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REPORT BY THE

Comptroller General

OF THE UNITED STATES

RELEASED

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Comparison Of Physician Charges And Allowances Under Private Health Insurance Plans And Medicare

GAO compared samples of physician charges and allowances at six Medicare carriers and found that physicians usually charge Medicare patients the same as other patients, but that Medicare usually allows less for physician's services than do private health insurance plans.

HEW headquarters officials said they do not know the intent of the provision in the Medicare law which says, in effect, that charges allowed as reasonable under Medicare should not be higher than charges allowed under Medicare carriers' private business in comparable circumstances. As a result, HEW regional offices, which make determinations of comparability, do not have guidelines for making consistent decisions.

The Subcommittee should consider deleting the comparability language from the law or should clarify it.



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HRD-79-111
SEPTEMBER 6, 1979



COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

B-164031(3)

The Honorable Charles B. Rangel, Chairman
Subcommittee on Health
Committee on Ways and Means
House of Representatives

Dear Mr. Chairman:

As your Subcommittee requested, we have compared physicians' charges and amounts allowed as reasonable under private health insurance plans to those amounts under Medicare. These charges and allowances were taken from private health insurance plans operated by contractors (carriers) that also pay Medicare claims. As discussed with your office, supplemental information on the experiences of two other Medicare carriers and the results of a Medicare beneficiary questionnaire will be provided to your Subcommittee as soon as it becomes available.

At your request, we did not obtain comments from the agency or contractors.

As arranged with your office, unless you publicly announce its contents earlier we plan no further distribution of this report until 3 days from its cover date.

Sincerely yours,

A handwritten signature in black ink, appearing to read "James A. Atchley".

Comptroller General
of the United States

COMPTROLLER GENERAL'S REPORT
TO THE SUBCOMMITTEE ON HEALTH,
HOUSE COMMITTEE ON
WAYS AND MEANS

COMPARISON OF PHYSICIAN
CHARGES AND ALLOWANCES
UNDER PRIVATE HEALTH
INSURANCE PLANS AND
MEDICARE

D I G E S T

GAO compared the actual and allowed charges for physicians at four commercial and two Blue Shield Medicare carriers for their private and Medicare businesses. These comparisons showed that:

--In only 9 percent of the cases sampled physicians charged their private health insurance plan patients less than they charged their Medicare patients. (See p. 9.)

--In only 7 percent of the cases sampled the allowed charges under the private plans were lower than those allowed under Medicare. (See p. 10.)

--Private plan allowed charges usually exceeded Medicare allowed charges by more than 10 percent. (See p. 11.)

--At three of the six carriers, each physician's customary (or usual) charge for a service, (see p. 9 for a definition of "service") rather than his/her actual charge, was the amount most often allowed for Medicare billings. At two carriers, the prevailing charge (see p. 3 for a definition of "prevailing charge") for each medical or surgical procedure by physicians in the area was the amount most often allowed. At the remaining carrier, the effect of the customary and prevailing charge limitations was about the same. (See p. 12.)

--Medicare reasonable charges for the doctors and procedures covered in this report were higher than the reasonable

MATTERS FOR CONSIDERATION
BY THE SUBCOMMITTEE

The Subcommittee should consider either

--deleting the comparability language in
the law or

--defining comparability so that it applies
to all private health insurance plans
which reimburse on a current reasonable
charge basis.

The advantages and disadvantages of these
two alternatives are discussed beginning on
page 24. GAO believes that the most desir-
able action would be to delete the compara-
bility language from the law. This would
have little, if any, financial effect on
the program. However, it would remove in-
consistencies in program administration
and alleviate an ineffective program re-
quirement and the administrative costs
associated with it.

At the Subcommittee's request, GAO did not
take the additional time to obtain comments
from the Department of Health, Education,
and Welfare or contractors.

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CHAPTER 1

INTRODUCTION

By letter dated June 29, 1978, the Chairman and the ranking minority member of the Subcommittee on Health, House Committee on Ways and Means, asked us to compare physicians' actual charges and reasonable charges under carriers' private and Medicare businesses. (See app. I.)

The Subcommittee has long been concerned about the steady increase in the number of unassigned claims for physicians' services under Medicare. It is concerned because, on unassigned claims, the difference between the physician's charge and the amount determined by Medicare to be reasonable becomes the beneficiary's liability. One reason given to the Subcommittee for the increase in unassigned claims is that physicians believe that Medicare's reasonable charges are too low.

However, the Subcommittee had also received information suggesting that, in at least one State, the amounts considered reasonable for purposes of payment under Medicare are sometimes considerably higher than the amounts allowed by the Medicare carrier in its private business. The Subcommittee was concerned because such charges contradicted Medicare law, which limits a Medicare charge to no more for a comparable service under comparable circumstances than the carrier allows in its private business.

The Subcommittee asked that we:

- Determine what data the carriers have provided to the Department of Health, Education, and Welfare (HEW) on comparability and what HEW has done with the data when verifying or analyzing comparability.
- Compare physicians' charges paid or allowed as reasonable by the carriers under their private plans to the Medicare amounts for like procedures by the same practitioners.
- Compare carriers' "customary" charge allowances under their private business with Medicare's "prevailing" charges for like procedures and physician specialties in the same geographic area.
- Compare the reasonable charge reductions made by the carrier under Medicare with the reductions made by

MEDICARE REIMBURSEMENT FOR
PHYSICIAN SERVICES

In fiscal year 1978 Medicare processed over 122 million claims and paid about \$6.9 billion in part B benefits--over \$5 billion of these benefits were for physician services. Reimbursements for physician services are based on the "reasonable charge" for these services, as determined by each carrier for its area of jurisdiction. Medicare reimburses the beneficiary or the provider 80 percent of reasonable charges after the beneficiary incurs \$60 in covered expenses a year (the deductible).

The reasonable charge for a physician's or a supplier's service is the lowest of three charges--the actual charge, the physician's or supplier's customary charge, and the prevailing charge. The actual charge is the charge that the physician or supplier bills for his/her service. The customary charge is the charge the physician or supplier usually bills most patients for the same service. The prevailing charge is the lowest charge high enough to include at least three-fourths of the bills for the same service billed by all the physicians or suppliers in the same area. 1/ The lowest charge is called the "reasonable charge."

As previously noted, Medicare law also requires that Medicare reasonable charges be limited to no more than what the carrier determines to be reasonable for a comparable service under comparable circumstances for its private health insurance plan(s).

In calculating the prevailing charge for a service in a locality, carriers use charge data from that locality. (A locality will usually be a subdivision of a State.) Carriers also recognize different prevailing charges within a locality for physicians in different specialties. Medicare payments for the same service, therefore, may vary among localities and among physicians in the same locality. This payment variation allegedly reflects preestablished patterns of charges for physicians and suppliers.

1/In 1972 the Congress decided to allow Medicare prevailing charges to go up only as much as inflation in general. This limit, called the "economic index," determines how much Medicare prevailing charges may increase above 1973 levels. For example, in fee screen year 1978 these charges were allowed to increase up to 35.7 percent above their fiscal year 1973 levels.

In fiscal year 1978 only about 50.6 percent of Medicare claims for physician services were assigned claims. Medicare assignment rates for the previous 3 years were 51.9 percent in 1975, 51 percent in 1976, and 50.5 percent in 1977.

Additional information on assigned claims and assignment rates, particularly in Connecticut, is included in our report dated May 31, 1978, to the Chairman, Subcommittee on Oversight and Investigations, House Committee on Interstate and Foreign Commerce (B-164031(4), HRD-78-111).

PRIVATE PLANS' USE OF HEALTH
INSURANCE ASSOCIATION OF
AMERICA DATA

During discussions of the commercial carriers (see apps. III through VI), we refer to a Health Insurance Association of America (HIAA) report which includes information on physicians' prevailing charges nationally. HIAA is the trade organization for commercial health insurance businesses (other than Blue Cross and Blue Shield)--about 320 member insurance companies that provide nearly 85 percent of the group and individual private health insurance coverage by commercial insurance companies in the Nation.

HIAA collects charge data on about 3 million charges submitted for 250 medical and surgical procedures performed in all States from the 30 largest member companies (representing about two-thirds of member companies' business). These data are updated every 6 months and sold to the public in either computer tape or hard copy format. Basically, the report lists the 250 procedures by zip code, showing the number of charges included in the sample (each medical procedure must have at least five claims before a prevailing charge is developed for a particular locality), the mean and mode charge, and the prevailing charge at each of seven percentile levels ranging from the 50th to the 95th percentile of physician charges. Three of the four commercial carriers reviewed by us used the HIAA report to some degree when computing their reasonable charge screens.

SCOPE OF REVIEW

The Subcommittee requested that we examine data from eight Blue Shield and commercial carriers that have private health insurance plans which reimburse physicians on a basis similar to Medicare. We selected four commercial carriers and four Blue Shield carriers. The commercial carriers were

These data include physicians' 1976 charges for common services to Medicare and private health insurance patients in five States.

According to Blue Cross and Blue Shield Association officials, these data purportedly included mostly the same type of information for the four Blue Shield plans that we collected for this review on the commercial insurance companies' businesses, and would have left little to be done on-site at the carriers. The data were to be available as soon as the necessary approvals were obtained from the individual carriers--with the exception of Alabama Blue Shield, which had not yet submitted its study data to the Associations' headquarters in Chicago.

As our review progressed, it became apparent that Alabama and Colorado Blue Shield would not have acceptable data available in time for meeting the Subcommittee's time frames. Therefore, the Subcommittee asked that we exclude Alabama and Colorado Blue Shield from our analysis and provide information on these two carriers later.

We obtained our hard copy sample of physician and claim experience from computer tapes used in the HCFA study. We were not allowed access to the tapes; consequently, we had to rely on data provided to us by the Associations with no assessment by us as to its reliability. Our computer specialists could find no practical method for tracing the sample data back to the source.

We coordinated our audit effort with HEW's internal audit staff.

We attempted to sample about 100 physicians that performed 1 or more of at least 10 medical and surgical procedures under the private and Medicare business at the commercial and Blue Shield Medicare carriers reviewed. These procedures were generally selected after each carrier agreed that the selected procedures would be most likely to have the highest claims volume under both businesses. As a result of our discussions with the carriers, it became necessary to draw our sample from differing procedures and for different time frames at each carrier to facilitate the practicality and timeliness of taking the sample.

The following table shows the number of physicians sampled and the number of services 1/ reviewed:

<u>Carrier</u>	<u>Number of physicians</u>	<u>Number of services identified</u>	
		<u>Private</u>	<u>Medicare</u>
Pan American	208	561	906
Occidental	88	252	19,067
General American	137	271	16,246
Connecticut General	139	325	3,207
Blue Shield of Massachusetts	152	9,747	49,060
Blue Shield of Florida	<u>152</u>	<u>2,675</u>	<u>30,828</u>
Total	<u>a/876</u>	<u>13,831</u>	<u>119,314</u>

a/The actual number of individual physicians identified in our sample (612) was lower than this figure because many physicians were identified under more than one procedure.

COMPARISON OF ACTUAL CHARGES

Physicians charged their private health insurance plan patients less than they charged their Medicare patients in only 9 percent of the cases sampled.

To compare the actual charges submitted by each physician for the private and Medicare businesses, each submitted charge for a procedure under the private plans was compared to the most frequent charge for each physician for the same procedure

1/A service is an individual medical or surgical procedure (appendectomy or office visit, etc.) that is performed by one of the physicians in our sample.

<u>Carriers</u>	<u>Number of services</u>	<u>Private allowed charges</u>		
		<u>Lower than Medicare</u>	<u>Equal to Medicare</u>	<u>Higher than Medicare</u>
----- (Number (%)) -----				
Pan American	561	10 (2)	110 (19)	441 (79)
Occidental General	252	5 (2)	61 (24)	186 (74)
American Connecticut General	271	3 (1)	61 (23)	207 (76)
Blue Shield of Massachusetts	325	2 (1)	67 (21)	256 (79)
Blue Shield of Florida	9,747	762 (8)	6,625 (68)	2,360 (24)
	<u>2,675</u>	<u>133 (5)</u>	<u>525 (20)</u>	<u>2,017 (75)</u>
Total	a/ <u>13,831 (100%)</u>	<u>915 (7%)</u>	<u>7,449 (54%)</u>	<u>5,467 (40%)</u>

a/Individual percents do not add to 100 percent due to rounding.

HOW MUCH HIGHER ARE PRIVATE
ALLOWANCES THAN MEDICARE
ALLOWANCES?

The previous table shows that private businesses normally allowed a higher charge than Medicare to the same physician for the same procedure. However, the table does not show how much higher the private allowed charge was than Medicare's allowed charge. We analyzed each physician's charges and determined that physicians were allowed over 10 percent more by private plans than by Medicare in 82 percent of the cases.

In our analysis the most frequently allowed charge for each physician for a procedure in the private health care plans was matched to the most frequently allowed charge for that physician for the same procedure under the Medicare program, whenever the amount allowed by the private plans exceeded the amount allowed under Medicare.

Because the difference between the private and Medicare allowed charges varied by procedures and physicians, we computed a percentage representing the extent that physicians were allowed more under the private business than under Medicare: For example, if physician A was most frequently allowed a charge of \$30 for a procedure under a private health plan, and he was most frequently allowed \$20 for that same procedure under that carrier's Medicare business; he was allowed 50 percent (\$30-\$20) more under the private plan

The Number Of Times That The Actual,
Customary, And/Or Prevailing Charge Resulted
In The Medicare Allowed Charge

<u>Carrier</u>	<u>Number of charges</u>	<u>Actual charge</u>	<u>Customary charge</u>	<u>Prevailing charge</u>	<u>Actual and customary the same</u>	<u>Customary and prevailing the same</u>	<u>Prevailing and actual the same</u>	<u>All three charges the same</u>	<u>Unknown (note a)</u>
Pan American	906	29	287	320	104	96	8	45	17
Occidental General	19,067	448	692	12,182	3,129	1,899	-	323	394
American Connecticut General	16,246	575	6,955	2,253	4,312	1,220	20	911	-
Blue Shield of Massachusetts	3,207	60	460	2,053	212	106	8	293	15
Blue Shield of Florida	49,060	546	20,256	9,373	8,169	4,455	25	6,235	1
	<u>30,828</u>	<u>2,056</u>	<u>13,569</u>	<u>9,530</u>	<u>3,439</u>	<u>962</u>	<u>24</u>	<u>1,191</u>	<u>57</u>
Total	<u>119,314</u>	<u>3,714</u>	<u>42,219</u>	<u>35,711</u>	<u>19,365</u>	<u>8,738</u>	<u>85</u>	<u>8,998</u>	<u>484</u>
	b/(100%)	(3%)	(35%)	(30%)	(16%)	(7%)	(0%)	(8%)	(0%)

a/Amount allowed was not the same as any of the three screen amounts.

b/Individual percents do not add to 100 percent due to rounding.

COMPARISON OF MEDICARE
REASONABLE CHARGE SCREENS
TO PRIVATE PLAN SCREENS

Medicare prevailing and customary charge screens were higher than the carriers' private business screens in only 11 percent of the cases we reviewed. We matched the Medicare and private plan prevailing screens and customary screens, where applicable, used by each carrier to determine which was higher. These screens usually determine how much of the actual charge the carrier will allow.

We compared the private plans' prevailing charge screens for each procedure code for each locality to Medicare prevailing charge screens for the same procedures and localities. The following table shows the number of comparisons we made for each carrier and the results.

<u>Carrier</u>	<u>Number of screen amounts compared</u>	<u>Medicare prevailing screen higher than private screen</u>	
		<u>Number</u>	<u>Percent</u>
Pan American	168	4	2
Occidental	102	4	4
General American	80	4	5
Connecticut General	141	a/48	a/34
Blue Shield of Massachusetts	80	5	6
Blue Shield of Florida	<u>23</u>	<u>1</u>	<u>4</u>
Total	<u>594</u>	<u>66</u>	11

a/Because Connecticut General's claims examiners are authorized to apply "tolerances" to the screens, this statistic tends to be misleading. (See p. 14.)

Comparison of Reasonable Charge Reductions for Sample Data
Under Private And Medicare Businesses

Carrier	Private business			Medicare business								
	Total number of charges	Charges reduced		Assigned charges			Unassigned charges					
		Number (%)	Amount reduced (percent) (note a)	Total	Reduced (%)	Total	Reduced	Amount reduced (percent) (note a)	Total	Reduced	Amount reduced (percent) (note a)	
Pan American	561	39 (7%)	13	906	705 (78%)	192	152	21	714	553	22	
Occidental	252	-	-	19,067	15,167 (80%)	-----Total charges were reduced 17% (note b)-----						
General American	271	5 (2%)	19	16,246	10,468 (64%)	4,570	2,822	23	11,676	7,646	17	
Connecticut General	325	-	-	2,721	2,260 (83%)	744	662	18	1,977	1,598	19	
Massachusetts B/S	9,747	5,429 (56%)	23	49,060	34,029 (69%)	40,012	26,564	24	9,048	7,465	21	
Florida B/S	<u>2,675</u>	<u>732 (27%)</u>	16	<u>30,828</u>	<u>24,113 (78%)</u>	<u>8,941</u>	<u>6,177</u>	23	<u>21,887</u>	<u>17,936</u>	22	
Total	<u>13,831</u>	<u>6,205 (45%)</u>		<u>118,828</u>	<u>86,742 (73%)</u>	<u>54,459</u>	<u>36,377</u>		<u>45,302</u>	<u>35,198</u>		
						(100%)	(67%)		(100%)	(78%)		

a/This represents the percent of only those charges that were reduced.

b/No breakdown by assigned or unassigned was available.

Consequently, this provision is inconsistently administered by HCFA.

Accordingly, if the Subcommittee decides to retain the comparability provision, it should define comparability so that all private health insurance plans which pay claims based on current reasonable charges are comparable to Medicare. This revision would make more private plans comparable to Medicare, and would, in theory, increase the provision's effectiveness by requiring more comparisons between the private businesses and Medicare. These comparisons may reduce Medicare payment screens, and perhaps result in program savings from decreased reimbursements. However, we believe that there are several problems, including increased administrative costs, that may minimize the desirability of this alternative. (See p. 24.)

STATUTORY REQUIREMENT

Section 1842(b)(3)(B) of the Medicare law requires that, under part B:

"Each * * * contract shall provide that the carrier--

* * * * *

"* * * will take such action as may be necessary to assure that, where payment under this part for a service is on a charge basis, such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policy holders and subscribers of the carrier."

This, in effect, assures that Medicare will not base reimbursements on a charge that is higher than a charge that the carrier would base its reimbursement on its private business. Assuming the carrier's private business reimburses for physicians' bills in a way that is comparable to Medicare, this section of the law acts as a fourth screen for Medicare payments in addition to the customary charge, prevailing charge, and actual charge screens.

CONFUSION IN INTERPRETING COMPARABILITY

The interpretation of this section of the law has been controversial for many years. For example, the Senate Finance

No criteria for determining comparability were included in the Medicare law. We could find no insight about the meaning of this section in the legislative history--it was apparently left up to the program's administrators to define comparability. Title 42, section 405.508 of the Code of Federal Regulations states:

"§405.508 Determination of comparable circumstances; limitation.

"(a) Application of limitation. The carrier may not in any case make a determination of reasonable charge which would be higher than the charge upon which it would base payment to its own policyholders for a comparable service in comparable circumstances. The charge upon which it would base payment, however, does not necessarily mean the amount the carrier would be obligated to pay. Under certain circumstances some carriers pay amounts on behalf of individuals who are their policyholders, which are below the customary charges of physicians or other persons to other individuals. Payment under the supplementary medical insurance program would not be limited to these lower amounts.

"(b) When comparability exists. 'Comparable circumstances,' as used in the Act and this subpart, refers to the circumstances under which services are rendered to individuals and the nature of the carrier's health insurance programs and the method it uses to determine the amounts of payments under these programs. Generally, comparability would exist where:

"(1) The carrier bases payment under its program on the customary charges, as presently constituted, of physicians or other persons and on current prevailing charges in a locality, and

"(2) The determination does not preclude recognition of factors such as speciality status and unusual circumstances which affect the amount charged for a service.

private payments on both the customary and prevailing charges; one company recognizes physician specialities in its determinations. The HCFA Atlanta Regional Office believes that Blue Shield of Florida's private health insurance plans are comparable to Medicare and, although it is required to reduce its Medicare allowed charges when the private screen is lower than the Medicare screen, the Atlanta HCFA personnel found no situations where this was necessary. The regional office made this assumption because Florida Blue Shield uses the same data base as Medicare for establishing its screens, and uses the 90th percentile of this data instead of the 75th percentile, as Medicare does. ^{1/} Yet Blue Shield of Massachusetts' private health insurance business is considered not comparable--apparently because of a number of minor differences (listed below) in the company's methods of computing reasonable charges between the private and Medicare businesses.

The regional office decisions on the two Blue Shield companies seem inconsistent, based on the following comparison:

Blue Shield of Florida's private plans are comparable to Medicare even though:

--It uses no indexes to limit prevailing charge increases, while Medicare does apply indexes.

--It uses more recent physician profile data than Medicare uses, and updates these data in a different month from Medicare.

--Its private plan prevailing charge screens are set at the 90th percentile, whereas Medicare uses the 75th percentile.

Blue Shield of Massachusetts' private plans are not comparable to Medicare because:

--It uses indexes to limit prevailing charge increases; but they are different from Medicare indexes. It also applies these indexes to its customary charge increases, while Medicare does not.

--It does not regularly update its physician profiles, while Medicare does.

--Its private plan prevailing charge screens are set at the 90th percentile, whereas Medicare uses the 75th percentile.

--It breaks the State into two geographic areas having separate sets of screens for Medicare, but it has only one set of screens for its private business.

^{1/}It should be noted that, contrary to this assumption, we found that Blue Shield of Florida's Medicare prevailing screen was higher than its private business prevailing screen in 1 of the 23 cases we compared.

than the Medicare reasonable charge screens, should set the limit on the amounts allowed for covered services rendered to the Medicare beneficiaries. There is nothing in the law, regulations, or the present Medicare Carriers Manual guidelines which requires that, for comparability purposes, the payment screens of a private health insurance plan must have been revised at the same time as the Medicare screens, or that exactly the same base period must be used for compiling the charge data that will be used for the computation of the private business allowances. The 'current' customary and/or prevailing charges of a carrier's private health plan, as cited above, refer to the payment screens that are presently in effect, i.e., payment levels actually being used in the carrier's private business for settling claims submitted by its policyholders or subscribers.

"Carriers must therefore continue to apply the comparability limitation based upon their payment screens that are presently in effect, even where an update under their private insurance plans has been deferred."
(Our underscoring.)

All of the apparent inconsistencies discussed above, in our opinion, show that the Medicare regional offices cannot apply the law or regulation according to a single set of criteria.

ALTERNATIVES TO PRESENT ADMINISTRATION OF THE COMPARABILITY PROVISION

We believe that HCFA's present administration of the comparability provision results in little, if any, reductions or limitations of Medicare program costs. Yet HCFA regional office personnel continue to compare private and Medicare data for 24 carriers every year. Our samples at six Medicare carriers showed no instances where Medicare payment screens were reduced to lower levels of private plan screens due to the law. Five of the six carriers reviewed were not considered comparable to Medicare and were not required to make any reductions for comparability. The sixth carrier was comparable to Medicare, but the regional office assumed that the private business payment screens could never be lower than Medicare screens because the private business

However, there are several problems with this alternative:

- There would be increased administrative costs to Medicare because HCFA regional office personnel would conduct comparative analyses of payment screens at more carriers. Although five of the six carriers reviewed did not have private plans considered comparable to Medicare, all six carriers based at least some of their private plans on current reasonable charges. Most Medicare carriers use this basis for at least some of their private plans.
- Many carriers use different claim coding and nomenclature systems for their private and Medicare businesses. Consequently, the comparison of payment screens on a procedure-by-procedure basis is difficult, if not impossible in some instances.
- New problems may occur in defining a current reasonable charge.

We were also told that Blue Shield of Massachusetts' situation has changed dramatically since the time period (calendar year 1976) covered in our review. Because of fiscal pressures, this carrier has found it necessary to restrict its private customary and prevailing screen increases to an economic index for the last 2 years (1977 and 1978).

In addition, the State insurance commissioner has restricted rate increases, forcing further limitations on physician reimbursement criteria for the coming year. This was done to hold down health care costs in the State. A carrier official stated that there will be an increasing number of cases where Medicare reasonable-charge screens will be higher than its own, because this carrier has been determined to be not comparable to Medicare. He said that this could occur for perhaps up to 50 percent of the screens. Requiring this carrier to reduce its Medicare screens to private levels could, according to the carrier, cause participation by physicians under the company's private business to be substantially reduced and Medicare assignment rates (which are very high in this State) to drop. This could adversely affect Medicare beneficiaries due to decreased assignments and reduced Medicare allowances.

AL ULLMAN, OREG., CHAIRMAN
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June 29, 1978

The Honorable Elmer B. Staats
Comptroller General of the
United States
General Accounting Office Bldg.
441 G Street
Washington, D.C. 20548

Dear Mr. Staats:

The Subcommittee has long been concerned about the steady increase in the number of unassigned claims for physicians' services under part B of the medicare program since on such claims the difference between the physician's charge and the amount determined by medicare to be reasonable becomes a liability of the beneficiary. During 1977, over three-fourths of the unassigned claims were subject to reasonable charge reductions which averaged about 20 percent of the amounts claimed. Considering medicare's 20 percent coinsurance provisions, the program could be considered to be reimbursing most of its beneficiaries for only about an average of 60 percent of their doctors' bills.

As you know, the staff of the Subcommittee has been discussing this issue for some time now with GAO staff. Just last week, the Subcommittee on Health held two days of hearings on several medicare issues, including current problems with reimbursement under part B. This letter is a result, in part, of the issues raised during initial discussions with GAO staff and the testimony presented during the Subcommittee's hearings.

One of the reasons given for the increase in unassigned claims is that the physician community believes that medicare's reasonable charge screens are too low. On the other hand, the Subcommittee has information suggesting that, in at least one state, the amounts considered reasonable for purposes of payment under medicare are, in some cases, considerably higher than the amounts allowed by the medicare carrier in its private business; and, in nearly every instance, higher than

(4) Comparisons of reasonable charge reductions made by the carrier under medicare with the reductions made by the carrier under its private line of business for "assigned" claims and "unassigned" claims.

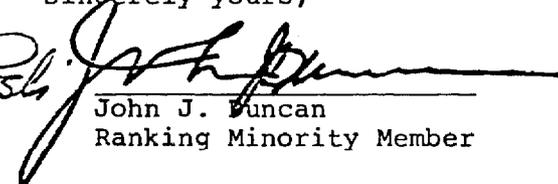
(5) Information on the extent to which medicare beneficiaries are not required to pay the reasonable charge reductions or the deductible and coinsurance amounts provided for in the law.

During our hearings on this issue last week, representatives of both the Health Insurance Association of America and Blue Cross-Blue Shield agreed to cooperate with the Subcommittee in its examination of the issue. Such cooperation should greatly facilitate the collection of necessary data for analysis by your agency.

Since the results of your work in this area are needed to assist the Subcommittee in its evaluation of the current part B assignment problem, we would appreciate your final report on this matter by February 1979. In addition, we would hope that as data become available, you will work with the Subcommittee staff in analyzing it so that preliminary results will be available to the Subcommittee during its current work on medicare amendments.

Sincerely yours,


Dan Rostenkowski
Chairman


John J. Duncan
Ranking Minority Member

Radical mastectomy	Surgical removal of breast(s) and any other cancerous tissue around the breast(s).
Routine followup brief hospital visit	A visit in a hospital for a relatively simple problem requiring a short period of time.
Routine followup brief office visit	A visit in a doctor's office for a relatively simple problem requiring a short period of time.
Sigmoidoscopy	Internal inspection of part of the colon, with the aid of a long examining tube.
Transurethral resection of prostate	Surgical removal of part or all of the prostate gland through the penis with the aid of a tube-like instrument.
Vaginal hysterectomy	Surgical removal of the uterus, fallopian tubes, and ovaries through the vagina.

The Pan American group plans reviewed normally had a \$100 deductible. The reimbursement percentage for major medical is usually about 80 percent. The following example details the provisions of the basic plan with major medical benefits:

Actual charge	\$800	Prevailing charge	\$600
Reasonable (allowed) charge	\$600		
1. Amount paid under basic plan (on fee schedule)			\$200
2. Amount considered to be major medical		\$400	(\$600 less \$200)
Less deductible (if not already met)		<u>-100</u>	
Amount eligible for reimbursement under major medical		300	
Reimbursement percentage		<u>80%</u>	
Amount paid under major medical		\$240	
3. Amount paid to beneficiary			
Basic plan		200	
Major medical		<u>240</u>	
Total			<u>\$440</u>

The above example shows that the health care plan attempts to reimburse the beneficiary, except for the cash deductible and coinsurance, the full reasonable charge.

Under the comprehensive plan, the reasonable charge for each service is determined as it is under the previous type of plan. After an annual cash deductible has been satisfied, the reasonable charge is multiplied by a reimbursement percentage which can be found in the contract, and this represents the amount of the payment. The following example illustrates the comprehensive plan's provisions:

As a result of this sampling procedure, the following number of physicians and services were identified for the private business:

<u>Procedure</u>	Number of physicians performing procedure	Number of services identified	
		<u>Private</u>	<u>Medicare</u>
Sigmoidoscopy	18	45	81
Hemorrhoidectomy	3	8	9
Cholecystectomy	5	7	17
Hernia repair	3	3	11
Cystoscopy, office	7	17	31
Cystoscopy, hospital	12	13	54
Transurethral resection of prostate	4	4	19
Total hysterectomy	10	12	12
Vaginal hysterectomy	4	5	4
Routine followup brief office visit	83	239	396
Routine followup brief hospital visit	33	159	163
EKG	<u>26</u>	<u>49</u>	<u>109</u>
Total	<u>a/208</u>	<u>561</u>	<u>906</u>

a/This total is greater than the 144 individual physicians identified because some doctors had been counted as performing more than one procedure in our sample.

Although the activity for these procedures was quite limited under the private business experience, the activity for the same physicians performing some of the same procedures under Medicare was quite voluminous. In order to limit the amount of information to be analyzed, we selected a maximum of five claims per physician for each procedure under Medicare for comparison.

COMPARISON OF ACTUAL CHARGES

In 9 percent of the cases, the physicians charged their private plan patients less than they charged their Medicare patients.

<u>Procedure</u>	<u>Number of services</u>	<u>Private allowed charges</u>		
		<u>Lower than Medicare</u>	<u>Equal to Medicare</u>	<u>Higher than Medicare</u>
Sigmoidoscopy	45	1	12	32
Hemorrhoidectomy	8	-	1	7
Cholecystectomy	7	-	1	6
Hernia repair	3	-	2	1
Cystoscopy, office	17	-	1	16
Cystoscopy, hospital	13	-	5	8
Transurethral resection of prostate	4	-	-	4
Total hyster- ectomy	12	3	3	6
Vaginal hyster- ectomy	5	1	1	3
Routine followup brief office visit	239	2	25	212
Routine followup brief hospital visit	159	1	36	122
EKG	<u>49</u>	<u>2</u>	<u>23</u>	<u>24</u>
Total	<u>561</u>	<u>10</u>	<u>110</u>	<u>441</u>
	(100%)	(2%)	(19%)	(79%)

HOW MUCH GREATER ARE PRIVATE PLAN
ALLOWANCES THAN MEDICARE ALLOWANCES?

The previous table shows that, under its private business, Pan American normally allowed a charge which was higher than the charge allowed under Medicare. The table, however, does not show how much the allowed private charges exceeded the allowed Medicare charges.

We attempted to find how much the charges differed by matching the most frequently allowed charge for each physician for a procedure under the private health care plans to the most frequently allowed charge for that physician for that procedure in Medicare.

Procedure	Number of charges	How much physicians' privately allowed charges exceeded their Medicare allowed charges				
		1-10%	11-25%	26-50%	51-75%	76% and over
Sigmoidoscopy	14	-	7	5	1	1
Hemorrhoi- dectomy	2	-	1	1	-	-
Cholecys- tectomy	4	1	3	-	-	-
Hernia repair	1	-	-	1	-	-
Cystoscopy, office	6	-	3	1	-	2
Cystoscopy, hospital	8	3	2	-	-	3
Transurethral resection of prostate	4	1	2	1	-	-
Hysterectomy	5	1	2	1	1	-
Vaginal hysterectomy	3	1	1	1	-	-
Routine followup brief office visit	74	5	30	28	7	4
Routine followup brief hos- pital visit	23	4	6	9	-	4
EKG	<u>12</u>	<u>-</u>	<u>3</u>	<u>7</u>	<u>1</u>	<u>1</u>
Total	<u>156</u>	<u>16</u>	<u>60</u>	<u>55</u>	<u>10</u>	<u>15</u>
	a/(100%)	(10%)	(38%)	(35%)	(6%)	(10%)

a/Individual percents do not add to 100 percent due to rounding.

SCREENS USED TO DETERMINE
MEDICARE ALLOWED CHARGES

The following table shows that the customary and pre-
vailing charge screens had about the same effect on the
amount allowed for Medicare billings:

Study published by the California Medical Association) for the medical or surgical procedure is multiplied by a conversion factor. A relative value is the representation of the time and difficulty associated with a procedure compared to other procedures. For example, a routine followup office visit may be assigned a value of "1." A comprehensive diagnostic history and examination may require six times the effort of the routine followup visit. Thus, the relative value for the comprehensive diagnostic history would be "6." The relative value for a procedure is then multiplied by a conversion factor to arrive at a fee. The carrier determines a conversion factor after analyzing all claims for the procedures in the geographic area.

HIAA develops prevailing charges for nine different localities in Louisiana. Pan American, however, has established eight prevailing charge localities in Louisiana for Medicare screens. We compared the prevailing charge screens in our sample under the private health care plans to the prevailing charge screens used under Medicare. This resulted in 168 comparisons of individual prevailing screen amounts. Out of the 168 comparisons, there were only 4 instances (2 percent) where the Medicare prevailing screen was higher than the private prevailing screen. This seems consistent with our findings on page 36 that Medicare allowances were higher than private business allowances in only 2 percent of the review cases.

REASONABLE CHARGE REDUCTIONS

During the sample year (April 1977 to March 1978) Pan American processed about 1.1 million Medicare claims, representing \$98.6 million in covered charges. ^{1/} About 57 percent of these claims were reduced. The reductions totaled over \$16 million (17 percent of the total submitted covered charges). From the beneficiaries' viewpoint, over 521,000 (48 percent) of the claims were unassigned, representing \$63.6 million in covered charges. About 65 percent of these claims were reduced. Overall, the beneficiaries were responsible for paying an average reduction of about \$21 per claim on all unassigned claims.

^{1/}These are charges for services that are covered under the Medicare program.

Comparison Of Reasonable Charge Reductions
Under Private And Medicare Businesses

	Private business			Medicare business							
	Charges reduced			Number of assigned charges			Number of unassigned charges				
	Total number of charges	Number	Amount reduced (percent) (note a)	Total	Reduced	Total	Reduced	Amount reduced (percent) (note a)	Total	Reduced	Amount reduced (percent) (note a)
Sigmoidoscopy	45	-	-	81	54	11	8	27	70	46	24
Hemorrhoidectomy	8	-	-	9	8	3	3	14	6	5	19
Cholecystectomy	7	-	-	17	15	3	2	15	14	13	14
Hernia repair	3	-	-	11	8	1	1	16	10	7	17
Cystoscopy, office	17	-	-	31	25	5	5	26	26	20	28
Cystoscopy, hospital	13	-	-	54	49	13	11	21	41	38	25
Transurethral resection of prostate	4	1	14	19	17	2	1	19	17	16	21
Hysterectomy	12	1	11	12	9	5	4	15	7	5	25
Vaginal hysterectomy	5	-	-	4	4	1	1	13	3	3	16
Routine followup brief office visit	239	30	15	396	349	83	79	27	313	270	27
Routine followup brief hospital visit	159	7	12	163	120	42	29	32	121	91	26
ERG	49	-	-	109	47	23	8	21	86	39	23
Total	561	39	13%	906	705	192	152	21	714	553	22
	(100%)	(7%)		(100%)	(78%)	(100%)	(79%)		(100%)	(77%)	

a/This represents the percent of only those charges that were reduced.

COMPARABILITY

A HCFA Dallas region official's interpretation of the law is that determining that a private plan is comparable can only be done after the carrier has declared that its private health care plans are comparable because HEW generally does not have access to private plan information. Pan American has not made such a declaration. Consequently, HCFA determined in 1975 that Pan American's private plans were not comparable. Since then, little has been done about comparability. None of the HCFA regional or headquarters' staffs have performed an indepth review for comparability between Pan American's private business and its Medicare business. The only criteria used by the HCFA regional office to judge comparability for Pan American was an interview with an insurance company official.

Pan American believes that its private health care plans are not comparable to the Medicare program because:

1. The data base is different. HIAA determines prevailing charges for a locality by obtaining at least five services for a procedure. However, Medicare uses three or four services to determine a customary charge and five customary charges to derive a prevailing charge for a service in a locality.

OCCIDENTAL LIFE INSURANCECOMPANY OF CALIFORNIA

Occidental Life Insurance Company of California is a subsidiary of Transamerica Corporation, a conglomerate with wide-ranging interests. In calendar year 1977 the carrier's group health insurance policies accounted for 2.8 million claims nationwide nearly \$398 million. In its southern California Medicare coverage area, Occidental has about 7,000 private business group health plans covering approximately 2.2 million persons (including the insured persons' covered family members). An Occidental official estimated that these plans generated about 470,000 claims nearly \$68 million in calendar year 1977.

PRIVATE BUSINESS

Our review covered 10 of Occidental's private health insurance plans. The following table shows the outline of benefits for each policy:

MEDICARE BUSINESS

Since the Medicare program began in July 1966, HEW has contracted with Occidental to process Medicare claims in Southern California. Originally servicing only Los Angeles and Orange counties, Occidental's area was increased in 1970 to include all of California's nine southern counties. In addition to Los Angeles and Orange, Occidental services the following counties in southern California:

San Luis Obispo	Ventura
Santa Barbara	Riverside
San Bernardino	Imperial
San Diego	

Occidental paid or applied to the beneficiaries' deductibles 4.2 million Medicare claims amounting to nearly \$383 million in calendar year 1977. Although the Medicare claims processing operation is highly computerized, Occidental's private operation is manual.

OUR SAMPLE

We attempted to identify 100 physicians that performed 1 or more of 13 medical and surgical procedures under both Occidental's private and Medicare businesses. These procedures were selected after an agreement between the carrier and us that they would be the highest volume procedures common to both businesses. We were required to manually screen the private plan files to develop a sample of physicians who fit our criteria. We did this for several plans of various sizes covering persons residing in Occidental's Medicare jurisdiction. We recorded information for claims for these plans having service dates from July 1977 through June 1978. We compared this information to available Occidental Medicare information for the same time period.

COMPARISON OF ALLOWED CHARGES

The allowed charges under the private plans were lower than those allowed under Medicare in 2 percent of the cases reviewed. The following table shows this comparison:

<u>Procedure</u>	Number of services	<u>Private allowed charges</u>		
		<u>Lower than Medicare</u>	<u>Equal to Medicare</u>	<u>Higher than Medicare</u>
Appendectomy	1	-	-	1
Proctosig- moidoscopy	9	-	2	7
Cholecystectomy	2	-	-	2
Hernia repair	4	-	1	3
Transurethral resection of prostate	4	-	1	3
Hysterectomy	1	-	-	1
Extraction of lens	4	1	-	3
Routine follow- up brief office visit	186	4	33	149
Routine follow- up brief hos- pital visit	21	-	17	4
Intermediate hospital visit	<u>20</u>	-	<u>7</u>	<u>13</u>
Total	<u>252</u>	<u>5</u>	<u>61</u>	<u>186</u>
	(100%)	(2%)	(24%)	(74%)

SCREENS USED TO DETERMINE
MEDICARE ALLOWED CHARGES

The table on the following page shows that the prevailing charge screen is the most common amount allowed for Medicare billings. It was applied alone in about 64 percent of the charges, and applied in another 12 percent of the time when it was the same as another screen.

COMPARISONS OF PRIVATE CUSTOMARY ALLOWANCES
TO MEDICARE PREVAILING ALLOWANCES

For identical services by the same physician, the "usual and customary" fee screen applicable to the carrier's private plan policy holders generally permits a larger allowed charge than the Medicare "prevailing charge" screen. This apparently results from three factors: (1) the data base used to compute the private plan screen is more recent than the Medicare data base, and it is thereby more likely to reflect rising fees, (2) the private plan screen is set to cover 90 percent of all charges for a particular service, compared to 75 percent for Medicare prevailing charges, and (3) annual increases in the Medicare prevailing charges are limited to increases in an economic index.

To determine usual and customary charges for its private policies, Occidental divides southern California into four geographical areas--for its Medicare prevailing charge screens, however, southern California is divided into 14 geographical areas.

We compared the prevailing charge screens for each procedure code for each locality under the private health care plans to the prevailing charge screens used for the same procedures and localities under Medicare. We found 102 different Medicare area/specialty combinations for the physicians in our sample. Of the 102 comparisons of individual prevailing screen amounts, only 4 (4 percent) show Medicare prevailing charges that are higher than the corresponding private plan screens. This seems consistent with our findings that Medicare allowances were higher than private business allowances in only 2 percent of the review cases. (See p. 49.)

COMPARISONS OF REASONABLE CHARGE
REDUCTIONS UNDER MEDICARE AND
PRIVATE PLANS FOR "ASSIGNED"
AND "UNASSIGNED" CLAIMS

During the sample year (July 1977 to June 1978), Occidental processed about 4.2 million Medicare claims which were paid or applied to the beneficiaries' deductible, representing \$501 million in covered charges. About 78 percent of these claims were reduced. The reductions totaled over \$94 million--19 percent of the total submitted covered charges. From the beneficiaries' viewpoint about 3.2 million (76 percent) of the claims were unassigned, representing \$376 million in covered charges--about 79 percent of these claims were reduced. Overall, the beneficiaries were responsible for paying an average reduction of about \$22.50 per claim on all unassigned claims.

Occidental officials stated that, under its private plans, an "assigned" claim means only that the beneficiary agrees to allow (1) the physician to bill the carrier directly and (2) the carrier to send the payment directly to the physician. Under the private plans an "assigned claim" does not mean that the physician is willing to accept the reasonable charge as full payment. However, this distinction seems unimportant, since there were no reductions in our sample of private plan charges. All of the 252 private plan charges were fully allowed as reasonable under Occidental's reasonable charge screen.

The following schedule shows, by procedure code, the total number of charges in our sample and the number of charges reduced.

According to the regional official, since Occidental's determination of reasonable charges considers neither a physician's specialty nor customary charges, it was concluded some years ago that Occidental's private plans were not comparable to Medicare. Accordingly, he stated, (1) Occidental has no responsibility for reporting any information about its private plans for the purpose of comparability and (2) the Bureau has no procedure to ensure that the comparability relationship between Medicare and the carrier's private plans has not changed.

According to Occidental officials, Medicare was designed (except for the coinsurance and deductible provisions) to fully reimburse beneficiaries for health care costs. In contrast, the officials stated that the carrier's private health plans are tailored to the needs of the purchasing entity, and benefits vary accordingly. None of Occidental's private policies are written intending to fully indemnify the insured persons from physician charges.

According to Occidental's "Group Health Benefits Manual," nearly all of the carrier's private health policies define "expense incurred" as:

"Only the fees and prices regularly and customarily charged for the medical services and supplies generally furnished for cases of comparable nature and severity in the particular geographic area concerned."

Occidental believes that this clause, commonly referred to as the "usual and customary clause," gives the insurance company the right to determine liability for a given charge as well as the charge itself, within a given geographic area. The usual and customary charge determinations are based on data furnished by HIAA and on Occidental's own experience. The methodology gives no consideration to an individual physician's specialty or customary charges.

Officials of both Occidental and the San Francisco Medicare regional office stated that Occidental's private plans are not comparable to Medicare within the meaning of the Medicare law. Occidental officials stated that, accordingly, the carrier takes no action to ensure that part B Medicare charge screens do not permit higher payments than Occidental's private plans for the same procedures.

million Medicare claims amounting to about \$157 million. The Medicare claims are processed on a computerized system.

OUR SAMPLE

We attempted to identify 100 physicians that performed 1 or more of 13 medical and surgical procedures under both General American's private and Medicare businesses. These procedures were selected as a result of an agreement between the carrier and us that they would probably have as much volume as any other procedures common to both businesses.

We sampled private health care claims from July 1, 1977, through September 30, 1978. Approximately 3,000 claims were reviewed to identify sample physicians. The physicians' names were then screened against Medicare records to match physicians' names as well as the types of service performed during the same 15-month timeframe. We found that 101 physicians had performed the same types of services under private health care plans and under the Medicare program. As a result of this sampling procedure, the following number of physicians and services were identified for the private business and were compared to activities under the Medicare program:

<u>Procedure</u>	Number of physicians performing <u>procedure</u>	Total number of services identified	
		<u>Private</u>	<u>Medicare</u>
Mastectomy	3	4	9
Bronchoscopy	1	1	126
Appendectomy	6	7	8
Proctosigmoidoscopy	17	19	626
Hemorrhoidectomy	4	5	23
Cholecystectomy	16	19	58
Hernia repair	22	26	128
Transurethral resec- tion of prostate	4	4	71
Hysterectomy	4	4	5
Extraction of lens	5	5	368
Routine followup brief office visit	24	45	3,589
Routine followup brief hospital visit	16	110	9,122
EKG	<u>15</u>	<u>22</u>	<u>2,113</u>
Total	<u>a/137</u>	<u>271</u>	<u>16,246</u>

a/This total is greater than the 101 physicians because some doctors performed more than one procedure in our sample.

COMPARISON OF ALLOWED CHARGES

Under its private business, the carrier always allowed the same amount or more than it did under its Medicare business:

<u>Procedure</u>	<u>Number of services</u>	<u>Private allowed charges</u>		
		<u>Lower than Medicare</u>	<u>Equal to Medicare</u>	<u>Higher than Medicare</u>
Mastectomy	4	-	-	4
Bronchoscopy	1	1	-	-
Proctosig- moidoscopy	19	-	2	17
Hemorrhoidectomy	5	-	-	5
Cholecystectomy	19	-	4	15
Appendectomy	7	-	-	7
Transurethral resection of prostate	4	-	-	4
Hysterectomy	4	-	-	4
Extraction of lens	5	-	-	5
Hernia repair	26	-	2	24
Routine follow- up brief office visit	45	2	5	38
Routine follow- up brief hospital visit	110	-	45	65
EKG	<u>22</u>	-	<u>3</u>	<u>19</u>
Total	<u>271</u>	<u>3</u>	<u>61</u>	<u>207</u>
	(100%)	(1%)	(23%)	(76%)

SCREENS USED TO DETERMINE
MEDICARE ALLOWED CHARGES

The table on the following page shows that the customary charge was the most common amount allowed for Medicare billings. It was applied alone in about 43 percent of the cases, and applied in another 41 percent of the time when it was the same as another screen.

COMPARISONS OF PRIVATE PLAN
SCREENS TO MEDICARE SCREENS

Allowances for General American's private plans are determined by the lower of the actual charge or the reasonable charge screen amounts. The actual charge is the amount billed by the physician. The reasonable charge amount is calculated by multiplying relative values (established by the 1964 Relative Value Study published by the California Medical Association) by conversion factors computed by General American. Conversion factors represent dollar rates which are assigned to three types of medical services (anesthesia, surgical, and physician visits). There are different conversion factors for each of the three types of services within each field office across the United States. The St. Louis office applied a single set of screens throughout all of Missouri. No provision is made to recognize physician specialties. General American will not allow an amount greater than its reasonable charge screen, except in extenuating circumstances.

According to a General American official, the company has a goal of reducing not more than 5 percent of private health care claims due to reasonable charge reductions. When a particular General American area office's reasonable charge reduction rate approaches 4 to 5 percent, the reasonable and customary charge screen is adjusted upward.

In contrast to the single statewide screen area under General American's private business, there are three pricing areas for Medicare within Missouri. These areas are not set out by geographic location, but by the pricing trends within a community. Doctors under Medicare are also grouped within their own specialty. There are approximately 30 recognized specialty codes for each of the three pricing areas in Missouri. Therefore, there may be as many as 90 prevailing allowances for each medical service within Missouri.

We compared the prevailing charge screens used for each procedure code under the private health care plans to the Medicare prevailing charge screens used for the specialties, localities, and procedures we included in our sample. This resulted in 80 comparisons of individual prevailing screen amounts. Out of the 80 comparisons, there were only 4 situations (5 percent) where the Medicare prevailing screen was higher than the private prevailing screen. This seems consistent with our findings on page 59 that Medicare allowances were higher than private business allowances in only 1 percent of the cases we reviewed.

REASONABLE CHARGE REDUCTIONS

During fiscal year 1978 General American processed about 1.3 million Medicare claims which were paid or applied to the beneficiaries' deductibles, representing \$123 million in covered charges. About 78 percent of these claims were reduced. The reductions totaled over \$21 million--17 percent of the total submitted covered charges. From the beneficiaries' viewpoint, over 807,000 claims were unassigned, representing \$82 million in covered charges. Over 656,000 of these claims were reduced. Overall, the beneficiaries were responsible for paying an average reduction of about \$18 per claim on all unassigned claims. Under the private health care plan, all claims are "unassigned," according to Medicare's definition.

From July 1, 1977, to September 30, 1978, General American's St. Louis office received 442,347 private plan claims and paid about \$81 million for health and dental care and weekly indemnity benefits. No information was available on the total number of claims reduced under the private business to develop the average reduction per unassigned claim. As mentioned earlier, General American has a goal to not reduce more than 5 percent of their private health care claims due to reasonable charge reductions.

The table on the following page shows, by procedure, the total number of charges in our sample, charges reduced, and whether the Medicare claims involved were assigned or unassigned. Overall, about 28 percent of the Medicare charges pertained to assigned claims.

COMPARABILITY

General American officials do not believe that their private health care plans are similar enough to the Medicare program to require comparison, and therefore no attempt is made to compare the amounts allowable under private health care plans with the amounts allowable under Medicare. HCFA officials stated that they made an initial evaluation of General American's Medicare and private health care businesses and determined that they were not comparable for several reasons. The reasonable charge screens used for the private plans do not provide for the different physicians' specialties as provided under Medicare. General American does not maintain physician profiles for individual doctors who provide services under the private plans as are maintained under the Medicare program. This precludes the carrier from establishing separate customary charge screens for each physician service, as is done under the Medicare program.

Another factor mentioned by the HCFA officials was that, under General American's private health care plans, Missouri is within one locality whereas, under Medicare, there are three areas within the General American service area in Missouri. We were also advised by HCFA that for the past several years the Regional Office had questioned the carrier about comparability, but it did not attempt to verify or substantiate the carrier's position.

Superimposed Catastrophic Insurance (a Blue Shield supplemental plan) applies a Blue Cross/Blue Shield fee schedule with a superimposed Connecticut General major-medical contract. Blue Cross/Blue Shield reimbursement for medical and surgical services is in accordance with the established fees on the schedule. If a physician's charge exceeds the fee schedule, Connecticut General pays 80 percent of the balance up to the amount Connecticut General considers reasonable and customary.

Under its comprehensive health plans, Connecticut General pays 80 percent of the reasonable charge. The company considers the reasonable charge to be the lower of (1) the actual charge or (2) the "reasonable and customary" determination, and computes its reasonable and customary allowance as follows:

Connecticut General uses HIAA data as a basis to create "Multi Guide" allowances. These are listings of allowable amounts at the 80th percentile plus 10 percent for five common surgical procedures by geographic area. In order to derive an allowed amount for all procedures, conversion factors are used. However, these amounts represent only guides for reasonable and customary determinations.

The company never allows more than a physician's submitted charge, but in cases where a submitted charge exceeds the Multi Guide, the Bristol office manager, where we conducted our review, has authorized claims examiners to allow charges up to \$25 over the Multi Guide. This results in about 96 percent of the claims being paid in full. In addition, Bristol supervisory personnel can authorize allowances which are 10 percent over the Multi Guide amount (up to \$100). Consequently, nearly all Bristol claims are allowed in full.

On the advice of Connecticut General's Director of Government Programs, we obtained private plan data only from the Bristol office. He said most plans handled by Bristol base payment on a reasonable and customary determination and would be suitable for our sample. Another company official said that reasonable charge type plans represent about 1,000 of Bristol's 1,200 plans, and they include 90 percent of its claims volume. The Director of Government Programs stated that charges allowed by the Windsor office, for its one policyholder, are based on a fee schedule that is not subject to a reasonable and customary fee determination. He said that, therefore, these allowances are not comparable to Medicare allowances.

Almost all services in our comparisons were provided in August, September, and October 1978.

COMPARISON OF ACTUAL CHARGES

In 5 percent of the cases we reviewed, physicians charged their private plan patients less than they charged their Medicare patients:

<u>Procedure</u>	<u>Number of services</u>	<u>Private actual charges</u>		
		<u>Lower than Medicare</u>	<u>Equal to Medicare</u>	<u>Higher than Medicare</u>
Routine followup brief office visit	119	5	112	2
Routine followup brief hospital visit	124	8	116	-
EKG	48	-	46	2
Sigmoidoscopy	25	1	23	1
Hernia repair	3	-	2	1
Cholecystectomy	3	-	3	-
Transurethral resection of prostate	<u>3</u>	<u>1</u>	<u>2</u>	<u>-</u>
Total	<u>325</u>	<u>15</u>	<u>304</u>	<u>6</u>
	a/(100%)	(5%)	(94%)	(2%)

a/Individual percents do not add to 100 percent due to rounding.

HOW MUCH HIGHER ARE
PRIVATE PLAN ALLOWANCES
THAN MEDICARE ALLOWANCES?

The following table shows that physicians were allowed over 10 percent more by private plans than they were by Medicare in 64 percent of the cases included in this analysis.

<u>Procedure</u>	<u>Number of charges</u>	<u>How much physicians' private allowed charges exceeded their medicare charges</u>				<u>76% and over</u>
		<u>1-10%</u>	<u>11-25%</u>	<u>26-50%</u>	<u>51-75%</u>	
Routine followup brief office visit	56	20	18	17	1	-
Routine followup brief hospital visit	13	7	-	6	-	-
EKG	15	5	8	1	1	-
Sigmoidoscopy	7	-	4	1	2	-
Hernia repair	2	1	1	-	-	-
Cholecys- tectomy	2	1	-	1	-	-
Transurethral resection of prostate	<u>2</u>	<u>1</u>	<u>1</u>	<u>-</u>	<u>-</u>	<u>-</u>
Total	<u>97</u>	<u>35</u>	<u>32</u>	<u>26</u>	<u>4</u>	<u>-</u>
	(100%)	(36%)	(33%)	(27%)	(4%)	

SCREENS USED TO DETERMINE
MEDICARE ALLOWED CHARGES

The table on the following page shows that the prevailing charge screen is the most common amount allowed for Medicare billings. It was applied alone in about 64 percent of the charges, and applied in another 12 percent of the time when it was the same as another screen.

COMPARISON OF MEDICARE PREVAILING
RATES WITH REASONABLE AND CUSTOMARY
ALLOWANCES UNDER PRIVATE PLANS

Determining a reasonable and customary (R&C) charge (prevailing charge) under Connecticut General's private plans is a two-step process. The Company's "Multi-Guide for Claims Evaluation" handbook provides an initial R&C allowance for each procedure, but the Bristol staff has considerable flexibility to allow a higher amount.

Many Medicare prevailing rates, primarily for office and hospital visits, exceed the corresponding handbook amounts. The potential, therefore, exists for the carrier to allow more under Medicare than it allows under its private plans. However, Bristol allowed every sampled private plan charge in full, even if it exceeded the handbook amount. As a result, Connecticut General almost always allowed more under its private plans than under Medicare.

The handbook provides a unit value for each medical procedure under Connecticut General's private business. By applying a conversion factor, expressed in dollars, Bristol benefit analysts can calculate the Multi Guide allowances for any listed procedure. The company develops its own conversion factors; one for each Multi Guide area. These geographic areas consist of groups of zip codes, and include the entire United States. Connecticut has four areas.

For Medicare, Connecticut General computes a prevailing rate for each medical procedure by Medicare area and specialty group. Since there are four Medicare areas in Connecticut and three physician specialty groups (see next the page), each procedure could have 12 prevailing rates:

- Multi Guide allowances are updated every 6 months, compared to once a year for Medicare prevailings.
- The company divides Connecticut into four areas for both Medicare and private plan business, but the areas are somewhat different.
- Only Medicare charges are considered in computing Medicare prevailings, and only a sample of HIAA charges are used for Multi Guide allowances.
- Connecticut General selects the 80th percentile charge and adds 10 percent to determine Multi Guide allowances, but it uses the 75th percentile charge for determining Medicare prevailings, subject to the index.
- Unlike Medicare, the company does not recognize physician customary charges or specialties before selecting the appropriate percentile charge.
- Medicare prevailing rates, unlike Multi Guide allowances, are limited by an economic index.

Recognizing the considerable differences between the criteria Connecticut General uses for developing prevailing screens under its private and Medicare businesses, we compared the prevailing charge screens (or R&C screens) used under the private health care plans to the prevailing charge screens used for the same localities and procedures under Medicare. This resulted in 141 comparisons of individual prevailing screen amounts. There were 48 situations (34 percent), where the Medicare prevailing screen was higher than the private prevailing screen. This is not consistent with our findings that Medicare allowances were higher than private business allowances in only 1 percent of the sampled cases, because the company allows its claims examiners to exceed the private screens subject to certain tolerances. (See p. 70.)

REASONABLE CHARGE REDUCTIONS

During fiscal year 1978 Connecticut General processed about 1.6 million Medicare claims which were paid or applied to the beneficiaries' deductibles, representing \$131 million in submitted covered charges. About 67 percent of these claims were reduced. The reductions totaled about \$18 million--14 percent of the total submitted covered charges. Over 872,000

Regional officials said they annually update Connecticut General's comparability status through discussions with company officials. The carrier's information is not verified by the regional office. In January 1978 a Connecticut General representative reported to the regional office that the company still did not use customary-charge screens to determine private plan allowable charges and, therefore, it still had no plans comparable to Medicare.

a Medicare claims volume of about 3.1 million claims totaling nearly \$200 million. It services about the same number of physicians under Medicare as it does in its private business. Medicare claims are processed on a computerized system which is different from the one the carrier uses for its private claims processing.

OUR SAMPLE

Blue Cross and Blue Shield Association computer tapes were sampled by a special program written for our purposes to identify 100 physicians at random that performed one or more of 10 preselected medical procedures. These procedures were selected in an agreement between the carrier and us that there would be numerous claims submitted for these procedures under both types of businesses, except for office visits, which the carrier does not routinely cover under its private business. We selected this procedure for comparison because of the high volume of data we collected for office visits for the commercial carriers. The sample information covered claims submitted during calendar year 1976, the most recent period available. We obtained sample data for both businesses for this time period.

As a result of this sampling procedure, the following number of physicians and services were identified for the private business:

<u>Procedure</u>	Number of physicians performing procedure	Number of services identified	
		<u>Private</u>	<u>Medicare</u>
Bronchoscopy	1	19	32
Appendectomy	3	16	5
Sigmoidoscopy	18	62	179
Cholecystectomy	5	27	16
Transurethral resection of prostate	2	3	19
Hysterectomy	7	19	11
Routine followup brief office visit	1	1	226
Routine followup brief hospital visit	83	7,304	45,927
EKG	<u>32</u>	<u>2,296</u>	<u>2,645</u>
Total	<u>a/152</u>	<u>9,747</u>	<u>49,060</u>

a/This number is greater than the 99 physicians actually identified in this sample because some physicians performed more than one sample procedure.

COMPARISON OF ALLOWED CHARGES

The allowed charges under the private plans were lower than those allowed under Medicare in only 8 percent of the cases we reviewed:

<u>Procedure</u>	Number of services	<u>Private allowed charges</u>		
		<u>Lower than Medicare</u>	<u>Equal to Medicare</u>	<u>Higher than Medicare</u>
Bronchoscopy	19	-	19	-
Appendectomy	16	-	8	8
Sigmoidoscopy	62	12	31	19
Cholecystectomy	27	2	12	13
Transurethral resection of prostate	3	1	2	-
Hysterectomy	19	-	11	8
Routine followup brief office visit	1	-	-	1
Routine followup brief hospital visit	7,304	635	4,781	1,888
EKG	<u>2,296</u>	<u>112</u>	<u>1,761</u>	<u>423</u>
Total	<u>9,747</u>	<u>762</u>	<u>6,625</u>	<u>2,360</u>
	(100%)	(8%)	(68%)	(24%)

HOW MUCH GREATER ARE
PRIVATE PLAN ALLOWANCES
THAN MEDICARE ALLOWANCES?

The table on the following page shows that physicians were allowed over 10 percent more by private plans than they were by Medicare in 74 percent of the cases included in this analysis:

THE NUMBER OF TIMES THAT THE ACTUAL, CUSTOMARY, AND/OR
PREVAILING CHARGE RESULTED IN THE MEDICARE ALLOWED CHARGE

Procedure	Number of charges	Actual charge	Cus- tomary charge	Prevail- ing charge	Actual charge and cus- tomary charge the same	Cus- tomary charge and pre- vailing charge the same	Actual charge and pre- vailing charge the same	All three charges the same	Unknown (note a)
Bronchoscopy	32	6	-	-	26	-	-	-	-
Appendectomy	5	-	3	1	1	-	-	-	-
Sigmoidoscopy	179	1	74	19	29	30	-	26	-
Cholecystectomy	16	2	12	1	1	-	-	-	-
Transurethral resection of prostate	19	1	18	-	-	-	-	-	-
Hysterectomy	11	1	8	-	1	-	-	1	-
Routine followup brief office visit	226	-	30	196	-	-	-	-	-
Routine followup brief hospital visit	45,927	518	19,049	8,719	7,389	4,266	25	5,961	-
EKG	2,645	17	1,062	437	722	159	-	247	1
Total	<u>49,060</u>	<u>546</u>	<u>20,256</u>	<u>9,373</u>	<u>8,169</u>	<u>4,455</u>	<u>25</u>	<u>6,235</u>	<u>1</u>
	(100%)	(1%)	(41%)	(19%)	(17%)	(9%)	(0%)	(13%)	(0%)

a/Amount allowed was not the same as any of the three screen amounts.

Under the carrier's private business, physicians sign participating agreements that they will accept as full payment whatever Massachusetts Blue Shield allows. Physicians not participating are not reimbursed for their services; no vehicle is available under Massachusetts Blue Shield's private plans which will allow payment directly to beneficiaries. Consequently, their assignment rate is nearly 100 percent.

During calendar year 1976 the carrier experienced a claims volume of about 3.3 million private health care claims representing about \$148 million in submitted charges. The amount of private reasonable charge (UCR) reductions was not made available to us. Since Massachusetts Blue Shield's private business involves literally all assigned claims, the beneficiaries, unlike Medicare beneficiaries, remain relatively unaffected by the amount or frequency of UCR reductions. The table on the following page shows by the type of business and, by procedure, the total number of charges in our sample and the number of charges reduced. About 82 percent of the Medicare charges pertained to assigned claims.

COMPARABILITY

Massachusetts Blue Shield believes that its private plans are not comparable to Medicare because:

- Medicare updates its profiles on a regular schedule, whereas Blue Shield updates its profiles on an irregular basis whenever it is financially feasible for the company to do so.
- Blue Shield profiles do not meet the test of comparability because they are not based on customary charges "as currently constituted" or on "current prevailing charges" in a locality, due to the irregularity of their updates.
- Blue Shield uses an economic index 1/ to limit its updates, but it is not the same one Medicare uses.
- The Blue Shield update limits apply to both customary and prevailing screens, whereas Medicare's limit only applies to prevailing.
- Medicare uses the 50th percentile of prevailing charges if a customary charge for a specific procedure cannot be computed because of insufficient services billed in the base year (for example, for new doctors). Blue Shield uses the 90th percentile of prevailing charges.
- The Blue Shield prevailing charge screens are currently set at the 90th percentile, as compared to the 75th percentile for Medicare.
- Medicare currently employs two areas of locality, while Blue Shield in 1975 reverted to a single locality.
- Medicare requires three claims to establish a customary profile if two claims use the same charge; they require four claims if two do not use the same charge. The private business uses two claims to establish a customary profile.

The HCFA Boston Regional Office has concluded that some of the differences listed above are sufficient for a noncomparability determination.

1/In addition, the Massachusetts commissioner of insurance is placing total dollar limits on increases.

As a result of this sampling procedure, the following number of physicians and services were identified:

<u>Procedure</u>	<u>Number of physicians performing procedure</u>	<u>Number of services identified</u>	
		<u>Private</u>	<u>Medicare</u>
Radical mastectomy	1	1	1
Appendectomy	2	3	3
Sigmoidoscopy	14	34	106
Hemorrhoidectomy	3	3	4
Cholecystectomy	5	5	8
Transurethral resection of prostate	6	7	92
Hysterectomy	10	43	22
Routine followup brief office visit	1	3	687
Routine followup brief hospital visit	71	2,275	26,926
EKG	<u>39</u>	<u>301</u>	<u>2,979</u>
Total	<u>a/152</u>	<u>2,675</u>	<u>30,828</u>

a/This number is greater than the 97 physicians actually identified in this sample because some physicians performed more than one sample procedure.

COMPARISON OF ALLOWED CHARGES

The allowed charges under the private plans were lower than those allowed under Medicare in only 5 percent of the cases we reviewed:

<u>Procedure</u>	<u>Number of services</u>	<u>Private allowed charges</u>		
		<u>Lower than Medicare</u>	<u>Equal to Medicare</u>	<u>Higher than Medicare</u>
Radical mastectomy	1	1	-	-
Appendectomy	3	1	-	2
Sigmoidoscopy	34	6	6	22
Hemorrhoidectomy	3	-	-	3
Cholecystectomy	5	2	1	2
Transurethral resection of prostate	7	1	-	6
Hysterectomy	43	1	1	41
Routine followup brief office visit	3	-	-	3
Routine followup brief hospital visit	2,275	100	495	1,680
EKG	<u>301</u>	<u>21</u>	<u>22</u>	<u>258</u>
Total	<u>2,675</u>	<u>133</u>	<u>525</u>	<u>2,017</u>
	(100%)	(5%)	(20%)	(75%)

HOW MUCH HIGHER ARE
PRIVATE PLAN ALLOWANCES
THAN MEDICARE ALLOWANCES?

The table on the following page shows that physicians were allowed over 10 percent more by private plans than they were by Medicare in 81 percent of the cases included in this analysis:

THE NUMBER OF TIMES THAT THE ACTUAL, CUSTOMARY, AND/OR
PREVAILING CHARGE RESULTED IN THE MEDICARE ALLOWED CHARGE

<u>Procedure</u>	<u>Number of charges</u>	<u>Actual charge</u>	<u>Cus- tomary charge</u>	<u>Prevail- ing charge</u>	<u>Actual charge and cus- tomary charge the same</u>	<u>Cus- tomary charge and pre- vailing charge the same</u>	<u>Actual charge and pre- vailing charge the same</u>	<u>All three charges the same</u>	<u>Unknown (note a)</u>
Radical mastec- tomy	1	-	1	-	-	-	-	-	-
Appendectomy	3	-	-	-	-	2	-	-	1
Sigmoidoscopy	106	20	12	15	3	29	-	27	-
Hemorrhoidectomy	4	2	2	-	-	-	-	-	-
Cholecystectomy	8	1	2	-	-	-	-	-	5
Transurethral resection of prostate	92	6	15	39	-	-	-	-	32
Hysterectomy	22	2	18	-	-	-	-	-	2
Routine followup brief office visit	687	-	-	555	-	132	-	-	-
Routine followup brief hospital visit	26,926	1,843	12,244	7,617	3,332	691	24	1,162	13
EKG	2,979	182	1,275	1,304	104	108	-	2	4
Total	<u>30,828</u>	<u>2,056</u>	<u>13,569</u>	<u>9,530</u>	<u>3,439</u>	<u>962</u>	<u>24</u>	<u>1,191</u>	<u>57</u>
	(100%)	(7%)	(44%)	(31%)	(11%)	(3%)		(4%)	

a/Amount allowed was not the same as any of the three screen amounts.

In calendar year 1976, Florida Blue Shield processed over 2.6 million private health care claims representing over \$99 million in claim costs. Florida Blue Shield does not keep information on reasonable charge reductions for its private business. The table on the following page shows, by type of business and type of procedure, the total number of charges in our sample and the number of charges reduced. About 29 percent of the Medicare charges pertained to assigned claims.

COMPARABILITY

The Atlanta HCFA Regional Office has determined that Florida Blue Shield's private health care plans are comparable to Medicare. This determination was made even though the carrier's private business does not use economic indexes to limit its annual prevailing screen increases, and it uses the 90th percentile of customary charges to establish its prevailing charge screens. Both of these situations constitute differences from the Medicare program.

Further, we were informed by HCFA Atlanta region officials that, while Florida Blue Shield's private plans are considered comparable to Medicare, they are not required to make any Medicare screen adjustments to comply with the law. The officials stated that the data base used to create the private and Medicare screens is the same; consequently, there should be no cases where the Medicare screens are higher. As noted on page 94, we found only 1 out of 98 prevailing and customary screen comparisons where Medicare screens were higher than the private screens.

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