers.

Commercial contractors, which play a key role in administering Medicare, routinely employ management-of-care techniques in their

capacity as private insurers. If they applied these techniques to Medicare, the program could possibly save billions of dollars annually. We believe that the following strategies show promise and they particularly target the fastest-growing and least-managed components of Medicare, such as home health and rehabilitation therapy services.

1. Allow Medicare to price services and procedures more competitively. This could include streamlining processes required to revise excessive payment rates and allow competitive bidding for services and the negotiating of prices.
2. Enhance Medicare's use of technology to check claims. This could include completing the modernization of Medicare's claims processing and information systems and expanding the use of high-technology computerized controls.
3. Require providers to demonstrate their suitability as a Medicare vendor before giving them unrestricted billing rights. This could include HCFA's establishment of preferred provider networks, development of more rigorous criteria for authorization to bill the program, and use of private entities to provide accreditation or certification.

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Mr. Chairman, this concludes my statement. I will be pleased to answer any questions.

For more information on this testimony, please call Edwin P. Stropko, Assistant Director, at (202) 512-7108. Other major contributors include Audrey Clayton and Hannah Fein.

RELATED GAO PRODUCTS

Medicare: Modern Management Strategies Needed to Curb Program Exploitation (GAO/T-HEHS-95-183, June 15, 1995).

Medicare Managed Care: Program Growth Highlights Need to Fix HMO Payment Problems (GAO/T-HEHS-95-174, May 24, 1995).

Medicare: Reducing Fraud and Abuse Can Save Billions (GAO/T-HEHS-95-157, May 16, 1995).

Medicare Claims Billing Abuse: Commercial Software Could Save Hundreds of Millions Annually (GAO/T-AIMD-95-133, May 5, 1995).

Medicare Claims: Commercial Technology Could Save Billions Lost to Billing Abuse (GAO/AIMD-95-135, May 5, 1995).

Medicare: Tighter Rules Needed to Curtail Overcharges for Therapy in Nursing Homes (GAO/HEHS-95-23, Mar. 30, 1995).

Medicare and Medicaid: Opportunities to Save Program Dollars by Reducing Fraud and Abuse (GAO/T-HEHS-95-110, Mar. 22, 1995).

Medicare's Secondary Payer Program: Actions Needed to Realize Savings (GAO/T-HEHS-95-92, Feb. 23, 1995).

Medicare: High Spending Growth Calls for Aggressive Action (GAO/T-HEHS-95-75, Feb. 6, 1995).

High-Risk Series: Medicare Claims (GAO/HR-95-8, Feb. 1995).

Medicare: Inadequate Review of Claims Payments Limits Ability to Control Spending (GAO/HEHS-94-42, Apr. 28, 1994).

Health Care Reform: How Proposals Address Fraud and Abuse (GAO/T-HEHS-94-124, Mar. 17, 1994).

Medicare: Greater Investment in Claims Review Would Save Millions (GAO/HEHS-94-35, Mar. 2, 1994).

Medicare: New Claims Processing System Benefits and Acquisition Risks (GAO/HEHS/AIMD-94-79, Jan. 25, 1994).

Medicare: Adequate Funding and Better Oversight Needed to Protect Benefit Dollars (GAO/T-HRD-94-59, Nov. 12, 1993).

Health Insurance: Remedies Needed to Reduce Losses From Fraud and Abuse (GAO/T-HRD-93-8, Mar. 8, 1993).

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