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STAFF DATA RELATING TO MEDICAID–MEDICARE STUDY

PREPARED BY THE STAFF

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE
RUSSELL B. LONG, *Chairman*

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STAFF DATA RELATING TO MEDICAID-MEDICARE STUDY

EXPLANATION OF CHART 1

Medical Assistance: Vendor Payments for Medical Care

It was in 1950 that the Congress first authorized "vendor payments" for medical care—payments from the welfare agency directly to physicians, health care institutions, and other providers of medical services. Federal sharing was liberalized in subsequent amendments, and by 1960 four-fifths of the States made provision for medical vendor payments. In 1951, vendor payments for medical care totaled slightly more than $100 million; by the end of the decade, they had increased to about one-half billion dollars. More than half of the total was spent under Old Age Assistance.

A new category of assistance recipient was established by the Congress in 1960 in the Kerr-Mills program: the "medically needy" aged, whose incomes were high enough that they did not need cash assistance payments, but who needed help in meeting the costs of medical care. Between 1960 and 1965, total vendor payments more than doubled, from about one-half billion dollars to $1.3 billion. Increases in vendor payments under Old-Age Assistance and the new Medical Assistance for the Aged program accounted for three-quarters of the increase.

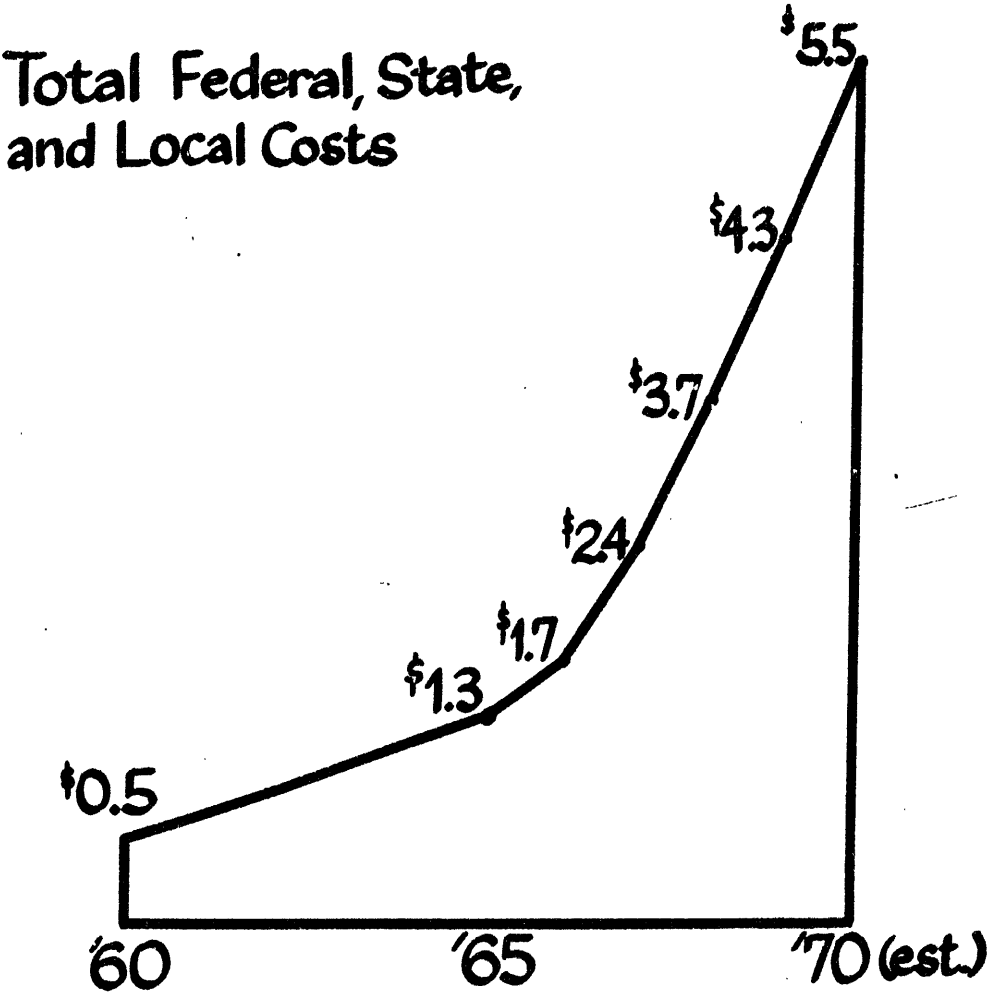
In 1965, a new medical assistance (Medicaid) program was enacted as a part of the Social Security Amendments of 1965 (which also included Medicare). The Medicaid program had these features: (1) it substituted a single program of medical assistance for the vendor payments under the categorical cash assistance and Medical Assistance for the Aged programs, with a requirement that beginning in January 1970 Federal sharing in vendor payments would only be provided under the Medicaid program; (2) it offered all States a higher rate of Federal matching for vendor payments for medical care; (3) it required each State to cover all persons receiving or eligible to receive cash assistance; (4) it permitted States to include medically needy blind, disabled, and dependent children and their families (as well as the medically needy aged) at the option of the State; and (5) it required that States include inpatient and outpatient hospital services, other laboratory and X-ray services, skilled nursing home services, and physicians' services; it permitted the States to include other forms of health care at their option.

Expenditures under the Medicaid program have increased much more rapidly than anyone had anticipated. Between 1965 and 1970, total Federal, State, and local costs will have risen from $1.3 to $5.5 billion.

CHART 1

Vendor Payments for Medical Care Have Risen Sharply Since Medicaid Was Enacted

(dollars in billions)



EXPLANATION OF CHART 2

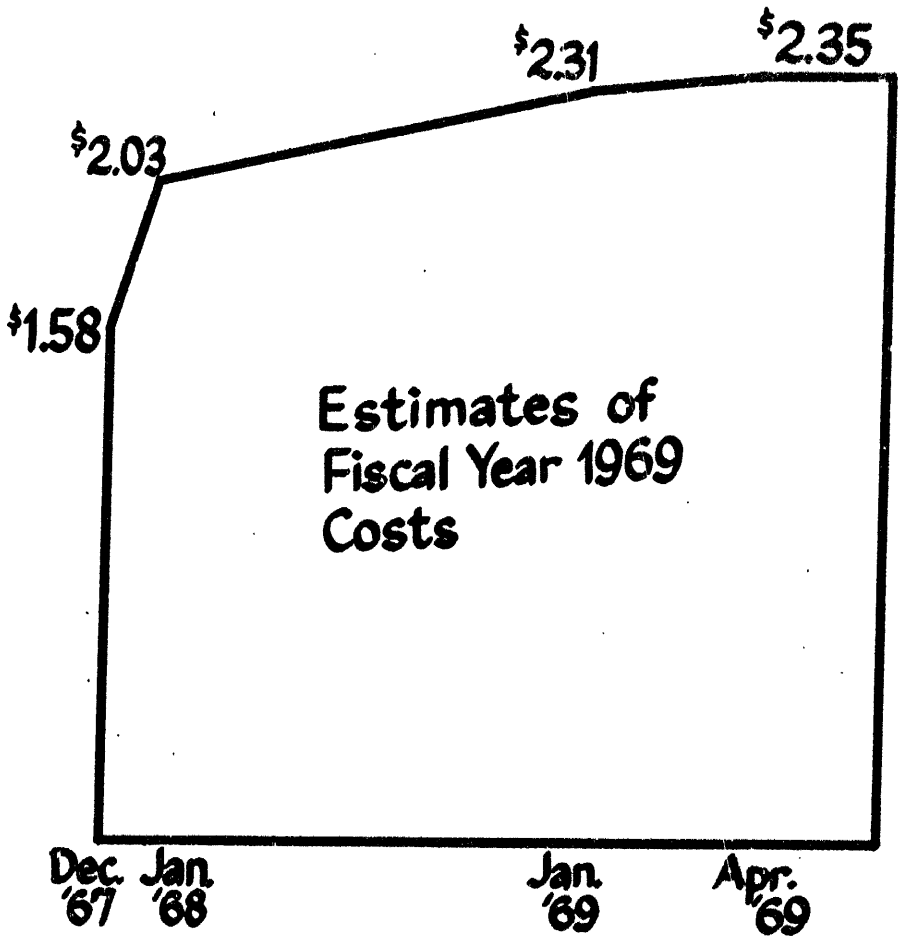
Revision in Estimates of Fiscal Year 1969 Medicaid Costs

The sharp rise in medical vendor payment costs and the difficulty of estimating the amounts required is shown dramatically in the revisions made in the estimates for fiscal year 1969. In December 1967, the Congress was told that fiscal year 1969 estimates would total $1.58 billion in Federal funds. One month later this estimate was revised upward by $450 million. In the budget submitted to the Congress this January, the estimate was increased by another $200 million, and in the revised budget submitted 3 months later another $40 million was added.

The current estimate of $2.5 billion is almost 50 percent greater than the estimate made 19 months ago.

CHART 2

Current Estimates of Federal Medicaid Costs in Fiscal Year 1969 are Almost 50% Higher Than Estimates Made 19 Months Ago (dollars in billions)



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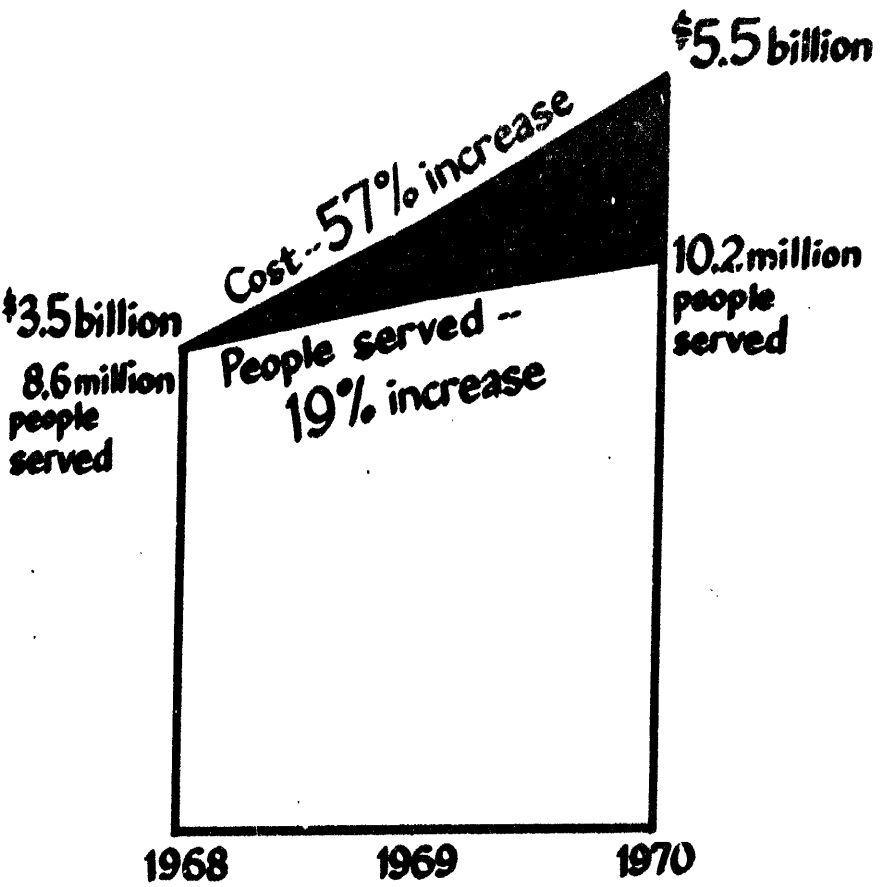
EXPLANATION OF CHART 3

Increased Medicaid Costs Outstrip Increases in Numbers of People Served

Though Medicaid costs are increasing rapidly, much of the increas is eaten up by the inflation in medical care costs. The 1970 budge estimates that the total Federal, State, and local cost of medica vendor payments will rise from $3.5 billion in 1968 to $5.5 billion i 1970—a 57-percent cost increase. During the same period, however the number of people served is estimated in the budget to increas from 8.6 to 10.2 million—a 19-percent increase, only one-third of th increase in cost.

CHART 3

Medicaid Cost Increases Between 1968 and 1970 are Estimated to be 3 times as great as the Increase in the number of people served



EXPLANATION OF CHART 4

Medical Vendor Payments as a Portion of Total Welfare Costs

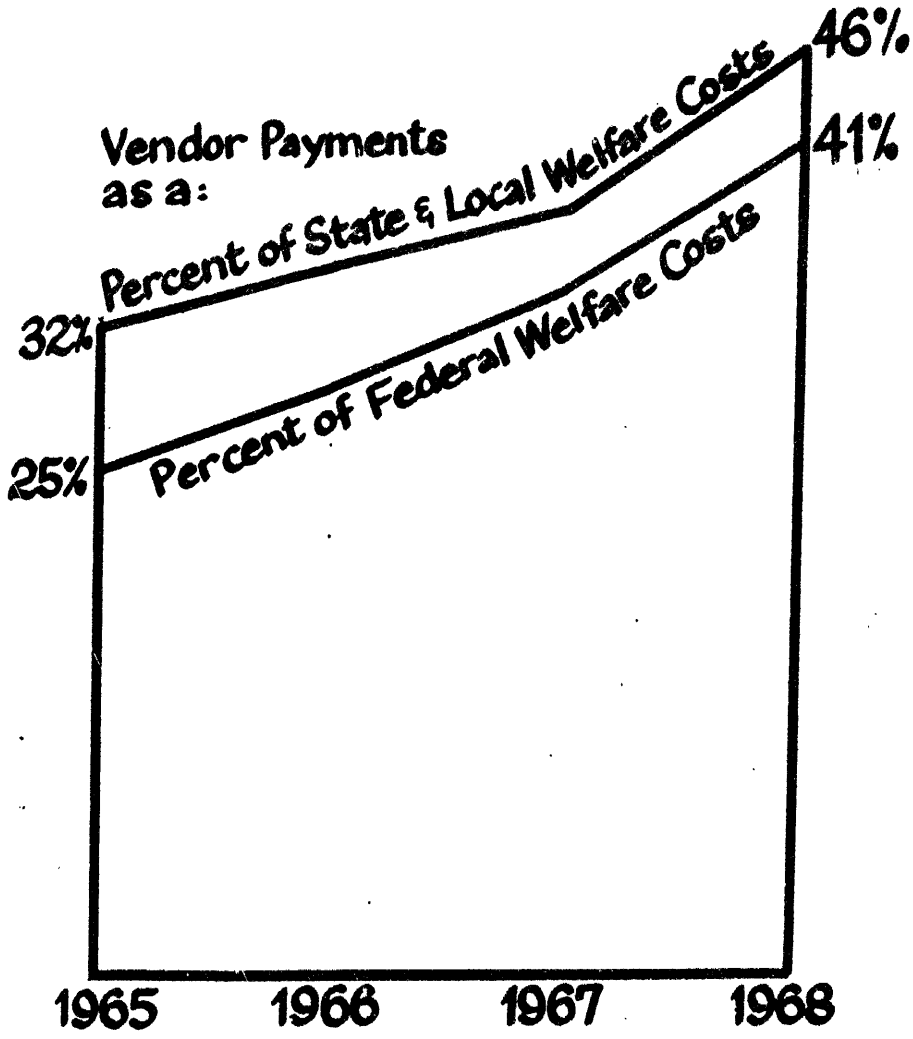
Increasing Medicaid costs have had a particularly severe fiscal impact on the States. Welfare costs typically constitute one of the largest items in the State budget, and vendor payments for medical care have represented an increasing share of welfare costs. In fiscal year 1965, just before Medicaid's enactment, medical assistance represented 25 percent of total Federal, State, and local welfare costs (excluding administrative costs). Over a 4-year period, this percentage has risen to 41 percent. Looking at State and local funds only, medical vendor payments have risen over the 4-year period from less than one-third to almost one-half of welfare expenditures (excluding costs of administration). In absolute dollar terms, the rise has been precipitous: from $764 million in State and local funds for medical vendor payments in fiscal year 1965 to $1,896 million in fiscal year 1968—a 150 percent increase within 4 years.

A questionnaire was sent by the staff to each Governor asking whether current Medicaid estimates were greater than earlier projected costs for the same years. About half of the States whose Medicaid programs were initiated in 1966 or 1967 responded that Medicaid costs are exceeding earlier projections. In a few States the costs are not exceeding earlier estimates only because the program has been cut back to fit within appropriation ceilings.

The questionnaire also asked whether Medicaid cost increases had forced the State to increase taxes, reduce other State programs, or take other action. One-third of the States initiating a Medicaid program in 1966 or 1967 have raised State taxes at least in part due to Medicaid costs; a number of Governors state that the tax increases in their States could be directly linked to greater-than-anticipated Medicaid costs. Several Governors attributed either cutbacks in other State programs or curtailment of growth in other programs directly to increased Medicaid costs.

CHART 4

Medical Vendor Payments Have Grown as a Portion of Total Welfare Costs



EXPLANATION OF CHART 5

Actuarial Estimates of 1970 and 1990 Hospital Insurance Benefits

The Medicare law enacted in 1965 included benefits under two parts: (1) Part A, Hospital Insurance, provided hospital benefits and extended care and home health benefits after hospitalization; and (2) Part B, Supplementary Medical Insurance, paid part of the cost of doctors' services, diagnostic services (such as X-ray and laboratory tests), and home health services (even without prior hospitalization). The Hospital Insurance program was to be financed through an employer-employee tax like the social security cash benefit programs. Almost all of the cost of the program was attributed to hospital benefits. In 1965, when the Medicare program was enacted, the actuarial cost estimates were based on current data on utilization of hospital care and hospital costs. Based on these data, the program was estimated to cost $2.9 billion in 1970 and $8.8 billion in 1990.

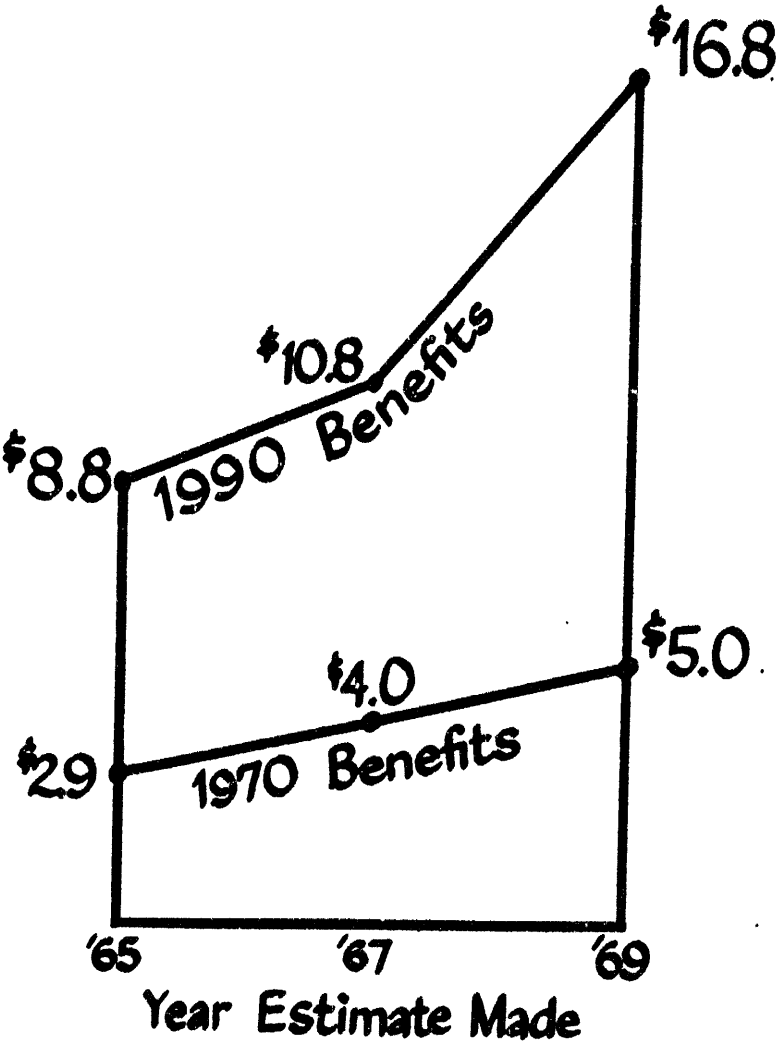
Preliminary experience led to a thorough reevaluation of the earlier actuarial estimates in 1967. At that time, cost estimates were increased by about 25 percent; 1970 costs were increased to $4 billion, while estimates of 1990 costs were increased to $10.8 billion.

Again in early 1969, the actuarial cost estimates were reevaluated, and new estimates were incorporated in the 1969 report of the Hospital Insurance Trust Fund trustees. For the first time, actuarial assumptions were more firmly based on actual program experience. The increases in projected program costs were dramatic; 1970 benefit payments are now estimated at $5 billion, and 1990 benefit payments are now projected at $16.8 billion—in both cases, almost twice the original estimates made in 1965.

CHART 5

Hospital Insurance Benefit Estimates Have Been Almost Doubled in 4 Years

(dollars in billions)

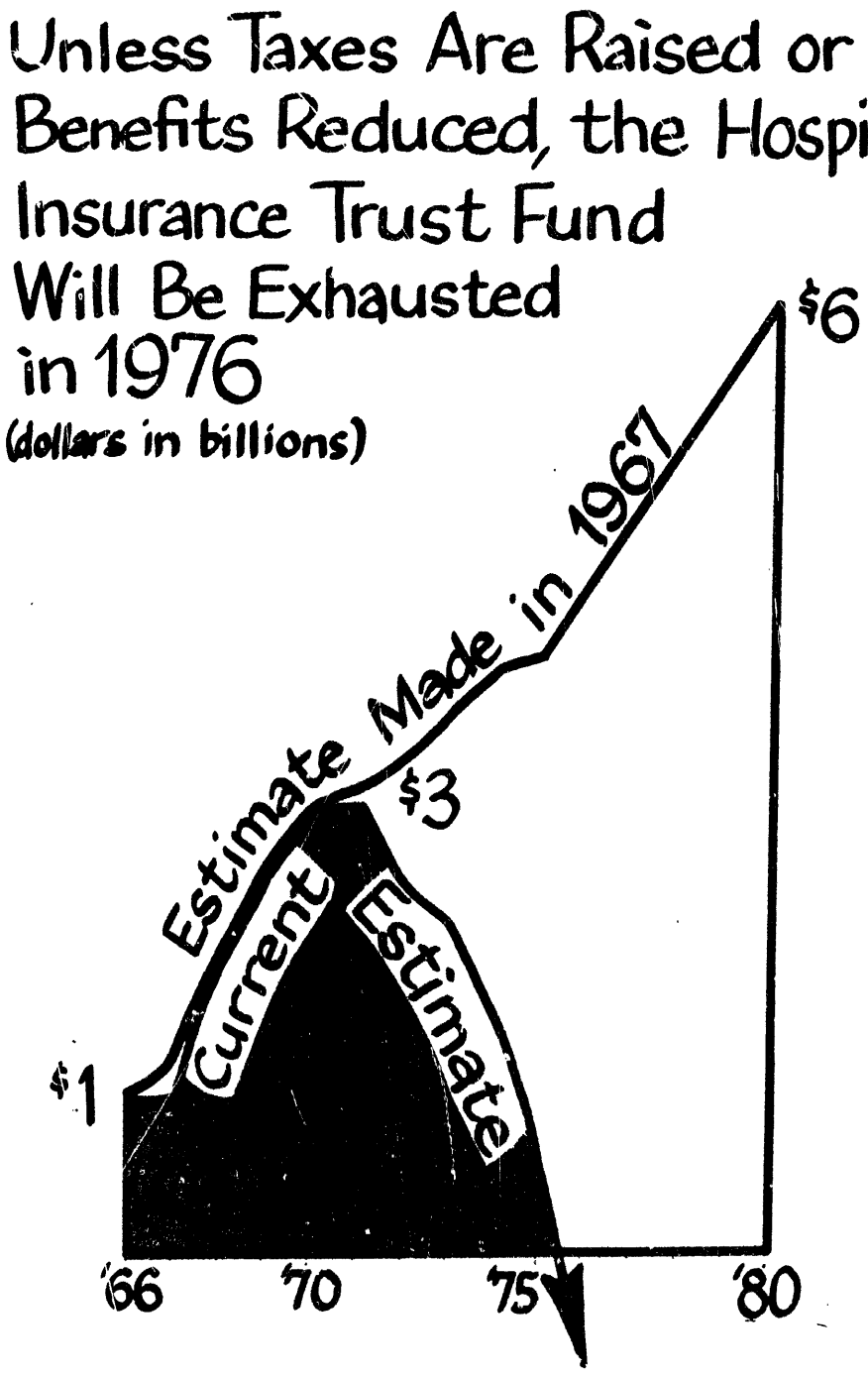


EXPLANATION OF CHART 6

Hospital Insurance Trust Fund Due To Be Exhausted in 1976

In 1967 the Congress increased Hospital Insurance taxes by about 25 percent to shore up the program's financing. Without this increase, the Social Security Chief Actuary had estimated that the Hospital Insurance Trust Fund would have been exhausted in 1970. The Hospital Insurance tax increase was meant to restore the actuarial soundness of the Hospital Insurance program—that is, to insure that tax income would more than equal benefit payments over the next 25 years. But the current projections of the progress of the Hospital Insurance Trust Fund included in the 1969 Trustees' Report show that unless taxes are increased or benefits reduced, the Trust Fund will be exhausted in 1976.

CHART 6



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EXPLANATION OF CHART 7

Restoring Actuarial Soundness of Hospital Insurance Program

With the actuarial projection that the hospital insurance trust fund will be exhausted in 1976, there are three ways of restoring the actuarial soundness of the Hospital Insurance program:

(1) Hospital Insurance taxes can be increased by 20 percent;

(2) The hospital deductible of $44 (about equal to 1 day of hospitalization) can be increased to $175 (about 4 days of hospitalization); or

(3) Cost controls can be put into effect.

Of course, it would be possible to combine these alternatives.

CHART 7

Alternative Ways of Restoring Actuarial Soundness of Hospital Insurance Program:

- Increase Hospital Insurance Taxes 20%

or

- Increase deductible from $44 to $175

or

- Control Costs

EXPLANATION OF CHART 8

Estimates of 1970 Hospital Costs Per Beneficiary

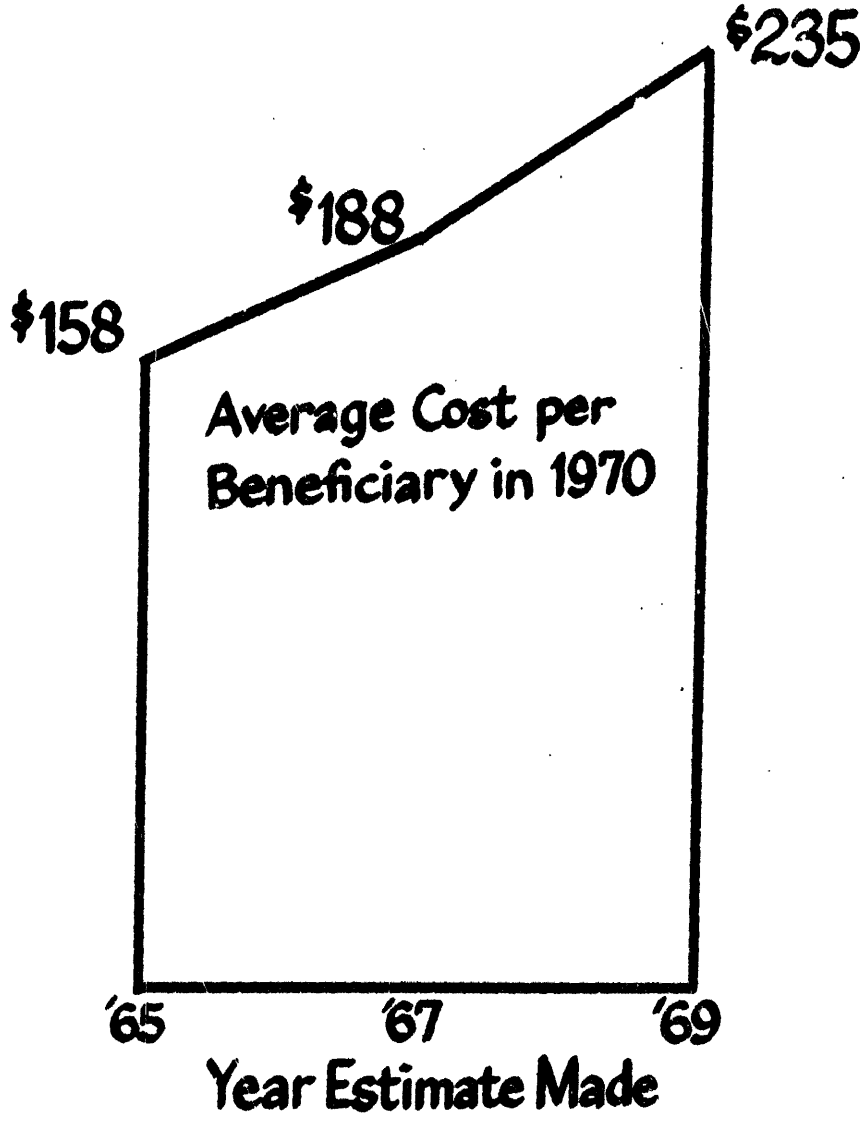
Under the 1965 actuarial estimates made when Medicare was enacted, it was assumed that average daily hospital costs would reach $50 by 1970. It was also assumed on the average, hospital insurance beneficiaries would spend 3.16 days in the hospital per year. The product of these two numbers, $158, represented the estimate of the annual hospital cost per beneficiary in 1970 (equivalent to the total hospital benefits divided by the number of persons enrolled in the hospital insurance program). Both of these assumptions were based on a careful analysis of experience with rising hospital costs and hospital utilization by persons over 65 during the previous decade. In fact, the assumptions were deliberately given a conservative bias by choosing a somewhat higher utilization than was warranted by experience at that time.

By 1967 it had become clear that hospital costs were increasing far more rapidly than had been projected. The revised actuarial estimates now assumed that 1970 average daily hospital costs would be more than $59. The same utilization rate (3.16 days of hospitalization per beneficiary per year) was assumed, and thus it was estimated that in 1970 the hospital cost per beneficiary would be $188.

By 1969, the first year's experience showed that hospital utilization had exceeded the earlier assumption by 20 percent. In the new actuarial estimates, it was assumed that the actual 1967 utilization rate of 3.8 days of hospitalization per beneficiary per year would continue in the future. The 1970 average daily hospital costs are now estimated at $62 for an average cost per beneficiary in 1970 of $235—almost a 50-percent increase above the estimate made in 1965.

CHART 8

Estimates of 1970 Hospital Costs per Beneficiary Have Been Increased Sharply



EXPLANATION OF CHART 9

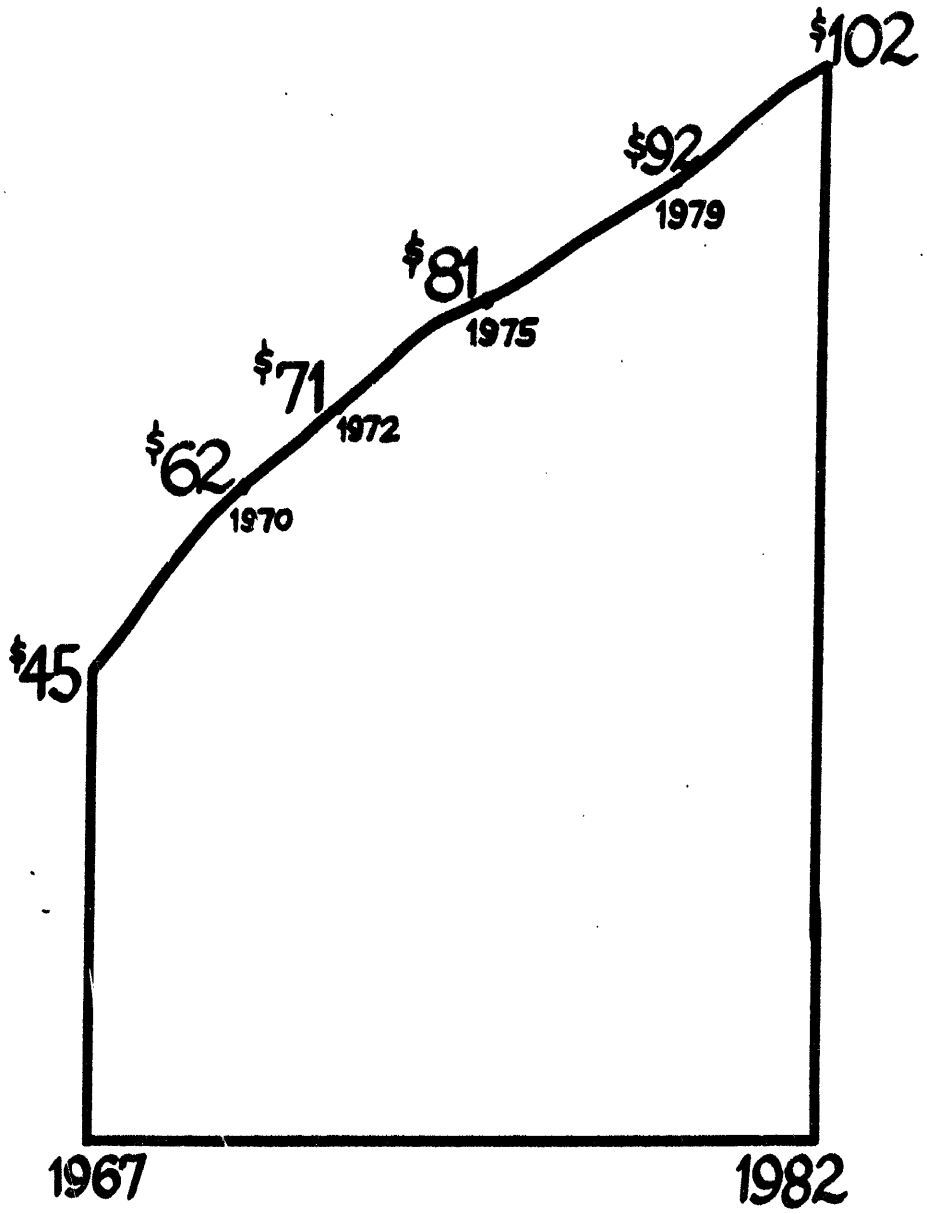
Projected Daily Hospital Rates

Under the 1969 actuarial projections it is assumed that the 1967 averag daily hospital cost of about $45 increased 13 percent in 1968 and wi.. increase by 12 percent in 1969, 9 percent in 1970, and by declining amounts after that until a stable annual increase of 3.5 percent is reached in 1975.

Under these estimates the average daily hospital rate will be about $62 in 1970, $71 in 1972, $81 in 1975, $92 in 1979, and $102 by 1982.

CHART 9

Estimated Daily Hospital Rates, 1967-1982



EXPLANATION OF CHART 10

Extended Care Benefits in 1967

The original actuarial estimates made in 1965 when Medicare was enacted assumed that on the average, each person enrolled in the hospital insurance program would spend one-sixth of a day in an extended care facility in 1967. Based on then recent experience, it was assumed that the average daily cost in an extended care facility would be $11.26. The product of these two numbers, $1.80, represented the estimate of the extended care benefit cost per beneficiary in 1967 (the equivalent of total extended care benefits under the program divided by the number of persons enrolled in the program).

Actual experience in 1967 showed that the cost per beneficiary per year was $18—10 times the earlier estimate. The actual average daily cost was $18.16, and the utilization rate was 1 day per beneficiary per year.

CHART 10

Extended Care Benefits in 1967 Cost 10 Times the Original Estimate

1967 estimate made in 1965:

$11 daily cost
x 0.16 days per beneficiary
$1.80 per beneficiary per year

Actual 1967:

$18 daily cost
x 1 day per beneficiary
$18 per beneficiary per year

EXPLANATION OF CHART 11

Supplementary Medical Insurance Deficit on an Accrual Basis

The financing of the supplementary medical insurance program is essentially different from that for the cash benefit and hospital insurance programs in several fundamental respects. First, the premium rate for any period is required by law to be set at such an amount that income from premiums and Government matching contributions accrued in the period is estimated to be sufficient to cover the benefit payments and processing costs related to all services furnished during that period. In this way, those enrolled in the program during any period for which a particular premium rate is applicable will, as a group, pay for half the cost of the services that they as a group receive during that period. Thus costs are measured on an accrued (incurred) basis when the services are provided, rather than on a cash basis, when the services are paid for.

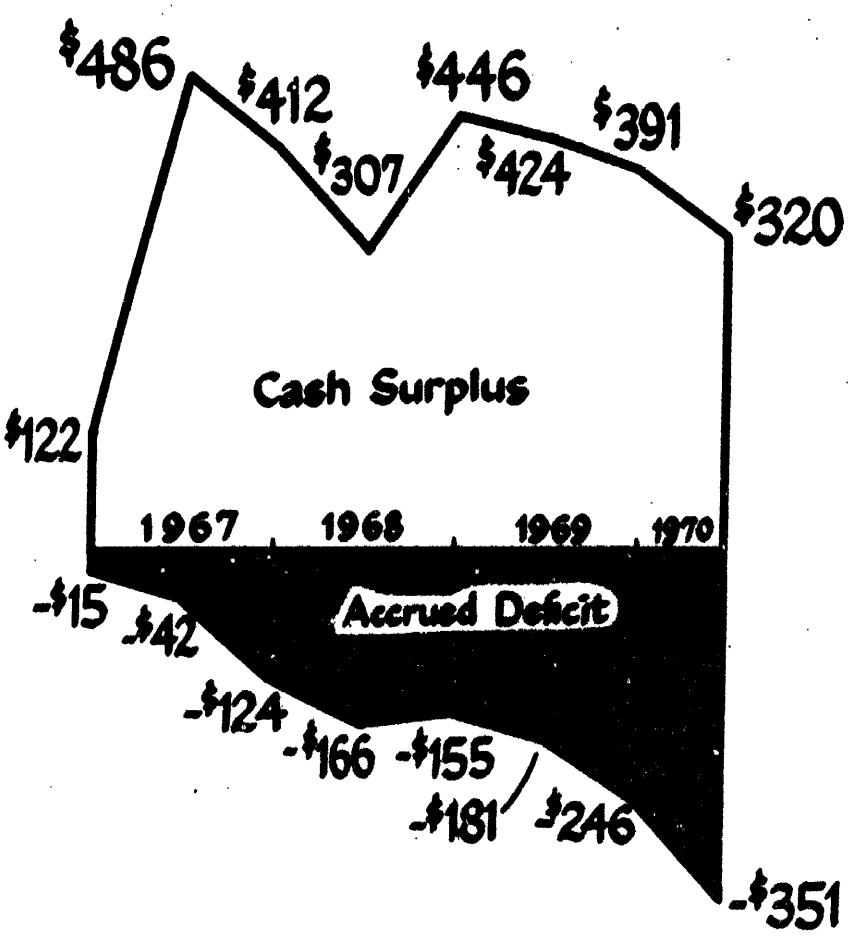
Second, the financing of the program is set only for short periods into the future, so that there is no need for long-term projections of the experience of the program. (The premium rate for each fiscal year period is promulgated before the January 1 that precedes the beginning of such fiscal year.) Further, there is no natural accumulation of an excess of income over disbursements as the covered population matures. The natural lag in the payment of benefits results in a cash surplus which provides some margin to insure enough assets on hand at any time to pay benefits should the premium prove inadequate by a small margin.

Since there is a delay in the submission and payment of bills, the supplementary medical insurance trust fund has shown a positive cash balance since the beginning of the program. However, this cash balance is expected to decline by more than $100 million during fiscal year 1970, when the $4 monthly premium is in effect.

The law, however, requires that monthly premiums be based on the estimated accrued costs. On this basis, the supplementary medical insurance program has shown a growing deficit from its inception, a deficit which is expected to grow during the current fiscal year. The deficit is expected to almost double between June 30, 1969 (—$181 million) and June 30, 1970 (—$351 million), because the $4 monthly premium for fiscal year 1970 is expected to be about 10 percent too low.

CHART 11

Supplementary Medical Insurance Has a Cash Surplus, but a Growing Deficit on an Accrual Basis (dollars in millions)



EXPLANATION OF CHART 12

Restoring Actuarial Soundness of Supplementary Medical Insurance Program

With the actuarial projection that the accrued deficit in the Supplementary Medical Insurance Trust Fund will almost double in the current fiscal year, there are three ways of restoring the actuarial soundness of the Supplementary Medical Insurance program:

(1) The monthly premium can be increased from $4 to $4.40;
(2) The deductible of $50 can be increased to $80; or
(3) Cost controls can be put into effect.

Of course, it would be possible to combine these alternatives.

CHART 12

Alternative Ways of Restoring Actuarial Soundness of Supplementary Medical Insurance Program:

- Increase monthly premium from $4.00 to $4.40

or

- Increase deductible from $50 to $80

or

- Control Costs

EXPLANATION OF CHART 13

Increases in Physician Fees

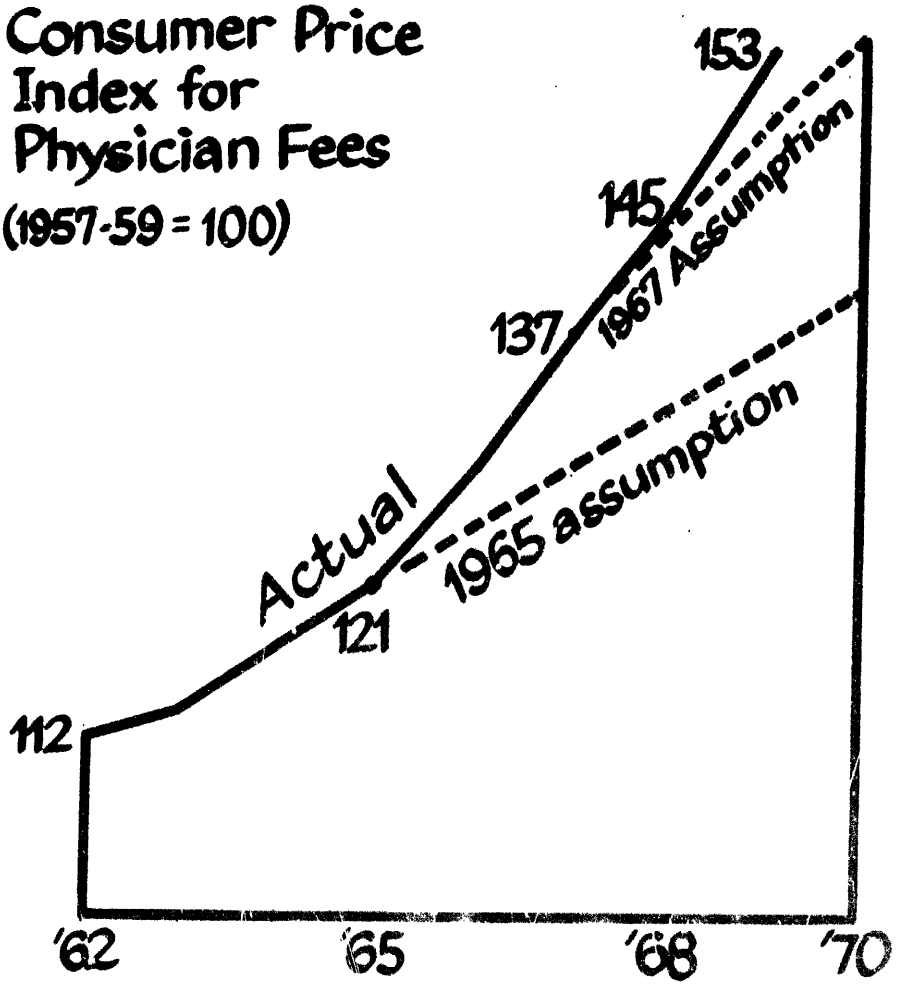
Between 1956 and 1965, physician fees had risen an average of 3 percent annually. The 1965 actuarial estimates assumed a continuation of this rate of increase.

However, physician fees between June 1965 and June 1967 actually rose at an annual rate of 6.5 percent per year (compared to the 3-percent average rate of the previous 10 years). In setting the supplementary medical insurance premium which was to go into effect in April 1968, it was assumed that physician fees would rise at the rate of 5 percent per year between July 1967 and July 1969, and by 3 percent per year thereafter.

Between June 1967 and June 1968, physician fees rose 5.5 percent (compared with the 5-percent increase previously estimated). The late 1968 actuarial estimate assumed that physician fees would increase 5 percent in 1969, 4.5 percent in 1970, and 3.5 percent in 1971. Despite the actuarial estimates which indicated the need for a 10-percent increase in the monthly premiums, it was decided not to increase the $4 monthly supplementary medical insurance premium on the assumption that either (1) there would be no increase in either physician fees or utilization of services between July 1969 and June 1970, or (2) reimbursement would much more often than in the past be based on less than the full charge. Between December 1968, the month of the promulgation of the $4 premium rate, and April 1969 physician fees rose 2.8 percent.

CHART 13

Physician Fees Have Increased More Rapidly Than The Estimates Assumed



EXPLANATION OF CHART 14

Intermediary and Carrier Costs

Though only a small portion of the total cost of the Medicare program, administrative costs have been subject to the same problem of unanticipated increases as have the benefit payments.

The President's budget for fiscal year 1968, for example, anticipated a need of $44 million for part A intermediaries (insurance companies and Blue Cross plans that handle Hospital Insurance claims) and $66.2 million for part B carriers (insurance companies and Blue Shield plans that handle Supplementary Medical Insurance claims), a total of $110.2 million. These funds soon proved insufficient; a special $25 million contingency fund was also exhausted; and a supplemental appropriation was sought. The actual fiscal year 1968 budget was $55.3 million for part A intermediaries (26 percent more than the original estimate) and $98.2 million for part B carriers (48 percent more than the original estimate), a total of $153.5 million.

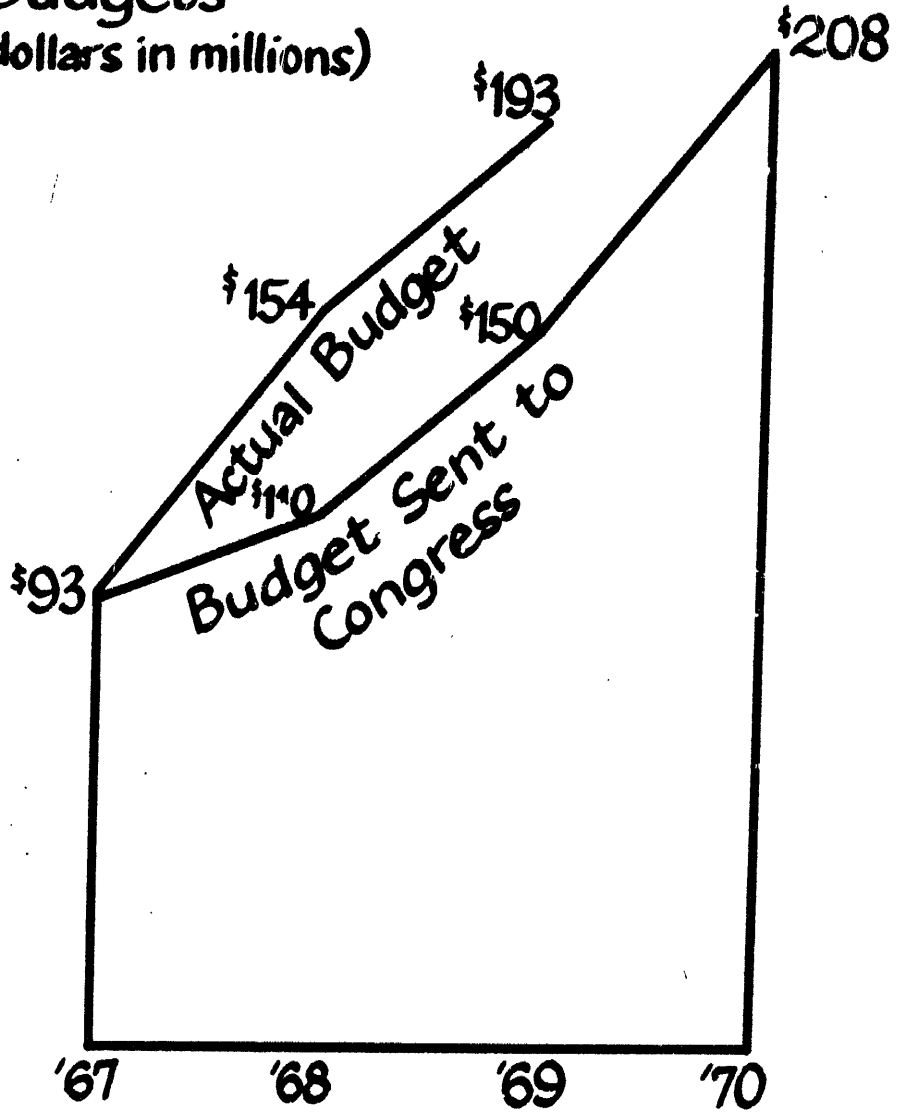
In fiscal year 1969, the story has been much the same. The original President's budget included $60.8 million for part A intermediaries and $89 million for part B carriers, a total of $149.8 million. As in fiscal year 1968, use of a special $25 million contingency fund was necessary. But this was not enough. A $16.5 million supplemental appropriation was sought by the President; the Senate added another $4.7 million to this amount because the Department of Health, Education, and Welfare determined that this additional amount was needed. The current estimate of need is $76.5 million for part A intermediaries (26 percent more than the original estimate) and $116.7 million for part B carriers (31 percent more than the original estimate), a total of $193.3 million.

The current 1970 budget estimates a need for $208 million for intermediary and carrier costs.

CHART 14

Intermediary and Carrier Costs Have Exceeded Original Budgets

(dollars in millions)



EXPLANATION OF CHART 15

Preliminary Findings: Medicaid

The January budget estimated Federal Medicaid costs in fiscal 1970 at $3.07 billion.

A revised estimate issued in April by the new administration shows a downward revision of $505 million. The reduction is estimated to occur as a result of elimination of the 2 percent bonus above costs paid to hospitals; a reduction of $120 million in Federal matching for care of the mentally ill; and limitation of payments to physicians to the lowest Blue Shield schedule in each geographic area. (It is our understanding that the administration has departed from its earlier position on the last item—limiting Medicaid payments to physicians.)

Some $238 million of the estimated reduction is attributable to downward revisions in State estimates of fiscal 1970 Medicaid spending. But one-half of this $238 million is nothing more than a bookkeeping change—a shift of skilled nursing home costs under Medicaid to intermediate care facility costs under Old-Age Assistance. Additionally, $120 million of the estimated reduction assumes a change in law with respect to the mentally-ill aged. Necessary implementing legislation has not been requested and in view of the legislative history of Federal matching for the mentally ill, congressional approval of such a proposal may be difficult to secure.

Medicare has served to increase the cost of hospital, physicians' and nursing home care of Medicaid. By HEW regulation, States must pay hospitals on the same formula as Medicare. The State of Connecticut has refused to follow that regulation, maintaining that to do so would cost it an additional $4 to $5 million a year.

Payment for physicians' services on the basis of "customary and prevailing charges" under Medicare has led to pressure by physicians for similar treatment under Medicaid. That pressure has been increased by published statements of the principal HEW Medicaid official that the Medicare method is the only "logical" way to pay for doctors' care under Medicaid.

A number of States have yielded to demands that they reimburse skilled nursing homes on the more generous basis under which extended care facilities are paid under Medicare.

Overutilization of care and services under Medicaid results from widespread abuse by recipients and providers of services coupled with a lack of effective control mechanisms.

Medicaid is both victim and cause of the superinflation in the medical care field through the increased demand on scarce resources which it has generated.

Federal officials have been lax in not seeing to it that States establish and employ effective controls on utilization and costs, and States have been unwilling to assume the responsibility on their own. The Federal Medicaid administrators have not provided States with the expert assistance necessary to establish and implement proper controls. Also, they have not developed mechanisms for coordination and communication among the States about methods of identifying and solving Medicaid problems.

CHART 15

Principal Preliminary Findings

- Medicaid
  - 1970 estimates of program costs too low
  - Reasons for high costs:
    - Impact of Medicare
    - Overutilization
    - General Inflation
    - Administrative laxity

EXPLANATION OF CHART 16

Preliminary Findings: Physician Reimbursement

The provisions of the statute and the clear congressional intent that Medicare carriers should not pay physicians more than they would ordinarily pay for their own subscribers has not been followed. Congress said that in paying physicians "consideration" should be given to customary and prevailing fees. Blue Shield had testified in 1965 that they regularly surveyed prevailing and customary physician fees, and that their fee schedules were very close and getting closer to prevailing fees. In actual practice the Medicare regulations require that payment should be made *solely* on the basis of customary and prevailing fees and that private insurance schedules should not have any influence on what Medicare pays. As a consequence, Medicare generally makes payments for the aged which are substantially higher than those paid under Blue Shield's most widely held contracts for the working population, and thus physicians' incomes have been inflated.

The need to maintain detailed data with respect to customary charges for each physician and for prevailing fees in each locality has led to weak administrative practices, unwarranted delays in payments to physicians and beneficiaries, and high administrative costs. There is a good deal of evidence that Medicare's pattern of inflated payments has also served to increase physicians' charges to the general public because a doctor is not permitted to charge more under Medicare (at least theoretically) than he does for his other patients.

Medicare is making payments for services by supervisory physicians in teaching hospitals—payments which were not generally made before Medicare.

These services, in fact, are not provided by those physicians but by residents and interns. Payment for these "services" may be costing as much as $100 million a year to Medicare. There is a question whether Medicare beneficiaries have a legal obligation to pay for such services. (Medicare payments are expressly prohibited by law in the absence of a legal obligation to pay.) Moreover, since the salaries of the interns and residents who actually provide the care are paid for under the hospital insurance program, Medicare may be paying for the same services twice.

There is substantial evidence that many physicians are engaging in the practice known as "gang visits" to nursing home and hospital patients. Under this practice a physician may see as many as 30, 40, and 50 patients in a day in the same facility—regardless of whether the visit is medically necessary or whether any service is actually furnished. The physician in many cases charges his full fee for each patient, billing Medicare for as much as $300 or $400 for one sweep through a nursing home.

There is evidence that physicians are now billing separately for services which were previously routinely included in a charge for an office visit or a surgical fee. For example, routine laboratory tests which were part of the office visit charge are now billed in addition to the fee for the visit. In some cases a surgeon now charges separately for preoperative and postoperative visits, services which used to be part of his surgical fee. This kind of price increase does not show up in the consumer price index figures set out in an earlier chart.

Conflict of interest situations occur with apparent widespread physician investment in nursing homes and proprietary hospitals. The physicians in these situations have an economic incentive to order as many services as possible and to extend the duration of stay for those of his patients whom he places in a medical facility in which he has an investment. It appears that many general practitioners are providing services—such as psychiatric counseling, injections, and laboratory work—to an extent unrelated to medical needs and solely for the purpose of maximizing their Medicare billings.

CHART 16

Principal Preliminary Findings

- Physician reimbursement
  - Congressional intent not followed
  - Lax carrier performance
  - As a result:
    - Payments much higher than Blue Shield's
    - Inflated physician incomes
    - Costly and complex administration
    - Inflated costs for total population
  - Unprecedented payments to supervisory physicians
  - Abuses:
    - "Gang visits"
    - Visits not necessary
    - Fragmentation in billing
    - Conflict of interest situations
    - Unnecessary services

EXPLANATION OF CHART 17

Preliminary Findings: Carrier and Intermediary Performance, Hospitals, Extended Care Facilities

With relatively few exceptions carriers and intermediaries have not been administering Medicare with the tight control necessary to the "efficient and economical" performance required by the law. Only a small proportion of the carriers now have in effect an adequate system for detecting and handling cases of abuse and overutilization.

Situations have occurred wherein a provider of health services transferred its insurance business to the government intermediary it had selected. Presumably, the intermediary would be reluctant to take action as the government's agent which would jeopardize its private business—a clear case of conflict of interest. In another case, the principal Medicare administrator of an insurance company served on the board of directors of a nursing home chain in New England (reportedly, the official recently resigned from that board).

Reports have been received of various intermediaries soliciting hospital and nursing homes for which they wish to act as intermediary, through implicit assurance that if selected they would treat the hospital or nursing home more generously with Medicare's money than the present intermediary. This situation leads to competition in spending Medicare money rather than conserving it.

In general, claims control procedures are ineffective. When asked for simple basic data about the physicians' services which Medicare paid for, one carrier advised that it would take 9 weeks and thousands of additional dollars to develop this simple information—information which they should have been routinely developing as a basic claims control. Another did not keep records on the total Medicare payments it made to individual physicians nor did it know how many different Medicare patients had been rendered service by the various doctors it paid.

Utilization review in hospitals is largely ineffective. Evidence of this may be seen in the tremendous jump in hospital utilization by Medicare beneficiaries. As the president of one State medical society put it: "Hospital utilization review works well in an area where there is a shortage of hospital beds. In other areas, however, where there is no shortage, utilization review is no more than token." A study in one State showed that only one-half of the hospitals had a utilization review plan which met the statutory requirement for sample review of admissio

The costs of hospital benefits during Medicare's first year of operation are not fully known because only 22 percent of hospitals have completed settlement with the Government. This lag of several years in settling accounts with hospitals makes Medicare estimating and accounting very difficult.

Utilization review in extended care facilities is generally either nonexistent or is a meaningless formality. In one State *not one* of the extended care facilities met this statutory requirement.

Another cause for concern is the alarming growth in chain operations in the nursing home field. Some of these chains actively solicit physician purchase of stock to assure a high occupancy rate. Other chains purchase stock of hospital supply and pharmaceutical supply houses. This leads to arrangements with respect to intercompany sales at what may very well be higher prices than would otherwise be paid—a form of captive market used to milk the Medicare trust funds.

Only a small percentage of nursing homes have finally settled with the Government for their first year under the program.

Unnecessary services are being provided on a widespread basis in nursing homes. Twenty Medicare patients were lined up in a nursing home hallway in their wheel chairs and given a single exercise by a physical therapy aide for a period of 5 minutes. Medicare was charged $9 for each of those patients for that service.

The majority of the extended care facilities participating in the program do not fully meet the standards set in the law and regulations.

CHART 17

Principal Preliminary Findings

- Carrier and Intermediary performance
  - Widespread lax administration
  - Conflict of interest situations
  - Intermediary solicitation of business
  - Poor claims control procedures
- Hospitals
  - Utilization review largely ineffective
  - Only 22% of 1st period accounts (1966-67) settled
  - Rapidly increasing costs
- Extended Care Facilities
  - Utilization review virtually nonexistent
  - Chain operations growing
  - Very few 1st period accounts (1967) settled
  - Unnecessary services
  - Participation of unqualified facilities

EXPLANATION OF CHART 18

Preliminary Findings: Reimbursement of Institutions, Federal Administration

Medicare has paid a 2 percent bonus to hospitals (1½ percent for proprietary facilities) above their actual costs. The committee has strongly criticized this cost-plus method of reimbursement since May, 1966. This method of reimbursement can only serve as a further incentive to inflate costs—the more costs can be increased, the greater the bonus. (The new Administration has recognized the validity of the Committee criticism and has announced that it would terminate payments of the bonus effective today, July 1, 1969.)

The Medicare reimbursement formula has other deficiencies. In most cases it pays a disproportionate share of unoccupied bed costs in a facility; it permits inflated depreciation allowances on inflated cost bases. Its reimbursement of covered costs without limitation is a built-in incentive for inefficiency and inflation.

Evidence exists that "kick back" arrangements between suppliers—such as pharmacies and physical therapists—and nursing homes may be widespread.

The administration of Medicare is inadequate and ineffective from the standpoint of insistence upon proper cost controls and utilization review. There is a high degree of tolerance for carriers and intermediaries who cannot reasonably be considered as "efficient and economical" as required by law. There is a lack of current program information with respect to costs and utilization which hampers both effective administration and estimating.

In their eagerness to get as much health care as possible to the greatest number of people, secondary concern seems to have been given to the quality of the care and the control of costs. The resulting severe actuarial deficiencies which have occurred in Medicare are then glossed over with statements that Congress need merely increase the Social Security tax, or wage base and the costs can be paid.

CHART 18

Principal Preliminary Findings

- Reimbursement of institutions
  - Formula provides 2% bonus
  - Pays for unoccupied beds
  - Supplier kickback arrangements
  - Inflated depreciation allowances
  - Incentive for inefficiency

- Federal Administration
  - Inadequate and ineffective controls
  - Tolerance of inefficient carriers and intermediaries
  - Lack of current program information
  - Cost of program apparently of secondary concern

EXPLANATION OF CHART 19

Preliminary Findings: Lack of Coordination, Medicare-Medicaid, Federal Tax Collector

There is a surprising lack of coordination between Medicare and Medicaid despite the fact that both programs are concerned with paying for health care. In fact, in hundreds of thousands of cases the two programs pay the same providers of services with respect to the same patients. The result at the Federal level is duplication of effort and an inability of one program to take advantage of whatever expertise and skills the other may have developed. There is no uniform system of coordinating information on possible fraud cases between the two programs.

At the State level, for example, Medicare may have information concerning abuses by a physician who also treats Medicaid patients. Medicaid officials in that State, however, do not have access to the details of the Medicare abuse.

Medicare carriers have been permitted to use a variety of so-called identification systems with respect to the physicians to whom they make payments. These systems use a wide variety of numbers—sometimes more than one number for the same physician. They have been characterized as comparable to Swiss bank accounts, since the effect is to make it very difficult to trace the Federal payment. Medicaid and Medicare paid some $2 billion to physicians in the past year. Unlike other payments to individuals, these are not reported to the Internal Revenue Service. The tax collector wants that information.

CHART 19

Principal Preliminary Findings

- Lack of coordination with other Government agencies
  - Medicare - Medicaid
    - Federal level
    - State level
  - Federal Tax Collector
    - $2 billion unreported
    - "Swiss bank account" numbers

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