



United States  
General Accounting Office  
Washington, D.C. 20548

Health, Education and Human Services Division

B-277367

July 18, 1997

The Honorable Thomas J. Bliley, Jr.  
Chairman, Committee on Commerce  
House of Representatives

Subject: Medicaid: Projected Cost of Expanding Coverage for Children

Dear Mr. Chairman:

This letter responds to your January 3, 1997, request for an estimate of the cost of expanding Medicaid coverage to include all children who are under age 18 and living in families with incomes below 300 percent of the federal poverty level (FPL). You also asked for information on the number of additional children who would be covered under an expanded program and Medicaid spending per child on a state-by-state basis.

In summary, we estimated there are 32.3 million children under age 18 living in families with incomes below 300 percent of FPL and currently not enrolled in Medicaid. Using estimates of the proportion of potentially eligible children who would actually enroll based on studies of past program expansions, we calculated that between 6 million and 9.5 million additional children might enroll in the program if it was expanded, at an additional cost ranging from \$6.8 billion to \$10.6 billion per year. The cost calculation was based on fiscal year 1995 Medicaid spending as reported by the Health Care Financing Administration (HCFA). As agreed with your office, we are not reporting this information by state, because we are uncertain about the accuracy of state-level data. Instead, the cost calculations are based on national average costs by age group.

First, to estimate the number of eligible children, we used data from the Current Population Surveys (CPS) to tabulate the number of children who were under 18, living at below 300 percent of FPL, and not enrolled in Medicaid. Because CPS counts are based on samples, we used a 3-year average, from 1994 to 1996, to improve the reliability of the estimates. This approach yielded an estimate of 32.3 million eligible children.

GAO/HEHS-97-170R Medicaid Coverage for Children

Studies of program expansions during the late 1980s and early 1990s concluded that children without private health insurance enrolled in Medicaid at rates ranging from 70 to 90 percent of those eligible.<sup>1</sup> Prior studies concluded that children with private insurance enrolled at much lower rates: About half continued their insurance but also enrolled in Medicaid, and up to 15 percent switched from private insurance to Medicaid.<sup>2</sup> We excluded from our estimates the eligible children who continued their private insurance because Medicaid is the payer of last resort. We assumed the costs for children jointly enrolled were small enough to be ignored. Moreover, HCFA does not collect the cost data necessary to include these children in our analysis.

Since previous research provides a range of enrollment rate estimates, we made enrollment calculations under three possible scenarios. The first scenario assumed that the uninsured would enroll at a rate of 70 percent and that the insured would not enroll in Medicaid. The second scenario assumed the uninsured would enroll at a 90-percent rate and that the insured would not

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<sup>1</sup>See Lisa Dubay and Genevieve Kenney, Revisiting the Issues: The Effects of Medicaid Expansions on Insurance Coverage of Children (Washington, D.C.: The Urban Institute, Oct. 1995), p. 9. The authors estimated that 70 percent of the uninsured enrolled in the program during past expansions of eligibility. See also David M. Cutler and Jonathan Gruber, "Does Public Insurance Crowd Out Private Insurance?" Quarterly Journal of Economics (May 1996), p. 407. These authors estimated that 90 percent would enroll.

<sup>2</sup>The following two studies estimated that none of the privately insured dropped their insurance and enrolled in Medicaid: Esel Y. Yazici, "Medicaid Expansions and the Crowding Out of Private Insurance," presented at the 18th Annual Research Conference of the Association for Public Policy Analysis and Management, Pittsburgh, Penn., Nov. 2, 1996, p. 21, and Lara Shore-Sheppard, "The Effect of Expanding Medicaid Eligibility on the Distribution of Children's Health Insurance Coverage," prepared for the Cornell/Princeton conference on "Reforming Social Insurance Programs," Sept. 1996, p. 18. David M. Cutler and Jonathan Gruber, "Peer Review: Medicaid and Private Insurance: Evidence and Implications," Health Affairs (Jan./Feb. 1997), p. 198, found that 15 percent of the insured dropped their insurance and enrolled. Finally, Dubay and Kenney, Revisiting the Issues: The Effects of Medicaid Expansions on Insurance Coverage of Children, estimated that about half the children covered by private insurance kept their private insurance and also enrolled in Medicaid when they became eligible.

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enroll. The last scenario assumed that the uninsured would enroll at a 70-percent rate and the insured at 15 percent.<sup>3</sup>

To estimate the cost of this expansion of Medicaid eligibility, we obtained information on fiscal year 1995 spending per child from HCFA. Spending per child ranged from \$875 for children aged 1 to 5 to \$2,176 for children under age 1. We calculated the cost increase for four age groups: under age 1, ages 1 to 5, ages 6 to 14, and ages 15 to 17.<sup>4</sup> We multiplied fiscal year 1995 spending per child by the estimated increase in enrollment.<sup>5</sup>

The enrollment rate assumptions and the associated estimates of increased enrollment and cost are summarized in table 1. Scenario 1 represents the lowest cost estimate, \$6.8 billion, based on enrollment rates of 70 percent for the uninsured and 0 percent for the insured. Alternatively, scenario 3 yields the highest cost estimate, \$10.6 billion, based on enrollment rates of 70 percent for the uninsured and 15 percent for the insured.

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<sup>3</sup>The estimate of a 90-percent participation rate was derived from the assumption that all enrollees came from the pool of uninsured children. Therefore, the only scenario we developed that assumed a 90-percent participation rate also assumed none of the insured would enroll in the program.

<sup>4</sup>Because HCFA does not collect data on Medicaid spending for 15- to 17-year-old children, we used a proxy for this age group: the spending per child for 15- to 20-year-old children

<sup>5</sup>See table I.1 in the enclosure for CPS counts, table I.2 for expected enrollment increases by age group, table I.3 for spending per child by age group, and table I.4 for cost calculations by age group.

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**Table 1: Scenarios for Enrollment Rate and Estimated Increases in Enrollment and Costs Under Medicaid Expansion, Fiscal Year 1995**

Scenarios	Enrollment rates (percentages)		Increased enrollment		Increased cost	
	Insured	Uninsured	Enrollees (in millions)	Percentages <sup>a</sup>	Amount (in billions)	Percentages <sup>a</sup>
1	0	70	6.0	45.0	\$6.8	47.1
2	0	90	7.7	57.8	8.7	60.5
3	15	70	9.5	71.8	10.6	73.9

<sup>a</sup>The percentage increase was calculated using the number of Medicaid enrollees obtained from CPS.

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If you have any questions regarding this letter or if we can be of further assistance, please call me at (202) 512-7114 or Jerry Fastrup, Assistant Director, at (202) 512-7211.

Sincerely yours,



William J. Scanlon  
Director, Health Policy and Financing Issues

Enclosure

ENROLLMENT AND COST ESTIMATES BY AGE COHORT

This enclosure provides detailed information on our calculations by age group. Table I.1 shows the estimated numbers of eligible children by age group. Table I.2 shows the estimated increased enrollment for the three scenarios by age group. Table I.3 shows the cost per child. Table I.4 shows additional cost calculations by age group.

Table I.1: Three-Year Average Estimates of Number of Children Who Would Be Eligible Under Medicaid Expansion, by Age Group

In millions

Eligible children	Under age 1	Aged 1 to 5	Aged 6 to 14	Aged 15 to 17	Total
Insured	1.1	6.8	12.3	3.5	23.7
Uninsured	0.5	2.3	4.2	1.6	8.6
<b>Total</b>	<b>1.6</b>	<b>9.1</b>	<b>16.5</b>	<b>5.1</b>	<b>32.3</b>

Source: CPS 1994-96.

Table I. 2: Estimates of Increased Enrollment Under Three Enrollment Rate Scenarios, by Age Group

Scenarios	Enrollment rates (percentages)		Increased enrollment (in millions)				
	Insured	Uninsured	Under age 1	Aged 1 to 5	Aged 6 to 14	Aged 15 to 17	Total
1	0	70	0.3	1.6	3.0	1.1	6.0
2	0	90	0.4	2.1	3.8	1.4	7.7
3	15	70	0.5	2.6	4.8	1.6	9.5

Table I.3: Medicaid Cost per Enrollee, by Age Group, Fiscal Year 1995

	Age groups				
	Under 1	Aged 1 to 5	Aged 6 to 14	Aged 15 to 17	Aged 15 to 20
Cost per child	\$2,176	\$875	\$881	\$1,846	\$1,170

Table I.4: Additional Cost of Expanding Medicaid Coverage, by Age Group

Scenario	Enrollment rates (percentages)		Additional cost (in millions)				
	Insured	Uninsured	Under age 1	Aged 1 to 5	Aged 6 to 14	Aged 15 to 17	Total
1	0	70	\$720	\$1,395	\$2,601	\$2,055	\$6,771
2	0	90	926	1,793	3,344	2,643	8,706
3	15	70	1,089	2,285	4,230	3,029	10,634 <sup>a</sup>

<sup>a</sup>Because of rounding, dollar amounts do not equal total.

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Health, Education and Human Services Division

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June 17, 1997

The Honorable Charles E. Grassley  
Chairman, Special Committee on Aging  
United States Senate

Subject: Medicare: Problems Affecting HCFA's Ability to Set Appropriate Reimbursement Rates for Medical Equipment and Supplies

Dear Mr. Chairman:

Medicare spent over \$4.3 billion in 1996 for medical equipment and supplies,<sup>1</sup> such as walkers, catheters, and glucose test strips for its beneficiaries. Problems in setting payment rates, however, raise concerns about whether the Health Care Financing Administration (HCFA) paid too much for these items. Our prior studies<sup>2</sup> and a report by the Office of the Inspector General (OIG)<sup>3</sup> in the Department of Health and Human Services (HHS) have documented that Medicare pays higher-than-market rates for some items. HCFA recognizes that it pays too much for some medical equipment and supplies, as we have reported, but believes a slow and cumbersome regulatory process for adjusting Medicare's payment rates severely hinders its efforts to address overpricing.

At your request, we are currently reviewing the underlying problems associated with setting appropriate Medicare reimbursement rates for medical

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<sup>1</sup>This amount includes expenditures for prosthetics, orthotics, and pharmaceutical drugs (such as nebulizer drugs) used in conjunction with durable medical equipment as well as expenditures for medical equipment and supplies.

<sup>2</sup>See Medicare: Excessive Payments for Medical Supplies Continue Despite Improvements (GAO/HEHS-95-171, Aug. 8, 1995) and Medicare Spending: Modern Management Strategies Needed to Curb Billions in Unnecessary Payments (GAO/HEHS-95-210, Sept. 19, 1995).

<sup>3</sup>Durable Medical Equipment - Review of Medicare Payments for Home Blood Glucose Monitors, HHS OIG, A-09-92-00034 (Washington, D.C.: Dec. 1992).

**GAO/HEHS-97-157R Medicare Payments for Medical Equipment and Supplies**

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equipment and supplies. Because the Congress may shortly consider legislation on Medicare payment rates, however, your office requested that we provide you with interim information on the problems we have identified to date.

Specifically, this correspondence identifies two basic problems with the Medicare reimbursement system for medical equipment and supplies: (1) HCFA does not know specifically what products it is paying for when it pays claims and (2) Medicare reimburses large suppliers and individual beneficiaries at the same rates, even though those rates do not account for the discounts large suppliers negotiate with manufacturers and wholesalers.

To develop our information, we analyzed Medicare payments for off-the-shelf, commonly used medical equipment and supplies. We also reviewed the laws, regulations, coding systems, and fee schedules for Medicare's payments for medical equipment and supplies. We obtained data on Medicare payments from HCFA's carriers and the statistical analysis contractor. We obtained information on product pricing, distribution channels, and purchasing practices through discussions with manufacturers, suppliers, and industry groups. We also collected prices and acquisition costs for selected items from HCFA contractors, various suppliers, wholesalers, manufacturers, a state Medicaid agency, and the Department of Veterans Affairs.

Finally, we obtained information on universal product numbering systems for medical products from the Department of Defense (DOD); associations representing medical equipment suppliers, distributors, and manufacturers; and a group of hospital buying groups, health care providers, manufacturers, and distributors working on building a consensus for product identification standards.

We performed our field work between March 1996 and June 1997 in accordance with generally accepted government auditing standards, except for (1) auditing the cost and pricing information obtained from suppliers and (2) examining the internal and data processing controls of the Medicare claims databases maintained by HCFA's contractors. The cost and pricing information we received from the multiple suppliers was fairly consistent. In addition, the statistical reports obtained from the Medicare claims databases were not critical to our findings.

#### RESULTS IN BRIEF

HCFA does not know specifically what products it is paying for when it pays Medicare claims for medical equipment and supplies, according to our work to date. HCFA does not require suppliers to identify specific products on their

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Medicare claims. Instead, suppliers use HCFA billing codes, some of which cover a broad range of products of various types, qualities, and market prices. For example, suppliers use one Medicare billing code for more than 200 different urological catheters, even though some catheters sell at a fraction of the price of others billed under the same code. Because Medicare pays suppliers the same amount for all the products covered by a billing code, the reimbursement system gives suppliers a financial incentive to provide Medicare patients with the least costly products covered by a billing code. In addition, because Medicare claims do not identify the specific product provided, HCFA lacks the information it needs to ensure that each billing code is used for comparable products.

To identify specific medical equipment and supplies, DOD and some other major purchasers are beginning to require suppliers to use a universal product numbering system. This system, which can also be used for bar coding the products, enables purchasers and insurers to identify specific products being used and track reimbursements for each product and groups of similar products as well as the market prices of specific products. HCFA officials, on the other hand, have not begun exploring the possibility of using the universal product numbering system in the Medicare program.

Medicare reimburses large suppliers and individual beneficiaries the same amounts for medical equipment and supplies, even though large suppliers negotiate substantial discounts with manufacturers and wholesalers, while individual beneficiaries pay retail prices. Large suppliers provide some products, such as urological catheters and drainage bags, to nursing homes and home health agencies, which then provide them to individual Medicare beneficiaries. In turn, the large suppliers can bill Medicare directly and get reimbursed at fee-schedule rates based on historical charges and catalog prices. For example, one supplier's weighted average cost for all catheters billed in 1996 under one Medicare billing code was less than \$1 per catheter; however, Medicare reimbursed the supplier at the program's fee-schedule allowance of \$10 to \$12 per catheter. HCFA has not considered establishing a separate fee schedule for products provided to nursing home and home health patients that accounts for their suppliers' substantially lower acquisition costs compared with the cost of products beneficiaries purchase directly.

### BACKGROUND

Medicare covers a wide variety of medical equipment, such as walkers and canes, and supplies such as urinary catheters, drainage bags, glucose test strips,

and ostomy products.<sup>4</sup> Medicare part B insurance covers these products for beneficiaries who live at home or in facilities used as homes, such as nursing homes.<sup>5</sup> Medicare pays 80 percent of the allowed amount, which is the lower of the actual charge submitted by the supplier or the amount allowed under a fee schedule. Medicare beneficiaries pay for the remaining 20 percent of the allowed amount.

HCFA classifies medical equipment and supplies into groups using the HCFA Common Procedure Coding System (HCPCS). HCFA assigns each group of products an HCPCS code intended to cover similar items, and all items covered by a code are reimbursed at the same rate. When suppliers submit a Medicare claim, they must specify an HCPCS code to identify the group that they believe best describes the specific item provided to the Medicare patient.

Four HCFA contractors, called Durable Medical Equipment Regional Carriers (hereafter referred to as carriers), process and pay Medicare claims for medical equipment and supplies.<sup>6</sup> Each carrier covers a separate region of the country. The Statistical Analysis Durable Medical Equipment Regional Carrier (referred to as the statistical analysis contractor) analyzes claims processed by the carriers and ensures that the carriers and suppliers uniformly interpret and use the HCPCS codes.<sup>7</sup>

Most Medicare part B payments for medical equipment and supplies are based on a fee-schedule system set forth under section 1834 of the Social Security Act.<sup>8</sup> Under this system, HCFA calculates a fee-schedule allowance for each HCPCS code for each state. The allowances for each state are based on the average historical charges that suppliers submitted in 1986 and 1987; the

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<sup>4</sup>Medicare part A covers inpatient care in a hospital or skilled nursing facility and home health or hospice care. Medicare part B covers physician services, outpatient hospital services, durable medical equipment, and various other health services.

<sup>5</sup>Medicare part B does not cover medical equipment and supplies for patients in skilled nursing facilities whose stay is covered by part A.

<sup>6</sup>These carriers are also known as DMERCs.

<sup>7</sup>The Statistical Analysis Durable Medical Equipment Regional Carrier is also known as the SADMERC.

<sup>8</sup>42 U.S.C. 1395m.

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historical charges are indexed forward using the consumer price index. To reduce variation among state payment rates, the state fees are subject to national floors and ceilings. The national floor is 85 percent of the median of all the state fees, and the ceiling is the median of all state fees for each billing code. No state fee may exceed the national ceiling or be less than the national floor.

For new medical equipment and supplies that do not match the description of an HCPCS code, the carriers use a gap-filling process to establish reimbursement rates. This process involves the carriers' creating a product price list by using the suggested retail prices found in catalogs. The fee-schedule allowance is the lower of the average or the median suggested retail prices found for products covered under the new HCPCS code.

HCFA recognizes that many of the Medicare fee-schedule allowances are now out of line with current market prices because the fee-schedule allowances do not reflect changes in technology and supplier costs. Some product prices may have increased at rates lower or higher than the consumer price index, which also forces the fee allowances out of line with market rates. HCFA is trying to adjust some fee-schedule allowances, but the regulatory process mandated by statute for making such adjustments is slow and cumbersome.<sup>9</sup> For example, adjusting the Medicare allowance for home blood glucose monitors took HCFA almost 3 years. For this reason, the administration is seeking legislative authority to streamline the process by allowing the carriers to adjust the Medicare allowances.

**HCFA'S CODING SYSTEM PROVIDES INSUFFICIENT INFORMATION FOR PROPERLY IDENTIFYING AND PAYING FOR PRODUCTS BILLED TO MEDICARE**

Suppliers who bill Medicare for medical products use billing codes that do not identify the specific items provided to beneficiaries. Because Medicare pays one fee for all products in a billing code, suppliers can furnish a low-cost item to a Medicare beneficiary and get reimbursed at a rate that covers a higher cost item billed under the same code. An official of the statistical analysis contractor said that the billing system results in "winners" (suppliers who are overpaid for low-cost items) and "losers" (suppliers who are underpaid for high-cost items) and that the winners and losers likely balance out. Because HCFA cannot track what items are being billed and provided, however, it does not

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<sup>9</sup>42 U.S.C. 1395m(a) (10) (B).

know to what extent suppliers are providing mostly low-cost items. Although the health care industry is moving toward the use of universal product numbers to more specifically identify medical equipment and supplies, HCFA has not explored this approach for improving information on products Medicare pays for.

#### HCFA's Coding System Does Not Identify Specific Products

HCFA's coding system for medical equipment and supplies provides insufficient information to identify the specific products suppliers provide to Medicare beneficiaries. The HCPCS coding system used by HCFA classifies medical equipment and supplies into general product groups, and, when suppliers bill Medicare, they specify the HCPCS code they believe best describes the specific equipment or supply item provided to a beneficiary. Suppliers and manufacturers may also petition HCFA or the carriers to establish new HCPCS codes for products they believe are not adequately described by or reimbursed under the HCPCS codes.

Some HCPCS codes are used for products that differ widely in properties, uses, and performance. Yet Medicare pays the same fee-schedule allowance (with minor variations among states) for all products billed under the same HCPCS code. For example, the HCPCS code for latex foley catheters<sup>10</sup> includes more than 200 short-term, medium-term, and long-term catheters. According to one manufacturer of foley catheters, specialized coatings affect the durability, function, and price of these catheters. Wholesale prices of these catheters range from \$1.09 for a short-term catheter to \$17.90 for a long-term catheter. Medicare's 1997 national floor and ceiling were \$9.95 and \$11.70, respectively, for all catheters in this HCPCS code.

The fee-schedule system used in conjunction with the HCPCS codes provides a financial incentive for suppliers to provide low-cost items to Medicare beneficiaries, and these items may or may not meet the patient's medical needs. Suppliers can increase their profits by charging Medicare the full fee-schedule allowance for a low-cost product that technically fits the code description. For example, although multiple types of latex foley catheters may be classified under the same HCPCS code, information we gathered from some suppliers showed that the basic short-term catheter was both the least expensive and the

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<sup>10</sup>A latex foley catheter is typically billed under HCPCS code A4338 (in-dwelling catheter; foley type; two-way latex with coating, such as Teflon, silicone-coated, silicone elastomer, or hydrophilic).

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most commonly provided catheter. HCFA cannot readily perform this type of analysis because suppliers do not have to identify the specific products for which they submit claims.

Industry groups and suppliers we contacted said they find the HCPCS coding system difficult to use. Suppliers and manufacturers often need help in deciding which HCPCS code is appropriate for specific products. In response, the statistical analysis contractor has set up a hot line to handle coding inquiries and medical policy and pricing questions; the hot line receives an average of 8,000 calls a month. Coding inquiries account for about 80 percent of the hot line's monthly calls. Coding inquiries about the HCPCS codes for ostomy and incontinence supplies are among the most prevalent.

#### Product-Specific Codes Are Available to Track Utilization

DOD and some hospital health care purchasing groups are beginning to require their suppliers to use product-specific codes, called universal product numbers, to identify individual medical products. This system requires manufacturers to bar code each product to identify characteristics such as the manufacturer identification number, product type, and packaging unit. Universal product numbers will enable these government and private purchasers to develop standard product groups, track market prices, and use prudent purchasing methods—paying for the medical equipment and supplies that meet quality standards at competitive market prices. Industry groups contend that Medicare, the nation's largest health care insurer, should be leading the effort to require the use of universal product numbers, especially because this coding system will allow HCFA to better classify products by HCPCS code, monitor suppliers' use of the billing codes, and adjust the Medicare fee-schedule allowances to more current market-based prices.

We met with HCFA officials to discuss the benefits of the bar coding system to the Medicare program, though HCFA has not yet explored using universal product numbers to track the cost and utilization of specific medical products. HCFA officials have not taken a position on using this coding system, according to discussions with us. At this time it is unclear whether the Secretary of HHS will promulgate universal product numbers as a product identification standard using the authority provided by the Health Insurance and Portability Act of 1996.<sup>11</sup>

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<sup>11</sup>P.L. 104-191, 110 Stat. 1936 (1996).

MEDICARE'S FEE SCHEDULE OVERPAYS LARGE SUPPLIERS

Medicare reimburses large suppliers who buy at volume discounts the same fee-schedule allowances as individuals who buy single items at retail prices. Large suppliers who bill Medicare include home medical equipment and supply companies and distributors who submit claims on behalf of beneficiaries in nursing homes. Because these suppliers submit claims on behalf of many beneficiaries, they can negotiate volume discounts for the products they buy. Individual beneficiaries, on the other hand, lack the purchasing power to obtain volume discounts. Therefore, fee-schedule allowances that adequately reimburse individual beneficiaries usually overpay large suppliers, even after accounting for their administrative costs.

The largest suppliers receive a significant portion of Medicare spending for many medical products. Although more than 150,000 suppliers bill Medicare for medical equipment and supplies, claims submitted by the top 10 suppliers often represent a large percentage of total allowed charges for certain HCPCS codes. For example, for one particular urological HCPCS code, the top 10 suppliers accounted for almost 55 percent of charges billed to Medicare between July 1, 1996, and September 30, 1996, according to our analysis. For five other HCPCS codes in our study, 10 suppliers accounted for 24 percent or more of total allowed charges.

Medicare's fee-schedule allowances are excessive compared with large suppliers' acquisition costs for some products. For example, one supplier reported that its weighted average cost for items billed in 1996 under the HCPCS code for a foley catheter was less than \$1. Medicare's reimbursement for each catheter was between \$10.06 and \$11.83, the 1996 respective national floor and ceiling for this item. In the same year, another supplier's weighted average cost for a bedside drainage bag was about \$2.25, though Medicare reimbursed the supplier between \$7.65 and \$9 for this item.

On the other hand, for some products, such as ostomy supplies, new technology has increased product quality and prices, and the Medicare payment rates do not adequately reimburse either suppliers or individual beneficiaries for these items. In such cases suppliers often do not accept claim assignment—making the Medicare beneficiary responsible not only for the 20-percent copayment, but also for the difference between the supplier's charge and the Medicare allowance.

Suppliers who bill Medicare on behalf of the beneficiary incur administrative costs associated with filing a claim. Most of these costs involve documenting

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medical necessity for the initial claim. Subsequent claims to reorder items for the same beneficiary take less time because suppliers have already gathered much of the information for the initial claim. According to suppliers, urological and ostomy products are the types of items that are often reordered.

Suppliers estimate that the average administrative cost for filing a Medicare claim for a reordered product is about \$10. Because suppliers typically include several related supplies on a single claim, this administrative cost is disbursed among multiple items. For example, a claim for a foley catheter may also include an insertion tray, a bedside drainage bag, and a leg drainage bag if the patient is mobile. Disbursing the administrative cost among the three or four items reduces this cost to between \$2.50 and \$3.35 per item.

Market competition to reduce product costs has driven suppliers to increase their purchasing power by consolidating with similar businesses or joining purchasing cooperatives. Hospitals, nursing homes, and suppliers have formed their own purchasing groups to get lower prices from manufacturers. The medical equipment and supplies market is constantly changing as suppliers seek to lower costs and gain new market share. Mergers, consolidations, acquisitions, and buying cooperatives have produced suppliers with greater purchasing power to lower product acquisition costs.

Although competitive market pressures have driven suppliers to find new ways to reduce their product costs, Medicare's fee schedule does not account for the savings from these cost efficiencies. Some large suppliers have contractual arrangements and corporate affiliations with nursing facilities and home health agencies. These arrangements allow suppliers to take advantage of significant volume discounts from manufacturers and wholesalers. HCFA, however, has not considered establishing a separate fee schedule to account for discounts for nursing facilities and home health providers that furnish medical products to beneficiaries in their care.

#### AGENCY COMMENTS

We made a draft of this correspondence available for review by HCFA program officials, and we also discussed the issues with them. The agency officials with whom we spoke expressed uncertainty about the benefits of using universal product numbers in the Medicare program and about the need for a separate fee schedule for medical equipment and supplies furnished to patients in nursing homes or through home health providers. We will provide HHS and HCFA an opportunity to comment in writing on our final report, which we expect to provide you in September 1997.

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As agreed with your office, unless you release its contents earlier, we plan no further distribution of this letter for 30 days. At that time we will make copies available to other congressional committees and members of the Congress with an interest in these matters and the Secretary of Health and Human Services.

Please call William Reis at (617) 565-7488 or me at (202) 512-7114 if you or your staff have any questions about the information in this letter. Other contributors to this study were Teruni Rosengren, Suzanne Rubins, and Thomas Taydus.

Sincerely yours,

A handwritten signature in cursive script that reads "William J. Scanlon".

William J. Scanlon  
Director, Health Financing and  
Systems Issues

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