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MEDICARE

High Spending Growth Calls  
for Aggressive Action

Statement of William J. Scanlon, Associate Director  
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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, or over \$440 million a day. The Congressional Budget Office estimates that by 2002 Medicare spending could exceed \$340 billion. 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 fraudulent and abusive payments. Our findings derive from numerous studies we have done on the Medicare program in recent years as well as ongoing studies. (See app. I for a list of the issued reports.)

In brief, the government faces strong obstacles to bringing Medicare expenditures under control. Broad-based payment system reforms have slowed aggregate spending, but Medicare's growth rates remain higher than overall inflation. And while additional reforms may be needed, their nature is the subject of much debate. There is less dispute, however, that Medicare pays too much for certain services and supplies. Fiscal pressures have led private and state-government payers increasingly to negotiate discounts with providers and to manage the form and volume of care. Medicare has not exercised its potential market power in similar fashion when buying certain services, such as rehabilitation therapy. Our evidence suggests that, in the near term, the government may want to revise the reimbursement policies for these excessively costly services to ensure that it is acting as a prudent buyer. The evidence also suggests that greater vigilance over wasteful or inappropriate payments could better protect Medicare funds against providers' fraudulent and abusive billings.

#### BACKGROUND

The Medicare program provides health insurance coverage for over 36 million elderly and disabled Americans. Its coverage is quite extensive, including physician, hospital, skilled nursing home, home health, and various other services. About 90 percent of beneficiaries obtain services on a fee-for-services basis, choosing their own physician or other health care provider, with charges sent to the program for payment. Medicare's payments are determined by a complex array of rules and procedures.

Seeking ways to constrain Medicare spending is a daunting task for good reason--the program is typified by paradox. On the surface, Medicare appears to be extensively regulatory, with thousands of pages of laws, regulations, and manuals governing program administration. Yet the individual decisions by millions of beneficiaries and hundreds of thousands of providers determine program spending. On the surface, Medicare is perceived to be a national program that is administered centrally. While on one level this is true, it is also true that commercial insurers--

like Aetna, Travelers, and Blue Cross and Blue Shield plans-- administer the program locally. By law, HCFA contracts with private insurers to process and pay Medicare claims. Today about 73 contractors perform this function, and each is required to work with its own medical community to set coverage policies and payment controls. Despite its image as a national program, therefore, Medicare's terms for covering medical care depend on each contractor, except in the few instances where HCFA has established national policies.

As intended, the contractor network has kept Medicare's policies within close reach of local provider communities. When HCFA issues guidelines and regulations, it does so only after extensive comment by the relevant segment of the health care industry. The program was designed this way to protect against undue government intervention in the nation's health care. As a consequence, however, HCFA faces obstacles in making the government a prudent buyer of health care services.

#### CONTROLLING MEDICARE SPENDING IS CHALLENGING

Competing pressures challenge the government's ability to control Medicare spending. The multiple stakeholders involved and the potential market impact of enacting Medicare cost containment reforms argue for proceeding cautiously, while growing budget deficits call for immediate corrective measures.

In the last decade, the Congress has enacted two major legislative reforms that have slowed Medicare spending. A prospective payment system (PPS) using diagnosis-related groups helped bring aggregate spending growth for inpatient hospital services from about 15 percent in the early 1980s to about 8 percent a year today. A fee schedule known as RBRVS (resource-based relative value scale) and limits on spending increases known as volume performance standards helped reduce aggregate physician payment growth from over 10 percent in the late 1980s to 2 to 5 percent over the last few years.

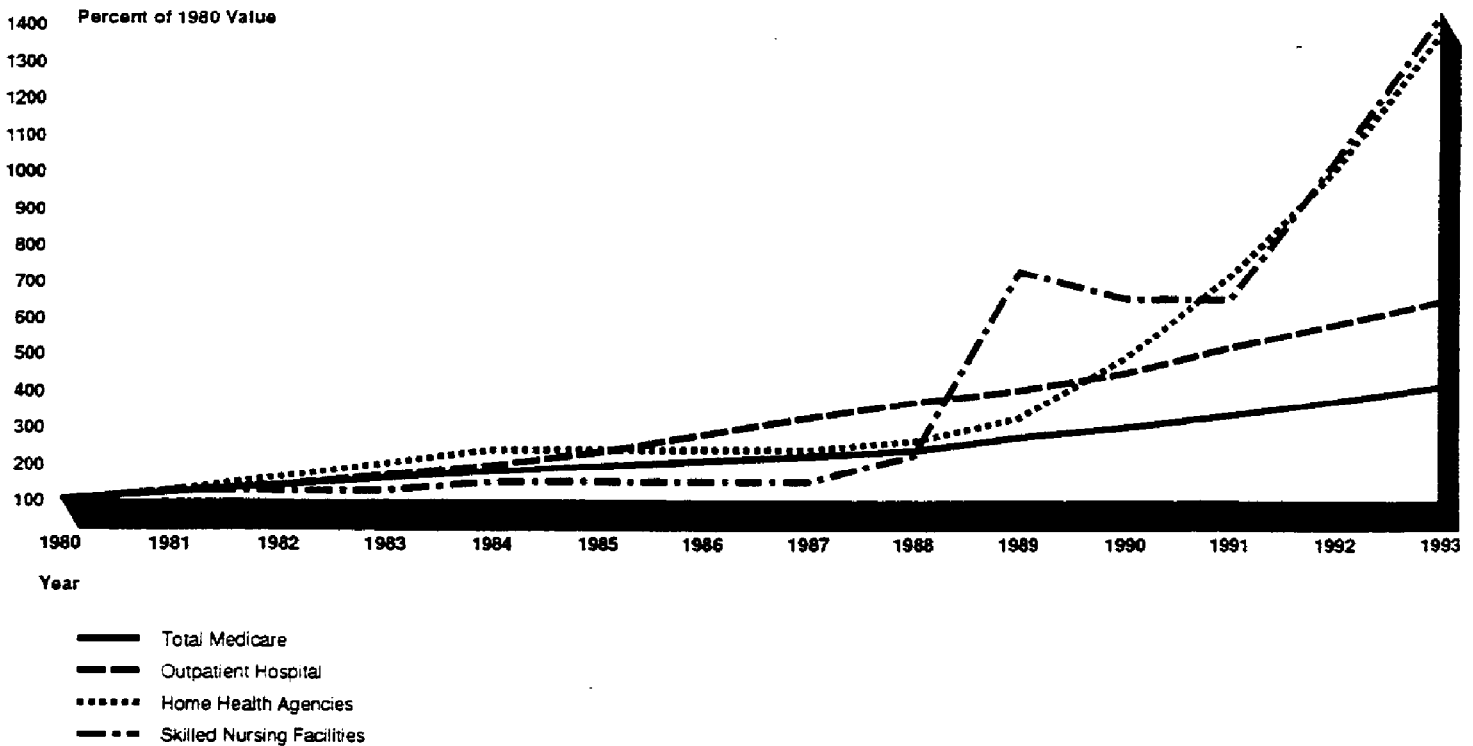
Still, Medicare spending growth remains at high levels for two reasons. First, the inpatient hospital and physician spending categories amount to \$112 billion--over 75 percent of total Medicare spending. Despite some moderation, growth in hospital payments, after accounting for the growth in beneficiary numbers, still exceeds the growth of the nation's economy as measured by the gross domestic product. The sheer size of these spending areas means that each percentage point of growth represents hundreds of millions of dollars and helps account for the projected more-than-doubling of spending to \$340 billion in 2002. (See table 1.)

Table 1: Medicare Payments and Growth Rates for Selected Service Categories

Year	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993
<b>Total Medicare Payments</b>	36.4	43.6	51.1	58.1	65.1	70.3	75.8	80.5	86.8	99.4	109.2	121.2	134.6	149
% Increase		20%	17%	14%	12%	8%	8%	6%	8%	15%	10%	11%	11%	11%
<b>Inpatient Payments</b>	24.5	29.4	33.9	37.8	42.3	44.9	46.5	47.1	49.1	55.5	59.8	65.7	72.5	78.1
% Increase		20%	15%	12%	12%	6%	4%	1%	4%	13%	8%	10%	10%	8%
<b>Physician Payments</b>	8.4	10.1	12.1	14.2	15.7	17.2	19.6	22.2	24.5	26.8	29.5	31.6	32.3	34
% Increase		20%	20%	17%	11%	10%	14%	13%	10%	9%	10%	7%	2%	5%

Second, spending growth for other categories--such as outpatient hospital, home health, and skilled nursing care services--has accelerated dramatically. Between 1992 and 1993, spending for outpatient services grew by 11 percent to about \$12 billion, and spending for home health and skilled nursing care each grew by about 40 percent to \$11 billion and \$5.7 billion, respectively. Ironically, this growth stemmed in part from the cost containment success of PPS, which prompted providers to shift the delivery of such procedures as cataract surgeries to outpatient settings. In addition, reduced hospital stays may have increased the demand for services provided by home health agencies and skilled nursing homes. (See fig. 1.)

Figure 1: Growth in Medicare Payments and Fastest Growing Services



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. Over the past decade, HCFA has been exploring ways to pay for these services prospectively, both to control prices of services and create incentives for appropriate utilization. However, sweeping changes to payment and coverage policies for major services like home health raise complex issues that may be difficult to resolve quickly.

LOOPHOLES AND OTHER WEAKNESSES PERVADE CERTAIN REIMBURSEMENT POLICIES

Immediate savings in the billions of dollars are possible, though, by modest adjustments to certain reimbursement policies. Loopholes in payment rules and flawed rate-setting methodologies

allow Medicare to pay too much, in certain cases, for rehabilitation therapy, magnetic resonance imaging (MRI), and anesthesia services. Consider the following cases:

- Skilled nursing homes and therapy companies have been able to pad administrative costs and inflate charges because of lax oversight of providers' cost reports and the resources needed to apply Medicare's general rules to specific circumstances. As a result, for some beneficiaries, Medicare has been charged the equivalent of hundreds of dollars per hour for occupational and speech therapy, though therapists' salaries are generally less than \$32 per hour.
- Medicare does not systematically lower payment rates for new technology services as they mature and become more widely used and as providers' costs per service decline. For example, Medicare payments for MRIs supported a proliferation of MRI machines in Florida, where payment rates were so high that even inefficient, low utilization providers could earn profits.
- 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 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.

Together these problems illustrate the government's need to act as a prudent purchaser. In each of these cases, Medicare has continued to pay higher rates than necessary in a competitive health care environment. Yet taking action is not a simple task. HCFA faces strong pressure from those who benefit from high payments, often with little countervailing pressure from any specific constituency to make reducing payments a priority.

For example, despite projected savings, HCFA has been unsuccessful in its attempts to change its method of reimbursing for anesthesia services. Similarly, since 1993 HCFA has been exploring ways to address the inappropriate billing and payment of rehabilitation therapy claims, while spending for these services is growing at nearly 30 percent a year. Finally, HCFA has taken some action to lower spending for MRIs and other expensive technology, but not before its initially generous reimbursements allowed an oversupply of certain technology to drive up overall health care spending. HCFA still needs to develop methods for reimbursing the capital costs of new technology based on the lower operating costs achievable through efficient utilization.

CONTROLS OVER FRAUD AND  
ABUSE OFTEN WEAK OR ABSENT

Other opportunities to cut possibly billions of dollars in spending involve implementing better controls over fraudulent and abusive Medicare payments. Over 98 percent of Medicare spending is for payments to providers. Program administration--claims processing and activities to prevent inappropriate payments--constitutes slightly more than 1 percent of total Medicare spending. Less than one-quarter of a percent goes toward checking for erroneous or unnecessary payments.

Controls over waste, fraud, and abuse help ensure that Medicare does not pay for unnecessary or inappropriate services. Some controls are electronic and are programmed into computer claims processing software. They trigger the suspension of payments by flagging claims for such problems as charging for an excessive number of services provided on a single day. They also suspend payments for such clerical errors as the incomplete or erroneous number of digits in a provider's billing number. The computer automatically holds the claim until the data are corrected. Medicare's electronic controls are developed and applied largely at the discretion of Medicare's claims processing contractors.

The best way to understand what better Medicare payment controls might accomplish is to examine what has occurred in their absence. In some instances, Medicare has paid providers' claims for improbably high levels of service or cost. For example, the following are abuses that have come to light through whistleblowers, not because program safeguard controls detected them:

- Over 5 years, Medicare paid \$3.1 million in mileage charges to a clinical laboratory for transporting specimens. This amount reflects a distance of 5.7 million miles, equivalent to circumnavigating the earth about 230 times.
- Over 16 months, a van service billed Medicare \$62,000 for ambulance trips to transport one beneficiary 240 times.

In fiscal year 1993, Medicare processed almost 700 million claims, about 250 million more than it processed 5 years earlier. Yet Medicare pays more claims with less scrutiny today than at any other time over the past 5 years. Funding declines, relative to the growing number of Medicare claims, have forced HCFA to lower the proportion of claims that contractors must review. In 1989, HCFA set targets for contractors to suspend processing and then review 20 percent of all claims; it reduced this target to 15 percent in 1991, 9 percent in 1992 and 1993, and 5 percent in 1994.



Similarly, HCFA's efforts to statistically profile claims that detect providers' questionable billing practices have also declined. Physicians, supply companies, or diagnostic laboratories have about 3 chances out of 1,000 of having Medicare audit their billing practices in any given year.

In some instances, for lack of adequate funding, contractors have curtailed or discontinued reviews of certain medical services, even when there was evidence of widespread billing abuse and potential for significant savings. For example, a contractor we visited last year temporarily reduced or suspended the use of five electronic controls that triggered further claims reviews. These reviews had previously resulted in the denial of claims submitted and \$4 million in savings over a 3-month period. The contractor suspended the use of the controls because the volume of claims they generated overwhelmed the claims review staff.

The decline in program spending for fraud and abuse controls corresponds in part with the 1990 passage of the Budget Enforcement Act. That act places stringent limits, or caps, on discretionary spending, which covers Medicare administrative costs, including the cost of contractors' fraud and abuse controls. Benefit payments, however, are not subject to these caps. This creates a dual problem. Any increase in spending for Medicare's fraud and abuse controls would require cuts in funding for other discretionary programs, such as education or welfare. A decline in benefit costs, however, even if attributable to savings from fraud and abuse activities, cannot be used as an offset. In fact, funding for fraud and abuse activities is in continual jeopardy, since cutting this funding frees up money for other discretionary programs.

HCFA studies indicate that spending for antifraud and abuse activities can reduce Medicare program costs on average by as much as 11 times the amount invested. In effect, by not adequately funding these activities, the federal government is missing a significant opportunity to control Medicare program costs.

HCFA'S BROAD ADMINISTRATIVE  
INITIATIVES COULD CUT MEDICARE  
SPENDING CONSIDERABLY

HCFA has begun two major initiatives to address long-standing problems with inappropriate payments. First, it established a data analysis requirement, called focused medical review, for contractors to better identify excessive spending. Second, HCFA let a contract to design a single automated claims processing system--called the Medicare Transaction System--that promises greater efficiency and effectiveness in claims processing.

Prior to the focused medical review requirement, contractors were expected to examine claims looking only for physicians and other providers whose claims suggested they might be overbilling or engaged in some other wrongdoing. Under the new requirement, contractors must also examine spending for medical procedures to identify questionable spending patterns and trends.

For example, when a Medicare contractor in Tennessee compared its payments for selected services with those of other contractors, it found an instance where total payments for a service--pathology consultations--were not in line with other contractors' totals. Specifically, the contractor was paying pathologists for consultations when the test results should have been interpreted by the requesting physician. The contractor revised its payment rule governing pathology consultations, and reimbursements for this service declined from \$2.7 million in 1988 to less than \$11,000 in 1992.

HCFA's development of a new claims processing system--MTS--is intended to replace the 11 different claims processing systems used by Medicare contractors with a single system expected to have improved capabilities. This system will serve as the cornerstone for HCFA's efforts to reengineer its approaches to managing program dollars. Using the current multiple systems, HCFA has difficulty aggregating information on spending, savings, and workload at the various claims processing contractors. Inadequate management information makes it difficult for HCFA to provide the oversight required of a national program. The new system, which promises to format claims data uniformly and produce comparable payment data, is expected to provide HCFA with prompt, consistent, and accurate management information. Full implementation is at least 3 years away. In 1994, we recommended continued top management and congressional oversight to ensure the system's success.

## CONCLUSIONS

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. Despite the urgency of controlling Medicare's high spending growth, however, the program's complexities militate against swift, simple solutions. Reforms have moderated spending growth for inpatient hospital and aggregate physician services, but the lower growth still increases Medicare spending in multibillion dollar increments. Moreover, for the program's fastest-growing spending components, such as home health services, the government faces significant challenges to implementing major cost containment reforms.

For the immediate future, HCFA could seek ways, with the assistance of the Congress, to make the government a more prudent

purchaser of health services. By correcting flawed reimbursement policies, such as those for rehabilitation therapy, high-cost technology, and anesthesia, Medicare could lower its spending growth rate. In addition, with adequate investment and attention to activities like HCFA's recent antifraud and abuse initiatives, Medicare could avoid making unnecessary payments that could amount to billions of trust fund and tax dollars.

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Mr. Chairman and Members of the Subcommittee, this concludes my statement. We will be happy to answer any questions.

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

RELATED GAO PRODUCTS

Medicare Part B: Regional Variations and Denial Rates for Medical Necessity (GAO/PEMD-95-10, Dec. 19, 1994).

Medicare: Referrals to Physician-Owned Imaging Facilities Warrant HCFA's Scrutiny (GAO/HEHS-95-2, Oct. 20, 1994).

Medicare: Technology Assessment and Medical Coverage Decisions (GAO/HEHS-94-195FS, July 20, 1994).

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).

Psychiatric Fraud And Abuse: Increased Scrutiny of Hospital Stays Is Needed for Federal Health Programs (GAO/HRD-93-92, Sept. 17, 1993).

High-Risk Series: Medicare Claims (GAO/HRD-93-6, Dec. 1992).

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

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

Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse (GAO/HRD-92-69, May 7, 1992) and related testimony (GAO/T-HRD-92-29, May 7, 1992).

Medicare: Variation in Payments to Anesthesiologists Linked to Anesthesia Time (GAO/HRD-91-43, Apr. 30, 1991).

Medicare: Need for Consistent National Policy for Special Anesthesia Services (GAO/HRD-91-23, Mar. 13, 1991).

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