REPORT TO THE
SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

Study Of The Application Of Reasonable Charge Provisions For Paying Physicians' Fees Under Medicare

B-164031(4)

Social Security Administration
Department of Health, Education,
and Welfare

BY THE COMPTROLLER GENERAL
OF THE UNITED STATES

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

B-164031(4)

The Honorable Frank Church, Chairman
Special Committee on Aging
United States Senate

Dear Mr. Chairman:

Pursuant to your request of September 11, 1972, we have studied the application of reasonable charge provisions for paying physicians' fees under Medicare throughout or in parts of Idaho, Missouri, California, and New Jersey.

We have obtained written comments from the parties responsible for the matters discussed in the report and have considered their comments in finalizing the report.

We do not plan to distribute this report further unless you agree or publicly announce its contents.

Sincerely yours,

Comptroller General
of the United States

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ABBREVIATIONS

GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
SSA	Social Security Administration

COMPTROLLER GENERAL'S REPORT TO THE CHAIRMAN, SPECIAL COMMITTEE ON AGING UNITED STATES SENATE

STUDY OF THE APPLICATION OF REASONABLE CHARGE PROVISIONS FOR PAYING PHYSICIANS' FEES UNDER MEDICARE

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D I G E S T

WHY THE REVIEW WAS MADE

In accordance with a request from the Chairman, GAO studied four paying agents' or carriers' application of the reasonable charge provisions for paying physicians' fees under part B of the Medicare program. These four were:

--The Equitable Life Assurance Society (Equitable) which served Idaho.

--The General American Life Insurance Company (General American) which served part of Missouri.

--The Prudential Insurance Company of America (Prudential) which served New Jersey.

--The California Physicians' Service (California Blue Shield) which served parts of California for regular Medicare beneficiaries and all of California for beneficiaries entitled to benefits under both Medicare and Medicaid (dual beneficiaries).

Basic facts

Part B of Medicare is a voluntary insurance program that provides eligible aged and disabled persons with protection against the costs of certain health care. The program covers principally the costs of physicians' medical and surgical services. Payments for these services are based on reasonable charges established in accordance with criteria set forth in the Social Security Act.

The reasonable charge is the lower of the amount billed for the service, the physician's customary charge for the service, or the prevailing charge for the service in the locality.

Medicare is administered by the Social Security Administration (SSA). The Department of Health, Education, and Welfare has contracted with private organizations, or carriers, to assist SSA by determining the rates and amounts of reasonable charges and by receiving, disbursing, and accounting for funds spent in paying the charges.

The beneficiary is responsible for the first $60 of reasonable charges for covered services in each year (increased from $50 effective January 1973 by the Social Security Amendments of 1972) and 20 percent of the reasonable charges for covered services exceeding $60 in each year.

Reasonable charges exceeding the $60 deductible and the 20-percent coinsurance amount may be paid either to a physician or supplier (assigned

claim) or to the beneficiary (unassigned claim), as agreed among them.

Physicians and suppliers ordinarily accept assignments of payments for services provided to dual beneficiaries and accept many for services provided to regular Medicare beneficiaries.

If a physician takes an assignment, he agrees that the reasonable charge determined by the carrier will be the full charge and that he will not bill the beneficiary for more than the applicable deductible and coinsurance amounts based on the reasonable charge.

If the physician does not accept an assignment, the patient is billed for the physician's full charge and is liable for the difference, if any, between the amount of the charge and the amount determined by the carrier to be the reasonable charge, as well as the applicable deductible and coinsurance amounts.

SSA pointed out to GAO that it is likely that some physicians do not view reasonable charge reductions on unassigned claims as amounts to be collected from their patients. Further, some beneficiaries carry complementary private insurance against certain costs--generally the deductible and coinsurance amounts--not paid by Medicare.

SSA requires that carriers establish and maintain procedures for granting physicians or suppliers and individuals enrolled under the program an opportunity for reconsideration and a fair hearing if they (1) are dissatisfied with the carrier's determination denying a request for payment or with the amount of the payment or (2) believe that a request for payment is not being acted upon with reasonable promptness.

A reconsideration is a prerequisite for a fair hearing. Effective with requests received after October 30, 1972, a fair hearing is considered only if the amount in controversy is $100 or more.

FINDINGS AND CONCLUSIONS

The four carriers reported to SSA that, during the first 9 months of 1972, they reduced the amounts claimed in 40 to 55 percent of the processed claims because the amounts charged exceeded the carriers' determinations of reasonable charges.

Reductions ranged from 10 to 12 percent of the covered charges for all claims processed. (See pp. 23, 30, 40 and 45.)

The percentage of claims reduced was higher for unassigned claims--where the beneficiary is liable for the reasonable charge reduction--than for assigned claims.

Although two carriers made relatively minor procedural errors in accumulating statistics, the reasonable charge reductions reported by the four carriers generally were accurate. (See pp. 23, 30, 40 and 46.)

The rate of reasonable charge reductions by the four carriers expressed as a percentage of the total covered charges on only the reduced claims ranged from about 15 to 17 percent. At only one carrier (Prudential) did the rate of reasonable charge reductions on unassigned claims exceed the rate of reduction on assigned claims. (See pp. 24, 31, 41 and 47.)

From 40 to 70 percent of the services on the reduced claims were subject to reasonable charge reductions whereas the charges for other services were allowed in full. The rate of reductions for only those services where the charges were reduced ranged from 17 to 25 percent. (See pp. 25, 32, 42 and 47.)

Physicians' visits to hospitals and nursing homes and patients' visits to physicians' offices were the services most frequently involved in the reasonable charge reductions.

For each of the four carriers, the largest single factor causing reductions in charges billed was the carrier's determinations that the amounts charged exceeded the physicians' own customary charges. (See pp. 25, 32, 42 and 48.)

The four carriers had generally complied with SSA requirements for establishing reasonable charges. However, three of the four carriers had incorrectly established some reasonable charges and the other carrier did not recognize physicians' specialties in establishing prevailing charges. (See pp. 27, 33, 43 and 51.)

Medicare beneficiaries and physicians or suppliers seldom contested the reasonable charge reductions; 1 percent or less of the claims denied or reduced were reconsidered or were the subject of appeals. The carriers' procedures for handling complaints appeared to be adequate and to provide for impartial and fair treatment of disputed claims.

However, one of the carriers had inaccurately reported the number of reconsiderations that were decided in favor of the claimants. Of the four carriers' reconsiderations, 22 to 53 percent were favorable to the claimants but almost all of the fair hearings were favorable to the carriers. (See pp. 28, 35, 44 and 52.)

Assignment of claims

According to SSA's Office of Research and Statistics, a high assignment rate is one indication of the medical community's general satisfaction with the Medicare program, especially with the program's level of payments for specific services and the promptness of payment.

General American's and California Blue Shield's reported assignment rates were not meaningful indications of physician satisfaction because of the high incidence of claims applicable to dual beneficiaries, where the physician or supplier is required to accept assignment of the Medicaid payment and ordinarily accepts assignment of the Medicare payment also. Excluding dual beneficiary claims from the calculations would reduce General American's 1972 net assignment rates from about 56 percent to 22 percent and California Blue Shield's rates from 77 percent to 28 percent. (See pp. 35, 36, 53 and 54.)

Equitable's net assignment rate decreased from 71 percent in 1969 to 31 percent in 1972, General American's net adjusted assignment rate (excluding dual beneficiaries) decreased from 34 percent in 1969 to 22 percent in 1972, and California Blue Shield's net adjusted assignment rate decreased from 36 percent in 1970 to 28 percent in 1972. (See pp. 29, 36, and 54.)

Because of the low assignment rate

in Idaho, about 70 percent of the $600,000 in reasonable charge reductions during the first 9 months of 1972 became liabilities of the Medicare patients. (See p. 29.)

Equitable and General American said the assignment rates were decreasing because physicians were dissatisfied with reasonable charge determinations. (See pp. 29 and 38.)

Also, General American and California Blue Shield said physicians were passing the paperwork burden of billing the program on to the patients by not accepting assignments. (See pp. 38 and 54.)

CHAPTER 1

INTRODUCTION

Pursuant to a request dated September 11, 1972, from the Chairman, Special Committee on Aging, United States Senate, GAO studied four carriers' application of the reasonable charge provisions for paying physicians' fees under the Medicare program. These four carriers were operating throughout or in parts of Idaho, Missouri, New Jersey, and California. (See app. I.)

The Chairman requested that we:

1. Evaluate the accuracy and completeness of the Social Security Administration's (SSA's) statistics on reasonable charge reductions contained in the carriers' workload reports.

2. Analyze random samples of Medicare claims reduced under the reasonable charge provisions. Among the matters requested to be considered were the extent that (1) claims were reduced by less than 5 percent, 10 percent, 20 percent, 30 percent, 40 percent, and 50 percent and over, (2) the same medical and surgical services were involved in these reductions, (3) the same physicians were involved in these reductions, (4) the claims reduced were assignments where the charges reduced are not supposed to be passed on to the patient, and (5) the reductions were caused by the customary or prevailing charge limitation.

3. Analyze the carriers' reasonable charge methodology to determine whether it is being applied uniformly and fairly.

4. Analyze the extent that the claim reductions are appealed and amended as a result of the carriers' fair hearing procedures.

During subsequent discussions with the Chairman's office, we agreed to obtain information on the rates of claim assignments.

SCOPE OF REVIEW

We evaluated the accuracy and completeness of SSA statistics on reasonable charge reductions contained in the carriers' workload reports.

For each of the first three carriers (Equitable Life Assurance Society, General American Life Insurance Company, and Prudential Insurance Company of America) we reviewed a random sample of about 250 claims from claims processed during the first 9 months of 1972. Because of the large volume of claims processed by the fourth carrier--California Physicians' Service (California Blue Shield)--and the difficulties and cost involved in retrieving a meaningingful random sample of claims covering a 9-month period, we arranged with the carrier and its data processing subcontractor to undertake a special project to analyze reasonable charge reductions made through the computer for the month of December 1972.

We reviewed the carriers' application of the reasonable charge provision to the claims processed and obtained information as to the amounts of, and reasons for, reasonable charge reductions. We obtained information on which services and physicians were most frequently involved in reasonable charge reductions of the claims.

We also examined carriers' records to obtain information on the extent that reasonable charge reductions were reconsidered and appealed as a result of complaints by beneficiaries or physicians and suppliers.

Further, we obtained information on the percentage of claims assigned during the last 4 years by physicians or suppliers in the areas covered by the four carriers.

We made our study at SSA headquarters in Baltimore and the carriers' offices in Boise, Idaho; St. Louis, Missouri; Millville, New Jersey; and San Francisco, California.

We examined the basic legislation authorizing Medicare and Department of Health, Education, and Welfare (HEW) regulations and SSA instructions implementing the program.

CHAPTER 2

DESCRIPTION OF PERTINENT FEATURES OF MEDICARE

Title XVIII of the Social Security Act (42 U.S.C. 1395), enacted on July 30, 1965, established the Medicare program, effective July 1, 1966, to provide eligible persons over age 65 with two basic forms of protection against the costs of health care. The Social Security Amendments of 1972, enacted October 30, 1972, expanded the program to include the disabled. One form of protection--hospital insurance benefits for the aged and disabled (part A)--covers inpatient hospital care as well as posthospital care in a skilled nursing facility or in patients' homes. This form of protection is financed by a special social security tax paid by employees, their employers, and self-employed persons.

The second form of protection, which is the subject of this report, is a voluntary program--supplementary medical insurance benefits for the aged and disabled (part B). It covers physicians' medical and surgical services, including consultations and home, office, and institutional visits, as well as other services ordinarily provided as part of a physician's service, such as diagnostic tests, medical supplies, and drugs which cannot be self-administered. Part B also covers such things as durable medical equipment, ambulance service, prosthetic devices (other than dental), and diagnostic tests performed by independent laboratories.

Part B is financed, in part, from the proceeds of premiums collected from each eligible beneficiary who has elected to be covered by the program. The premiums are matched by equal amounts appropriated from the general revenues of the Federal Government.

The beneficiary is responsible for the first $60[1] of reasonable charges for covered services in each year, and for 20-percent coinsurance for reasonable charges above the first $60 deductible amount. The remaining 80 percent of the reasonable charges exceeding $60 in each year is paid under part B of the Medicare program. The President, in

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[1]Increased from $50 by the Social Security Amendments of 1972, effective January 1, 1973.

his fiscal year 1974 budget message, stated that legislation will be proposed to increase the deductible from $60 to $85 and the coinsurance from 20 to 25 percent effective January 1, 1974. On October 16, 1973, the Secretary of HEW submitted for the consideration of the Congress a draft bill which included provisions to increase the deductible and coinsurance amounts as stated in the President's budget message.

PAYMENTS FOR SERVICES ON THE BASIS OF REASONABLE CHARGES

Under the medical insurance program (part B), payments for physicians' services are based on reasonable charges. Section 1842 of the Social Security Act provides that, in determining the reasonable charges for services, consideration shall be given to physicians' or suppliers' customary charges for similar services, as well as to the prevailing charges for similar services in the locality.

Carriers must determine the reasonable charges in conformance with the requirements of the statute and SSA regulations and in a way which is equitable both to those rendering the services and to those paying the premiums. SSA has provided guidelines to insure overall consistency with respect to the concepts carriers apply in determining these charges.

In conformance with section 1842 of the Social Security Act, SSA instructed Medicare carriers that the reasonable charge allowed for a service may not normally exceed the lowest of (1) the actual charge for the service, (2) the customary charge for a similar service generally made by the physician or other person furnishing the service in the locality, or (3) the prevailing charge for a similar service in the locality. (Higher amounts may be allowed in a given instance for a specific, named service but only where the additional fee is warranted by unusual circumstances or medical complications and the service is, in fact, different from that for which the normal fee is reasonable.)

To carry out the statute's reasonable charge provisions, the Medicare carriers develop lists of the customary charges for services rendered by the physicians and suppliers in their service areas and develop prevailing charges based on

these customary charges. Carriers update customary and prevailing charges early in each fiscal year, using the available statistics on charges physicians and suppliers have made for services during the preceding calendar year. For example, the limits used during fiscal year 1973 were based on the charges made in calendar year 1971.

Customary charge

In calculating customary charges, carriers list, in ascending order, each charge the physician or supplier has made for a particular service during the preceding calendar year. The lowest actual charge which is high enough to include the median of the listed charges is then selected as the customary charge for the service. The customary charge for a specific service may, therefore, vary from one physician to another. SSA guidelines also contain other provisions for establishing customary charges for new physicians.

Prevailing charge

The prevailing charge for a given service in a locality is set at the 75th percentile of the customary charges for the service in the locality and is weighted by how often physicians or suppliers rendered the service (as reflected in the Medicare carrier's data). Just as customary charges may vary among physicians and suppliers, prevailing charges which are derived from the overall pattern of charges in a community may differ among localities.

For example, if customary charges for an appendectomy in a locality were at four levels, with 10 percent of the services rendered by physicians whose customary charge was $150, 40 percent by physicians who charged $200, 40 percent by physicians who charged $250, and 10 percent by physicians who charged more than $300, the prevailing limit would be $250, since this is the level that would cover at least 75 percent of the cases.

The prevailing charges in a locality may differ for physicians who engage in specialty practice. For example, a cardiologist may charge $25 for a specific examination while a general practitioner's charge may be $15 for a similar examination. Both charges may be customary for each physician and fall within the respective prevailing charge in their locality. Each of these charges, therefore, might be accepted as a reasonable charge.

Implementation of phase II of the President's Economic Stabilization Program

As indicated above, allowable charges are updated annually to take into account physicians' and suppliers' actual charges for services in the immediately preceding calendar year. Thus, for fiscal year 1973, carriers calculated allowable charges from actual charges for calendar year 1971.

However, the Price Commission ruled that the Medicare allowable charges in effect on November 13, 1971, must be considered as base prices for phase II purposes, and that, as a result, they could not be increased by more than 2.5 percent during fiscal year 1973. On the basis of actual increases in physicians' and suppliers' charges in calendar year 1971, the charges allowed under the Medicare program for fiscal year 1973 would normally, in the absence of the Economic Stabilization Program, have been increased by about 6.2 percent in the aggregate. To implement the Price Commission's ruling, only 40 percent (2.5 is about 40 percent of 6.2) of the increases that would ordinarily have been allowed were recognized in calculating Medicare's allowable charges for fiscal year 1973.

METHODS OF PAYING FOR MEDICAL SERVICES

Under part B of the Medicare program, reasonable charges exceeding the $60 deductible and the 20-percent coinsurance amount for covered services for a beneficiary may be paid either to a physician or supplier (assigned claim) or to the beneficiary (unassigned claim), as they agree. Physicians and suppliers ordinarily accept assignments for services provided to dual beneficiaries (Medicaid-Medicare recipients) and accept many assignments for services provided to beneficiaries of Medicare only.

If a physician takes an assignment, he agrees that the reasonable charge determined by the carrier will be the full charge and that he will not bill the beneficiary for more than the applicable deductible and coinsurance amounts based on the reasonable charge. If the physician does not accept an assignment, the patient is billed for the physician's full charge and is liable for the difference, if any, between the amount of the charge and the amount determined by

the carrier to be the reasonable charge, as well as the applicable deductible and coinsurance amounts.

On an unassigned claim, the beneficiary may claim reimbursement from the carrier on the basis of either a paid or unpaid itemized bill. SSA told us that it may be misleading to characterize the resonable charge reductions on unassigned claims as liabilities--particularly on bills not yet paid by the beneficiary--because of the likelihood that some physicians do not view the reductions as amounts to collect from their patients. Also, some beneficiaries carry complementary private insurance against some of the cost for which they are liable. The number of people in the four States included in our study who, at the end of 1969, had complementary insurance under the Blue Shield plans that generally covered the deductible and coinsurance amounts of the reasonable charges were as follows.

State	Medicare enrollees with Blue Shield complementary insurance	Percent of State population age 65 and over
Idaho	2,969	4.4
Missouri	109,538	19.6
New Jersey	243,269	35.8
California	78,412	4.5

The number of people carrying complementary insurance with other insurance firms was not readily available.

A report on health insurance statistics prepared by the Office of Research and Statistics, SSA, states that:

> "Because physicians and suppliers are free to accept or reject assignment, these rates provide a general indication of medical community satisfaction with the SMI [supplementary medical insurance] program, especially with the level of amounts paid by the program for specific services and the promptness of payment."

SSA reports the percentage of all claims that were assigned and the percentage of claims assigned (net assignments), exclusive of claims submitted by hospitals for the

services provided by hospital-based physicians and claims from some prepaid group practice plans, which are considered assigned by definition. The reports show the following assignment and net assignment rates for the last 4 calendar years.

	1969	1970	1971	1972
Assignment rate	65.5	64.6	62.3	59.0
Net assignment	61.5	60.8	58.5	55.1

If an assignment is not made and the beneficiary applies for payment, his claim must be supported by an itemized bill from the physician or supplier; the carrier can pay the beneficiary 80 percent of the reasonable charges above the $60 deductible.

States having a Medicaid program[1] can enter into a "buy-in" agreement with HEW to obtain the supplementary insurance benefits under part B of the Medicare program for those persons eligible for both Medicaid and Medicare. The State pays the monthly premium, the annual $60 deductible, and 20 percent of the reasonable charges for services covered under part B. The Medicare program pays the remaining 80 percent of the reasonable charges for covered services. States may contract with private organizations (fiscal agents) to assist in administering the Medicaid program. California and New Jersey have such contracts, and the same organizations act as both Medicaid fiscal agent and Medicare carrier.

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[1]The Medicaid program--also enacted in July 1965--is a grant-in-aid program under which the Federal Government pays from 50 to 83 percent--depending on the per capita income in each State--of the costs incurred by the States in providing medical assistance to individuals who are unable to pay for such care.

CARRIERS' ROLE IN ADMINISTERING PART B OF MEDICARE

To provide for the administration of benefits under part B, the Congress authorized the Secretary of HEW to enter into contracts with carriers to (1) determine the rates and amounts of reasonable charges and (2) receive, disburse, and account for funds spent in paying the charges.

The reports of the House Ways and Means Committee and the Senate Finance Committee on the bill (H.R. 6675) that became the Medicare law expressed the view that medical benefits under part B should be administered by private carriers because private insurers, group health plans, and voluntary medical insurance plans have experience in reimbursing physicians. Both Committee reports also expressed the intent that the Secretary of HEW, to the extent possible, enter into contracts with enough carriers, selected on a regional or other geographical basis, to permit comparative analysis of their performance.

SSA has instructed carriers to prepare monthly summaries of their claims-processing activities. Carriers are to report total covered charges for all claims, the number of claims reduced, and the total amount of reductions as a result of reasonable charge determinations.

Appeals process--review (reconsideration) and fair hearing

SSA requires that carriers establish and maintain procedures for granting physicians or suppliers and individuals enrolled under part B an opportunity for a reconsideration and a fair hearing if they (1) are dissatisfied with the carrier's determination denying a request for payment or with the amount of the payment or (2) believe that a request for payment is not being acted upon with reasonable promptness. A reconsideration is a prerequisite for a fair hearing. On assigned claims, both the beneficiary and the assignee can request reconsideration and a fair hearing.

Reconsideration

A dissatisfied party to a carrier's initial determination may request that the carrier reconsider the

determination. The request must be made in writing and filed with the carrier which made the initial determination or with a Social Security office.

The purpose of a reconsideration is to provide a new, independent, and critical reexamination of the claims. The reviewer looks not only at the point in issue but at the entire claim. The employee who made the initial determination should not be the one to reconsider the case. The claimant is given an opportunity to submit any relevant and material evidence in writing but is not given an opportunity to make a personal appearance.

The determination notice after reconsideration must be in writing and mailed to the claimant. The notice states the basis for the reconsideration determination and advises the claimant of his right to request a hearing if he is not satisfied with the determination and, after October 30, 1972, if the amount in controversy is $100 or more.

Fair hearing

The purpose of a fair hearing is to give an individual dissatisfied with the decision on his claim an impartial review and an opportunity (1) to present in person the reasons for his grievance and (2) if he desires, to be represented by legal counsel or any other qualified individual.

The requirement that $100 or more must be in controversy before a claimant is entitled to a fair hearing was added by the Social Security Amendments of 1972. The amount in controversy may comprise disputed amounts of a single claim or a series of claims.

A party to a carrier's reconsideration determination is entitled to a fair hearing if he files a written request with the carrier or a Social Security office. A claimant who requests a hearing must be given adequate written notice of the time and place set for the hearing and information as to the specific issues to be determined. The hearing must be scheduled for a time and place convenient to the claimant and must be conducted by a competent, qualified, and impartial individual designated by the appropriate carrier official. The hearing officer must be an individual who has not been involved in any way with the determination in

question and has neither advised nor given consultation on the claimant's request for payment which is the basis for the hearing.

A complete record of the hearing proceedings is to be made.

As soon as practicable after the close of a hearing, the hearing officer makes a decision on the basis of the documents, requests, papers, or other written evidence included in the hearing record. The decision must be in writing and contain a statement of the issues, a statement of the evidence with reference to exhibits where appropriate, a statement of rationale, specific findings of fact, and a conclusion. A copy of the decision is mailed to each party to the hearing.

Upon motion of either the hearing officer or any party to a hearing, any decision of a hearing officer may be reopened and revised within 1 year of the date of the decision.

SSA reviews hearings to promote uniformity in the hearings process and to help identify areas in which guidelines must be expanded or revised. Therefore, each carrier is requested to forward a copy of the hearing officer's decision and appropriate documents to SSA.

The Social Security Act does not provide for an appeal of carriers' fair hearing decisions to SSA or for judicial review of such decisions by State or Federal courts.

DENIALS AND REDUCTIONS OF AMOUNTS CLAIMED

Claims may be denied in full or in part for reasons such as duplicate claims being submitted, claimant not eligible, services not covered, and services not medically necessary. Amounts claimed that are not denied are called covered charges. Covered charges are subject to reductions based on reasonable charge determinations.

During fiscal year 1972, 8,057,900 claims were denied in full or in part, which meant the disallowance of $382,121,500, or 10.6 percent of amounts claimed during the

year. Denials because of duplicate claims and services not covered or not medically necessary accounted for the largest part of the amount disallowed.

During fiscal year 1972, reasonable charge reductions of covered charges were made on 23,701,600 claims. These reductions totaled $362,281,500, or 11.2 percent of the covered charges on claims processed during the year.

This report discusses only the reasonable charge reductions.

CHAPTER 3

SUMMARY OF INFORMATION DEVELOPED

The four carriers reported to SSA that, during the first 9 months of 1972, they reduced the amounts claimed because the amounts charged exceeded the carriers' determinations of reasonable charges, as shown below.

Carrier	Percent of processed claims that were reduced			Percent of reductions of covered charges for all processed claims
	Total	Assigned	Unassigned	
Equitable	54.9	44.4	61.2	10.5
General American	43.1	35.8	54.8	10.2
Prudential	40.8	34.5	48.9	10.1
California Blue Shield	50.6	49.3	55.6	11.8

Thus, on about half the claims processed, some charges were reduced because the amounts charged exceeded the carriers' determinations of reasonable charges. The frequency of reasonable charge reductions was higher for unassigned claims--where the beneficiary is liable[1] for the reasonable charge reduction--than for assigned claims.

ACCURACY AND COMPLETENESS OF REPORTED REASONABLE CHARGE REDUCTIONS

We believe that, although General American and Prudential made relatively minor procedural errors in accumulating statistics, the reasonable charge reductions reported by the four carriers generally were accurate.

ANALYSIS OF REDUCED CLAIMS

To assess the effect of the reasonable charge reductions, we selected samples of reduced claims at each of the four

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[1]As noted on page 11, SSA told us that, particularly on unassigned claims where the beneficiary has not paid the physician's bill pending Medicare reimbursement, some physicians may not view the reasonable charge reductions as amounts to be collected from their patients.

carriers[1]. The reasonable charge reductions expressed as a percentage of the covered charges on only the reduced claims were as follows.

Carrier	Reasonable charge reductions on reduced claims (percent of covered charges) Total	Assigned	Unassigned
Equitable	17	17	17
General American	16	19	14
Prudential	16	15	17
California Blue Shield	15	16	13

These reduction percentages are averages and could represent some very high reductions and some very low reductions. Therefore, to determine the extent that the claims were reduced by less than 5 percent, by 10 percent, by 20 percent, by 30 percent, and so forth, we analyzed the reduced claims according to the ranges of the percentages that the covered charges on the selected claims were reduced.

Each of the four carriers' reasonable charge reductions were generally (i.e., from 64 to 77 percent of the time) less than 20 percent of the charges for covered services. Reasonable charge reductions that were more than 50 percent of the covered charges occurred on only 1 or 2 percent of the reduced claims reviewed. The average amount of reductions for a claim ranged from about $9 at California Blue Shield to $19 at Prudential.

The carriers usually reduced the charges for most of the services on the reduced claims. The charges for the remaining services on the reduced claims were allowed in full. The frequency and rate of reductions for only those services with reduced charges are as follows.

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[1]Our study design at California Blue Shield was different from our design at the other carriers, but we believe the results are comparable, except as specifically noted. (See p. 6.)

Carrier	Reduced claims: Percent of services with reduced charges	Reduced claims: Percent charges were reduced
Equitable	55	25
General American	58	23
Prudential	71	22
California Blue Shield (note a)	42	17

[a]Represents only reasonable charge reductions made through the computer. Other reasonable charge reductions were made as a result of manual examination of claims.

Except for California Blue Shield, our samples of reduced claims did not include a large number of claims made by any one physician or group of physicians--most had only one or two reduced claims. At California Blue Shield, we noted that the physicians whose charges were most frequently reduced had higher frequencies and rates of charge reductions on their assigned claims than on their unassigned claims. Our study was not designed to identify the reasons for assigned claims' being more extensively reduced than unassigned claims. However, since our sample covered the same medical or surgical procedures, such reductions suggest to us that the physicians may be charging more on assigned claims than on unassigned claims in an effort to increase their customary charge profiles without passing the higher unallowed charges on to their Medicare patients.

The largest single factor causing the carriers to reduce reasonable charges was the carriers' determinations that the amounts charged exceeded the physicians' own customary charges.

Physicians' visits to hospitals and nursing homes and patients' visits to physicians' offices were the services most frequently involved in reasonable charge reductions.

METHODS OF DETERMINING REASONABLE CHARGES

With a few exceptions, the carriers complied with SSA requirements for establishing reasonable charges. Some of the exceptions follow.

--Incorrect charge limits were determined for new physicians, or established physicians were incorrectly treated as new physicians (Equitable and General American).

--Data on physicians' customary charges was limited, which could have resulted in too frequent use of only prevailing charges (Prudential).

--Incorrect reasonable charge determinations for nursing home visits generally resulted in allowances that were too low (General American).

--Combining charge data for specialists and nonspecialists in developing prevailing charges (California Blue Shield) resulted in a lack of uniform reasonable charges used by two carriers operating in the same area.

CLAIM REDUCTIONS APPEALED AND AMENDED

Beneficiaries and physicians seldom protest, or appeal to the carriers, the carriers' reasonable charge reductions. The four carriers' reconsideration and fair hearing activities were very low in relation to the number of claims denied and reduced. Reconsiderations of denied or reduced claims ranged from .1 percent at Prudential and California Blue Shield to 1 percent at General American. The percentages for fair hearings were lower.

Of the reconsiderations, about 22 percent were favorable to the claimants at Prudential and from 39 to 53 percent were favorable to the claimants at the other three carriers. On the other hand, almost all of the fair hearing decisions were favorable to the carrier. Our reviews of the fair hearings did not disclose any improper findings.

This suggests to us that, if beneficiaries request the carriers to take another look at their reduced or denied claims, their chances of obtaining some adjustment range from fair to very good. On the other hand, once a carrier has reconsidered a claim, a claimant's chances of obtaining adjustments through more formal protest seems remote. One reason why so few adjustments are made as a result of fair hearings may be that the carriers have reconsidered their

initial determinations, including additional information furnished by claimants, before the claims reach the fair hearing stage and, consequently, the likelihood of finding errors in the carriers' determinations is substantially reduced.

ASSIGNMENT OF CLAIMS

An assignment rate represents that percentage of the processed claims for which the physician or supplier accepts an assignment of benefits from the beneficiary and agrees to accept the carrier's determination of the reasonable charge as the full charge for the service. SSA has taken the position that a high assignment rate is one indication of the medical community's general satisfaction with the Medicare program, especially with the program's level of payments for specific services and the promptness of payment. (See p. 11.) This position assumes that physicians and suppliers are free to accept or reject assignments.

However, General American's and California Blue Shield's reported assignment rates are not meaningful indications of physician satisfaction because of the high incidence of claims applicable to dual beneficiaries for which the physician or supplier has no real option not to take an assignment. Excluding dual beneficiary claims from the calculations would reduce General American's 1972 net assignment rate from about 56 percent to 22 percent and California Blue Shield's[1] rate from 77 percent to 28 percent.

Equitable's assignment rate decreased from 71 percent in 1969 to 31 percent in 1972; General American's net adjusted assignment rate (excluding dual beneficiaries) decreased from 34 percent in 1969 to 22 percent in 1972; and California Blue Shield's net adjusted assignment rate decreased from 36 percent in 1970 to 28 percent in 1972. This suggests to us that more of the reasonable charge reductions are being passed on to the beneficiaries. For example, because of the low assignment rate in Idaho, about 70 percent of the $600,000 in reasonable charge reductions during the first 9 months of 1972 became liabilities of Medicare patients.

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[1]SSA has advised us that it does not agree that excluding dual beneficiary claims will produce more accurate assignment statistics. (See p. 36.)

Equitable and General American said the assignment rates were decreasing because physicians were dissatisfied with reasonable charge determinations. Also, General American and California Blue Shield said physicians were passing the paperwork burden of billing the program on to the patients by not accepting assignments.

Detailed information related to each of the four carriers is presented in the following chapters.

CHAPTER 4

EQUITABLE'S APPLICATION OF REASONABLE CHARGE PROVISIONS

Equitable is the carrier responsible for paying claims under part B of the Medicare program in Idaho.

Equitable reported the following claims-processing activities and reasonable charge reductions for the first 9 months of 1972.

Number of claims			Amount of covered charges		
Processed	Reduced	Percent reduced	Total	Reductions	Percent of reductions
105,308	57,796	54.9	$5,710,102	$599,570	10.5

According to Equitable's reports, 61.2 percent of the 65,700 unassigned claims and 44.4 percent of the 39,600 assigned claims processed during the period were reduced because the amounts claimed exceeded reasonable charges.

EVALUATION OF THE ACCURACY AND COMPLETENESS OF REPORTED REASONABLE CHARGE REDUCTIONS

Because much of the data for the SSA workload reports was compiled at Equitable's main office in New York, we were not able to verify the reported reasonable charge reductions during our visit to the carrier's office in Boise. However, on the basis of our analysis of a sample of reduced claims, selected at random from magnetic tapes furnished by the main office, we believe that Equitable's workload reports are reasonably accurate as to the number of claims reduced.

Equitable reported that about 55 percent of the processed claims were reduced and that the reasonable charge reductions were 10.5 percent of the total covered charges billed during the period. Our analysis of the records contained on the magnetic tapes for the 9-month period indicated that the billed charges in about half of the records were reduced. Equitable's reports indicated that, for the reduced claims, the average reduction was $10.40 a claim, whereas the average reduction in our sample of reduced claims was about $14. However, the average amount of covered charges for the claims in our sample ($83.40) appears considerably

higher than the amount of charges on a typical claim, which could explain the variance.

ANALYSIS OF CLAIMS REDUCED UNDER REASONABLE CHARGE PROVISIONS

We analyzed a random sample of 247 reduced claims processed between January 1 and September 30, 1972 (70 assigned claims and 177 unassigned claims which included 1,744 covered services). All but 10 of the services were physician's services. The 247 claims involved covered charges of about $20,600 which were reduced $3,450, or about 17 percent. Charges for 953, or about 55 percent, of the 1,744 covered services were reduced.

Our analysis of the sample of claim reductions revealed no differences between the rate of reasonable charge reductions for assigned and unassigned claims. The covered charges for the 70 assigned claims averaged $64.77 a claim and were reduced an average of $10.86, or 17 percent. The covered charges for the 177 unassigned claims averaged $90.71 a claim and were reduced an average of $15.19, or also 17 percent.

The number of assigned and unassigned claims are shown below according to ranges of the percentage that the covered charges on each claim were reduced.

Percent of reduction	Total claims			Assigned claims			Unassigned claims		
	Number	Percent	Average reduction	Number	Percent	Average reduction	Number	Percent	Average reduction
Less than 5	36	14.6	$ 5.34	14	20.0	$ 2.50	22	12.5	$ 7.14
5.1 to 10	33	13.4	5.95	8	11.4	6.38	25	14.1	5.81
10.1 to 20	88	35.6	11.35	23	32.9	10.44	65	36.7	11.67
20.1 to 30	46	18.6	20.40	6	8.6	22.79	40	22.6	20.04
30.1 to 40	35	14.2	26.60	15	21.4	17.06	20	11.3	33.75
40.1 to 50	7	2.8	12.98	4	5.7	10.22	3	1.7	16.67
Over 50	2	.8	50.50	-	-	-	2	1.1	50.50
Total	247	100.0	$13.96	70	100.0	$10.85	177	100.0	$15.19

About 36 percent of the 70 assigned claims and about 37 percent of the 177 unassigned claims were reduced more than 20 percent. None of the assigned claims and about 1 percent of the unassigned claims were reduced more than 50 percent.

As noted on page 24, 55 percent of the 1,744 covered services on the 247 claims were reduced. Our analysis indicated that, although the total amounts claimed on the 247 claims were reduced an average of 17 percent, the reductions for only those services with reduced charges averaged about 25 percent.

Charges for physicians' visits to patients in homes, hospitals, and nursing homes and patients' visits to physicians' offices accounted for 62 percent (592) of the 953 services with reduced charges. Claims for laboratory procedures, X-rays, and injections also were frequently reduced.

Our sample did not contain a large number of claims made by any one physician or group of physicians. However, one physician had six reduced claims and one clinic group had eight reduced claims.

Equitable reduced covered charges primarily because the charges exceeded the doctors' own customary charges. A combination of low fees at the beginning of the Medicare program, the lag between the time a doctor started charging a higher fee and the time it was recognized on his profile (individual record of fees used to determine his customary charge), and the economic stabilization controls placed on the program may have contributed to these reductions.

Equitable's reasons for reducing the charges billed for the 953 services are shown below.

	Services having reduced charges			
	Number	Percent	Amount of reduction	Percent
Billed charges exceeded customary charge (note a)	532	55.8	$1,407	40.8
Billed charges exceeded prevailing charge (note b)	248	26.0	1,696	49.2
Other reasons	173	18.2	347	10.0
	953	100.0	$3,450	100.0

[a]Billed charge may also equal or exceed the prevailing charge.

[b]Reduced primarily on the basis of fee schedules of allowable charges for inexpensive routine services, such as injections and laboratory services.

Equitable made minor errors in processing 25, or about 10 percent, of the 247 reduced claims. These errors resulted in total overpayments of $112 and total underpayments of $107. The carrier advised us that several of these were clerical errors and that adjustments were to be made in all cases of underpayments and when the amount of the overpayment was over $5.

EQUITABLE'S METHOD OF DETERMINING REASONABLE CHARGES

Equitable generally complied with SSA procedural requirements for establishing reasonable charges for services but incorrectly established some reasonable charges, as discussed below. Also, in establishing prevailing charges, charges to patients not covered by Medicare were not being included. SSA officials said that Equitable had been excused from the requirement for including such charges but that Equitable had to make limited studies to insure that Medicare patients were not being charged more than other patients.

Incorrect charges for new physicians

Because customary charges cannot be computed for new doctors on the basis of their prior experience, SSA has instructed all carriers to establish the customary charges for new physicians at the 50th percentile of the available customary charges of the other physicians in the same specialty and locality.

The customary charges for new doctors in Idaho for fiscal year 1973 were incorrectly established below the 50th percentile. Equitable's headquarters personnel said that this was a computer problem which they were aware of and which they had decided to have personnel in Boise correct manually. Headquarters personnel, however, neglected to inform Boise personnel of the problem. We were unable to determine the extent of the problem, but Equitable could have reduced any charges submitted for a new doctor considerably below what the reasonable charges should have been. After we brought the error to the attention of carrier officials, they began manually correcting these customary charges.

Inconsistent reasonable charge determinations for surgical assists

Procedures for establishing reasonable charges for surgical assists were inconsistently applied. A rate per hour was used for both northern and southern Idaho and was sometimes used for the Boise area. At other times, assistant surgeons in the Boise area were allowed 20 percent of the fee allowed the principal surgeon. Some doctors performed identical assists for the same surgeon at about the same times and were

allowed different amounts because of the inconsistent application of criteria for establishing reasonable charges.

ANALYSIS OF CLAIM REDUCTIONS APPEALED AND AMENDED AS A RESULT OF EQUITABLE'S RECONSIDERATION AND FAIR HEARING PROCEDURES

During the period January 1 through September 30, 1972, 450 claims were reconsidered, which is equivalent to about 0.6 percent of the claims reduced or denied during the period. Of the 450 reconsiderations, 181, or 40 percent, were decided in favor of the claimants. The carrier stated that favorable decisions were made in those cases primarily because of additional information that was received incident to the requests for reconsideration.

Since the inception of the program in July 1966, Equitable has held only 4 fair hearings (1 involving 24 claims by 16 beneficiaries)--all since December 1971. Equitable received other requests for fair hearings but an Equitable official told us that they were settled without actually going to fair hearings. Equitable officials attribute the low percentage of reconsiderations and fair hearings to (1) low fees charged by physicians during the first years of the program which usually were paid in full and (2) personal contact between Equitable or SSA representatives and beneficiaries where the reasons for claim reductions were explained.

The beneficiaries involved in the fair hearings were given prompt hearings in reasonably convenient locations. In two of the fair hearings, the hearing officer ruled that Equitable had allowed the proper reasonable charges. In another hearing, the hearing officer allowed a small amount more than Equitable had initially approved. In the remaining hearing involving 24 claims, the hearing officer agreed with Equitable that 14 claims for anesthesia service should be denied but reversed Equitable's decision on the other 10 claims because the doctor presented information showing extenuating medical circumstances which made anesthesia necessary.

ASSIGNMENT OF CLAIMS

SSA reported the following assignment rates for claims Equitable received during the last four calendar years.

	Calendar year			
	1969	1970	1971	1972
Assignment rate	73.4	65.2	49.7	36.0
Net assignment rate	71.2	62.0	44.7	30.8

Physicians or suppliers accepted an assignment for 70, or 28 percent, of the 247 claims in our sample.

As shown above, the rate of claim assignments has substantially decreased. An Equitable official atributed the decline to the low fees charged by Idaho physicians at the beginning of the Medicare program, followed by an awareness through professional meetings that doctors in other areas were charging and being allowed more under the program. He said that, after the Idaho doctors finally increased their fees, Equitable could not allow their full charges; one way of receiving their full charges was to pass the difference between the actual charge and the allowed charge on to the patient by not accepting an assignment of Medicare claims.

The effect of this low assignment rate is that about 70 percent of the $600,000 in reasonable charge reductions during the first 9 months of 1972 became liabilities of the Medicare patients.

Effect of dual beneficiaries on reported assignment rates

We could not find out the number of claims for dual beneficiaries; for these beneficiaries the physician or supplier has no real option not to accept an assignment. However, Idaho has entered into a buy-in agreement with HEW to obtain supplementary insurance benefits for dual beneficiaries under part B of the Medicare program. In calendar year 1970, 4,208 individuals 65 years old and older (about 15 percent of all persons receiving reimbursable part B Medicare services in the State) were provided physician services under the buy-in agreement. Thus, assignment rates computed after excluding claims processed for these dual beneficiaries probably would be considerably lower than the net assignment rates SSA reported.

CHAPTER 5

GENERAL AMERICAN'S APPLICATION OF REASONABLE CHARGE PROVISIONS

General American is the carrier responsible for paying claims under part B of the Medicare program in 84 counties in eastern Missouri and in St. Louis. (Blue Shield of Kansas City, whose activities are not discussed in this report, is the carrier responsible for claims in the other 30 counties of Missouri.)

General American reported the following claims-processing activities and reasonable charge reductions for the first 9 months of calendar year 1972.

Number of claims			Covered charges		
Processed	Reduced	Percent reduced	Total	Reductions	Percent of reduction
642,148	276,691	43.1	$36,975,475	$3,769,669	10.2

According to General American's reports, 54.8 percent of the 246,500 unassigned claims and 35.8 percent of the 395,700 assigned claims processed during the period were reduced because the amounts claimed exceeded reasonable charges.

EVALUATION OF THE ACCURACY AND COMPLETENESS OF REPORTED REASONABLE CHARGE REDUCTIONS

The statistics showing the number of reduced claims were a byproduct of General American's day-to-day claims-processing activities. Our review of computer programs and the claims-processing system indicated that General American had applied controls to help insure the accuracy and completeness of the statistics.

We tested the accuracy of the reported reductions for the 9-month period by analyzing 689 claims, selected at random, to determine the number reduced. Of the 689 claims, 296, or 43 percent, were reduced; the average reduction was $13.13.

In our opinion, this is reasonably close to the 43.1 percent and the $13.62 average reduction ($3,769,669 reductions÷276,691 reduced claims) reported by General American for the period.

General American overstated the covered charges on claims processed during the 9 months by including about $3.7 million in charges for claimed services that were denied. Thus, it reduced total allowable covered charges by about 11.3 percent, rather than by the reported 10.2 percent.

ANALYSIS OF CLAIMS REDUCED UNDER REASONABLE CHARGE PROVISIONS

The 296 reduced claims in our sample (161 assigned claims and 135 unassigned claims) included 1,919 covered services, of which all but 23 were physicians' services. The 296 claims involved covered charges of $24,439, which were reduced a total of $3,888, or about 16 percent. The charges for 1,115, or about 58 percent, of the 1,919 covered services were reduced.

The covered charges for the 161 assigned claims averaged $65.22 a claim and were reduced an average of $12.34, or 19 percent. The covered charges for the 135 unassigned claims averaged $103.25 a claim and were reduced an average of $14.09, or 14 percent.

The number of assigned and unassigned claims are shown below according to the range of the percentage that the covered charges on each claim were reduced.

Percent of reduction	Total claims			Assigned claims			Unassigned claims		
	Number	Percent	Average reduction	Number	Percent	Average reduction	Number	Percent	Average reduction
Less than 5	36	12.2	$ 2.98	14	8.7	$ 3.02	22	16.3	$ 2.96
5.1 to 10	60	20.3	8.40	28	17.4	7.86	32	23.7	8.87
10.1 to 20	107	36.1	10.50	56	34.8	5.26	51	37.8	16.26
20.1 to 30	52	17.6	19.14	32	19.9	17.47	20	14.8	21.83
30.1 to 40	25	8.4	20.42	20	12.4	20.78	5	3.7	19.00
40.1 to 50	11	3.7	25.00	7	4.3	16.79	4	3.0	39.36
Over 50	5	1.7	74.40	4	2.5	84.25	1	0.7	35.00
Total	296	100.0	$13.13	161	100.0	$12.34	135	100.0	$14.09

General American reduced covered charges by more than 20 percent on about 31 percent of the 296 claims. About 39 percent of the 161 assigned claims and about 22 percent of the 135 unassigned claims were reduced more than 20 percent. About 2 percent of the assigned claims and about 1 percent of the unassigned claims were reduced over 50 percent.

As noted on page 31, charges for 58 percent of the 1,919 covered services on the 296 claims were reduced. Although the total amounts claimed on the 296 claims were reduced an average of 16 percent, the reduction for only those services with reduced charges averaged about 23 percent.

Charges for physicians' visits to homes, hospitals, and nursing homes and patients' visits to physicians' offices accounted for 88 percent (976) of the 1,115 services and 51 percent ($1,994) of the $3,888 in reduced charges.

The 1,115 services included 46 surgery-related and anesthesia services. The charges for these services were reduced about $1,400 (about 36 percent of the total reductions).

Billed amounts for five of the surgical services were reduced $100 or more each. The largest single reduction in our sample was on an assigned surgical claim which was reduced from $450 to $175.

The 296 claims were for services provided by 275 physicians or suppliers. Only 35 of the physicians or suppliers were involved in more than 1 claim. One physician submitted four claims totaling $57, of which General American allowed $42. Five physicians were involved in 3 claims each and 29 physicians or suppliers were involved in 2 claims each. More than one physician may be involved in an unassigned claim.

General American reduced covered charges primarily because the charges exceeded the physicians' own customary charges. The reasons for the carrier's reduction of charges billed for the 1,115 services are shown below.

	Reduced services			
	Number	Percent	Amount of reduction	Percent
Billed charges exceeded customary charge (note a)	869	77.9	$2,617	67.3
Billed charges exceeded prevailing charge	150	13.5	971	25.0
Other reasons	96	8.6	300	7.7
Total	1,115	100.0	$3,888	100.0

[a]Billed charge may also equal or exceed the prevailing charge.

General American made clerical errors in processing 15, or 5 percent, of the 296 reduced claims. These errors resulted in total overpayments of only $13--none of which exceeded $5--and total underpayments of only $56. General American officials advised us that adjustments would be made for the underpayments.

GENERAL AMERICAN'S METHOD OF DETERMINING REASONABLE CHARGES

Except as noted below, General American generally complied with the SSA procedural requirements for establishing reasonable charges.

Incorrect reasonable charges for nursing home visits

SSA guidelines provide that, when a physician sees more than one patient during a visit to a nursing home, the allowable charge for the visit should be no higher than the reasonable charge for a followup office visit. Our sample of reduced claims included charges for 43 routine nursing home visits. For 15 of the 43 charges, General American allowed physicians more or less than the reasonable charge for a followup office visit because General American's methodology did not produce the desired result. In 13 cases General American underpaid the claimants a total of $74, and in two cases it overpaid the claimants a total of $12. General American personnel said that SSA had previously brought this matter to their attention and that they planned to take corrective action.

Established physicians
treated as new physicians

The fiscal year 1972 profiles were incomplete because General American did not compile customary charges for 42 established physicians, which caused it to consider them as new physicians. The amount of the reimbursement would have been different for three of the claims included in our sample if the physicians' historical charges had been compiled. Two of these claims were underpaid a total of $19, and one claim was overpaid $40. General American officials said that they would review the reimbursements for services rendered by these 42 physicians and determine whether adjustments should be made. We did not note any similar problems in the fiscal year 1973 profiles.

ANALYSIS OF CLAIM REDUCTIONS APPEALED AND AMENDED AS A RESULT OF GENERAL AMERICAN'S RECONSIDERATION AND FAIR HEARING PROCEDURES

At the request of the claimants, General American reconsidered about 1 percent of the claims denied or reduced between January 1 and September 30, 1972. General American reported that, during the first 9 months of calendar year 1972, it reconsidered 3,768 claim decisions and resolved 51 requests for fair hearings. It reported that 39 percent of the reconsiderations and 24 percent of the fair hearings resulted in additional payments to the claimants.

Our review of the hearing files, which usually contained a stenographic transcript, did not disclose any improper findings. In two cases, the claimants contended that the physicians' billings did not completely describe the services, and the hearing officer delayed his ruling until after the physicians explained the billings.

Inaccurate reporting of reconsiderations favorable to claimants

SSA's instructions require carriers to report all reconsiderations where any part of the decision was favorable to the claimant. General American, however, reported only those reconsiderations where the total amount in dispute was awarded to the claimant. Thus, about 60 percent of the 3,768 reconsiderations were favorable to the claimant, rather than the 39 percent reported. General American changed its method of reporting reconsideration decisions after we brought the discrepancy to its attention.

ASSIGNMENT OF CLAIMS

SSA reported the following assignment rates for claims General American received during the last 4 calendar years.

	Calendar year			
	1969	1970	1971	1972
Assignment rate	72.4	69.1	64.8	61.4
Net assignment rate	67.5	64.4	60.1	56.4

Reported assignment rates not meaningful

As discussed on page 10, physicians or suppliers ordinarily accept assignments of claims for services provided to dual beneficiaries. The SSA reports, however. do not show an assignment rate computed on the basis of total claims for which the physician or supplier really had an option not to accept an assignment. As shown below, the rate of claims assignments--excluding dual beneficiaries' claims--computed on the basis of total claims for which the physician or supplier had an option not to accept assignments is much lower than the assignment rates reported by SSA.

	Calendar year			
	1969	1970	1971	1972
Adjusted net assignment rate	33.8	36.8	23.4	22.3

Physicians or suppliers accepted assignments of 161, or 54 percent, of the 296 reduced claims in our sample. However, 119 of the assigned claims were for services provided to dual beneficiaries. Thus, only 24 percent of the claims were assigned for which the provider had a real option not to accept an assignment. In our opinion, the reported net assignment rate of about 56 percent in the area of Missouri covered by General American does not provide a meaningful indication of the medical community's current level of satisfaction with the Medicare program, especially with the program's level of payments for specific services and the promptness of payment. (See p. 11.)

SSA comments

In commenting on our observations as to the meaningfulness of SSA's reported assignment rates, SSA advised us that:

> "We cannot agree that excluding all claims of these dual beneficiaries will produce more accurate assignment statistics, nor can we agree that all of the physicians involved should be assumed not to take assignment. Traditionally, these patients have represented a high portion of noncollectible bad debts to the physician, and we believe a large number of the physicians would elect to take assignments on these situations."

SSA also pointed out that, although some States do require physicians to accept assignments on Medicare-Medicaid claims, physician participation in Medicare is strictly voluntary, as is the treatment of dual beneficiaries.

We do not question the accuracy of SSA's assignment statistics nor do we assume that the physicians involved in treating the dual beneficiaries would or would not have elected to take assignments if they were free to do so. We merely excluded the dual beneficiary claims in computing an adjusted net assignment rate for those claims where the physicians or suppliers had a real option not to take an assignment. Our point is that, when assignment statistics include a substantial number of dual beneficiary claims, the assignment rates are considerably higher than they would otherwise be if the assignment rates were computed on the basis of only those claims where an assignment decision was not virtually mandatory. Further, we believe that a physician's decision to participate in Medicaid or his decision to treat or not to treat a dual beneficiary in need of care involves different issues than those involved in a decision to accept or not to accept an assignment on a Medicare claim.

How unassigned claims can affect beneficiaries

The 296 claims included claims involving 127 physicians or suppliers who did not accept assignment of the claims we reviewed. Of the 127, 43 each had charges exceeding $35,000 in 1972 for services to Medicare beneficiaries. To determine the extent that these 43 physicians usually did not accept assignments and to measure the impact of such unassigned claims on the beneficiaries, we analyzed the physicians' claim activities for 1972. The 43 physicians' combined charges were $3.5 million--$2.6 million, or 74 percent, on unassigned claims and $900,000 on assigned claims. The allowed charges were $2.9 million. Thus, these physicians' charges ($3.5 million) were reduced by about $600,000.

Of the $2.6 million on unassigned claims, General American allowed $2.1 million. It reimbursed the beneficiaries $1.3 million of the $2.1 million allowed after applying the deductible and coinsurance provisions. Therefore, of the $2.6 million in charges on unassigned claims, the beneficiaries were liable for $1.3 million--or 50 percent--of the total charges. The beneficiaries' liability included the

$50 deductible and the 20-percent coinsurance factor applied to the allowable charges, plus about $500,000 for charges reduced or denied.

Decrease in assignment rate

As shown above, the rate of claims assignments has decreased. For all claims, the assignment rate decreased from 72.4 percent in calendar year 1969 to 61.4 percent in calendar year 1972. The adjusted net assignment rate, computed on the basis of excluding dual beneficiaries' claims, decreased from 33.8 percent in calendar year 1969 to 22.3 percent in calendar year 1972.

Of the 127 physicians or suppliers in our sample who had not accepted assignments of the claims we reviewed, 25 had charges exceeding $35,000 for each of the years 1970, 1971, and 1972. The amount of assignments for 18 of the 25 physicians decreased from 1970 to 1972. The percentage of total charges on claims assigned for the 18 physicians decreased from 49 percent in 1970 to 32 percent in 1972.

Why assignments decreased

We obtained comments from 14 physicians (or their office assistants), whose claims were included in those we reviewed, regarding their position on accepting assignments of Medicare claims. Three of the 14 said they ordinarily accepted assignments; one reason was to insure payment of the bills. Eleven said they ordinarily did not accept assignments because:

--If they accepted assignments, they were required to accept the carrier's reasonable charge determination (6 physicians).

--The paperwork for billing the program was too time consuming, or they considered it the patient's responsibility to obtain reimbursement from the program (5 physicians).

Seven of the 11 said they had not changed their policy regarding acceptance of assignments. Four advised us that they had changed their policy and were accepting even fewer assignments because of the requirement that they accept the reasonable charge determinations.

General American officials recognize that assignments have been decreasing and attribute this largely to (1) physicians' unwillingness to accept the reasonable charge and (2) SSA's increased emphasis on enforcing the assignment provision prohibiting collection of the reduced amounts from the Medicare beneficiary.

Since 1970 General American has increased its efforts to detect violations of the assignment agreement. It issued bulletins to physicians in April 1970 and February 1972 calling attention to the requirements for claim assignments. At the time of our visit, two physicians were suspended from receiving payments on assigned claims because they had not honored the terms of the assignment agreement. Carrier officials identified eight physicians or groups of physicians who changed their policy and were accepting fewer assignments after being found in violation of the agreement.

An official of the St. Louis Medical Society told us that the society had not taken a position on whether physicians should accept assignment of Medicare claims. He said that, since some members were strongly opposed to assignments, it was unlikely the society would adopt a position of recommending assignments.

CHAPTER 6

PRUDENTIAL'S APPLICATION OF REASONABLE CHARGE PROVISIONS

Prudential is the carrier responsible for paying claims under part B of the Medicare program in New Jersey.

Prudential reported the following claims-processing activities and reasonable charge reductions for the first 9 months of calendar year 1972.

Number of claims			Covered charges		
Processed	Reduced	Percent reduced	Total	Reductions	Percent of reduction
1,339,643	546,199	40.8	$94,800,124	$9,600,414	10.1

According to Prudential's reports, 48.9 percent of the 582,000 unassigned claims and 34.5 percent of the 758,000 assigned claims processed during the period were reduced because amounts claimed exceeded reasonable charges.

EVALUATION OF THE ACCURACY AND COMPLETENESS OF REPORTED REASONABLE CHARGE REDUCTIONS

Prudential's data on reasonable charge reductions appears to be reasonably accurate, even though the reported amount of reductions may have been slightly overstated and the number of claims reported as reduced for reasonable charges was understated.

Prudential made reasonable charge reductions through its computer system and through manual examination. Our review of the computer programs and related controls indicated that the amounts of reasonable charge reductions made by the computer should have been accurate. For claims processed before December 1972, a problem existed in accumulating the number of claims reduced and the amount of the reductions when a claim was reduced for more than one reason. For example, if a claim was reduced because of both duplicate and unreasonable charges, the claim was counted as a partial denial because of duplicate charges only and the

total reduction was reported as a reasonable charge reduction. On the basis of our analysis of a sample of 250 reduced claims, however, we do not believe that the misstatements were material.

As of December 1, 1972, Prudential had revised its system of accumulating statistics so that it could identify the portion of a claim reduction applicable to duplicate charges and the portion of the reduction applicable to reasonable charge determinations. However, Prudential is still understating the number of claims reduced due to reasonable charge determinations because Prudential is reporting claims reduced for more than one reason as claims denied in full or in part but not as claims reduced due to reasonable charge reductions.

ANALYSIS OF CLAIMS REDUCED UNDER REASONABLE CHARGE PROVISIONS

We analyzed a random sample of 250 reduced claims (104 assigned claims and 146 unassigned claims) which included 1,422 covered services, of which all but 66 were physicians' services. The 250 claims involved covered charges of $29,666 which were reduced by $4,784, or about 16 percent. The charges for 1,011, or about 71 percent, of the 1,422 covered services were reduced. The covered charges for the 104 assigned claims averaged $161.24 a claim and were reduced an average $23.94, or 14.8 percent. The covered charges for the 146 unassigned claims averaged $94.60 a claim and were reduced an average $15.71, or 16.6 percent.

The number of assigned and unassigned claims are shown below according to the ranges of the percentage that the covered charges on each claim were reduced.

Percent of reduction	Total claims			Assigned claims			Unassigned claims		
	Number	Percent	Average reduction	Number	Percent	Average reduction	Number	Percent	Average reduction
Less than 5	27	10.8	$ 4.87	12	11.5	$ 6.95	15	10.3	$ 3.21
5.1 to 10	36	14.4	8.48	12	11.5	12.17	24	16.4	6.64
10.1 to 20	106	42.4	14.48	42	40.4	19.79	64	43.8	10.99
20.1 to 30	50	20.0	29.84	19	18.3	32.81	31	21.2	28.01
30.1 to 40	22	8.8	34.94	14	13.5	45.04	8	5.5	17.25
40.1 to 50	7	2.8	27.26	4	3.8	31.75	3	2.1	21.27
Over 50	2	.8	180.50	1	1.0	48.00	1	.7	313.00
Total	250	100.0	$ 19.14	104	100.0	$23.94	146	100.0	$ 15.71

Prudential reduced charges by more than 20 percent on about 32 percent of the 250 claims. About 37 percent of the 104 assigned claims and about 29 percent of the 146 unassigned claims were reduced more than 20 percent. About 1 percent of the assigned and unassigned claims were reduced over 50 percent.

As noted on page 41, charges for 71 percent of the 1,422 services covered by the 250 claims were reduced. Although the total amounts claimed on the 250 claims were reduced an average 16 percent, the reductions for only those services with reduced charges averaged about 22 percent.

Charges for medical services furnished in a physician's office were the most frequently reduced on the 250 claims. Reductions in the charges for laboratory tests were also common. The 1,011 services with reduced charges included 62 surgery-related services, charges for which were reduced about $1,070, or 22 percent of the total reductions.

The largest single reduction in our sample was $313 on an unassigned claim for $575 involving various consultations, visits, and other services in a physician's office.

The 250 claims were for services provided by 271 physicians or suppliers; of these providers, 11 had 2 claims reduced and 1 had 3 claims reduced. More than one physician may be involved in an unassigned claim. Prudential reduced physicians' charges for services primarily because the charges exceeded the physicians' customary charges. The reasons Prudential reduced charges billed for the services covered by the 250 claims are shown below.

	Services with reduced charges			
	Number	Percent	Amount of reduction	Percent
Billed charges exceeded customary charge (note a)	710	70.2	$2,420	50.6
Billed charges exceeded prevailing charge	220	21.8	1,776	37.1
Other reasons (note b)	81	8.0	588	12.3
Total	1,011	100.0	$4,784	100.0

[a]Billed charge may also equal or exceed the prevailing charge.

[b]Consisted primarily of charges for nonphysician services such as durable medical equipment and independent laboratory services which exceeded Prudential's fee schedules.

PRUDENTIAL'S METHOD OF DETERMINING REASONABLE CHARGES

Except as noted below, Prudential complied with SSA procedural requirements for establishing reasonable charges for physicians' services. Prudential did not comply with SSA requirements for establishing reasonable charges for nonphysician services.

Limited data on physicians' customary charges

In October 1972, SSA completed a review of Prudential's methods of establishing reasonable charges. SSA's principal finding was that the charges for only the 18 most frequently performed physicians' services were included in physicians' profiles and used for establishing customary charges for fiscal year 1973. If a profile did not include a customary charge for a service, Prudential used the prevailing charge to establish the reasonable charge. According to SSA, if only the prevailing charge is used, more might be allowed for a physician's service than would be allowed if the customary charge is calculated.

Prudential generally agreed with SSA's finding and was expanding its system to include data on more procedures in the physicians' profiles.

Inadequate reasonable charge data for nonphysician services

Prudential evaluates charges for nonphysician services, such as durable medical equipment, prosthetic devices, and ambulance services, on the basis of fee schedules without regard to customary and prevailing charges. The fee schedules are based on a limited number of price lists obtained from suppliers. Prudential officials said they had requested price lists from many suppliers but only a few suppliers responded. They acknowledged that the few available price lists did not provide sufficient data. A Prudential official said that Prudential delayed developing customary charges for these items, which represent less than 3 percent of the claims processed, because of anticipated legislation which would have placed the items on a Statewide fee schedule.

SSA has taken exception to Prudential's method of establishing reasonable charges for nonphysician services, and

Prudential officials have agreed to include charges for non-physician services in their customary and prevailing charge system.

ANALYSIS OF CLAIM REDUCTIONS APPEALED AND AMENDED AS A RESULT OF PRUDENTIAL'S RECONSIDERATION AND FAIR HEARING PROCEDURES

About 0.1 percent of the claims denied or reduced during the period January 1 through September 30, 1972, were reconsidered by Prudential. It reported that it reconsidered 706 claims and held 30 fair hearings during the 9-month period; only 8 of the fair hearings involved reasonable charge determinations.

Of the 706 reconsiderations, 154, or about 22 percent, were resolved in favor of the claimant. Of the 30 fair hearings, 2 were reported as being resolved in favor of the claimant.

ASSIGNMENT OF CLAIMS

SSA reported the following assignment rates for claims Prudential received during the last 4 calendar years.

	Calendar year			
	1969	1970	1971	1972
Assignment rate	58.8	57.3	59.2	55.8
Net assignment rate	52.7	52.6	54.5	51.5

As indicated by the above statistics, the assignment rates have remained fairly consistent in New Jersey. Further, the claims for dual beneficiaries--where the physician or supplier does not have a real option not to accept an assignment--did not materially distort the statistics. Only about 6 percent of the claims received and processed during calendar years 1970, 1971, and 1972 were for services provided to dual beneficiaries. Thus, even by excluding such claims, the assignment rate of claims in New Jersey from 1970 through 1972 was about 50 percent.

CHAPTER 7

CALIFORNIA BLUE SHIELD'S APPLICATION OF REASONABLE CHARGE PROVISIONS

The California Physicians Service (California Blue Shield) is the carrier responsible for paying claims under part B of the Medicare program in all of California except for nine southern counties. It is also the fiscal agent for the Medicaid (Medi-Cal) program for California, except for San Diego and Santa Clara Counties,[1] and processes Medicare claims in the nine southern counties of California when the Medicare beneficiary also is eligible for Medicaid benefits (dual beneficiary).

California Blue Shield reported the following claims-processing activities and reasonable charge reductions for the first 9 months of 1972.

Number of claims			Covered charges		
Processed	Reduced	Percent	Total	Reductions	Percent of reductions
3,840,090	1,944,620	50.6	$158,486,910	$18,671,655	11.8

According to California Blue Shield's reports, it reduced 55.6 percent of the 830,000 unassigned claims and 49.3 percent of the 3,010,000 assigned claims processed during the period, because the amounts claimed exceeded reasonable charges.

Because of the large volume of claims it processed and the difficulties and costs involved in retrieving a meaningful random sample of claims covering a 9-month period, California Blue Shield made an arrangement with its data processing subcontractor to undertake a special project to analyze reasonable charge reductions made through the computer for the

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[1]Under an experimental program started August 1, 1972, another fiscal agent began processing Medicaid claims in these two counties, except for claims applicable to dual beneficiaries, which California Blue Shield continued to process.

month of December 1972. Therefore, most of the data presented in this chapter is in a different format than the data presented for the previous three carriers.

EVALUATION OF THE ACCURACY AND COMPLETENESS OF REPORTED REASONABLE CHARGE REDUCTIONS

For the month of December 1972, California Blue Shield reported to SSA that it made reasonable charge reductions totaling $1,849,793 on 202,154 claims, or 59 percent of the claims processed that month. These reductions were 10.9 percent of the total reported covered charges.

The reductions in our study totaled $1,337,650, or a difference of about $512,000. Our study, however, involved only reductions made through the computer (computer-generated reductions), whereas the reductions reported to SSA also included reasonable charge reductions resulting from the manual examination of claims, such as reductions to charges for incidental surgery when California Blue Shield considered such services to be already included in the principal surgery charges. We were able to account for $368,000 of the $512,000 difference. The $144,000 unreconciled variance represented about 8 percent of the $1.8 million reported reductions, or a difference of less than one percentage point in the 10.9-percent reported reductions.

ANALYSIS OF CLAIMS REDUCED UNDER REASONABLE CHARGE PROVISIONS

The 202,154 claims reduced in December 1972 included 154,029 assigned claims and 48,125 unassigned claims. These claims included covered charges totaling about $12.5 million

which were reduced by $1,849,793, or 14.8[1] percent. The rates of reduction on assigned and unassigned claims were 15.8 percent and 13 percent, respectively.

The computer-generated reasonable charge reductions of $1,337,650 covered by our study were applicable to 411,733 covered services and involved charges of $8,068,489. Thus, the reductions ($1,337,650) for only those services with charges reduced through the application of computer-generated profiles averaged 16.6 percent.

The frequency and rate of computer-generated reasonable charge reductions for services included on assigned and unassigned claims is summarized as follows.

	Number of services on claims processed (note a)	Services with reduced charges		Charges reduced		
		Number	Percent reduced	Amount charged	Amount of reduction	Percent of reduction
Assigned claims	632,251	273,663	43.3	$5,286,423	$ 921,221	17.4
Unassigned claims	315,942	138,070	43.7	2,782,066	416,429	15.0
Total	948,193	411,733	43.4	$8,068,489	$1,337,650	16.6

[a]Excludes denials and other noncomputer reductions.

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[1]California Blue Shield objected to our computation of the percentage of reasonable charge reductions on only the covered charges on reduced claims. It similarly objected to our computation of percentages of reasonable charge reductions for only the services for which covered charges were reduced. It stated that the proper base for computing the percentage of reasonable charge reductions should be the total amount of covered charges for all claims and that this is the only way to derive the correct percentage of reduction; however, the computation method it advocates is not what the Chairman asked us to follow in analyzing samples of Medicare claims that were reduced under the reasonable charge provisions. (See p. 5.) Further, the overall 11.8 percent reduction shown in the table on page 45 does reflect California Blue Shield's preferred method.

As indicated below, California Blue Shield reduced the charges for physicians' or suppliers' services primarily because the charges exceeded the physicians' or suppliers' customary charges.

	Services with reduced charges			
	Number	Percent	Amount	Percent
Billed charges exceeded customary charge (note a)	276,265	67	$ 887,456	66
Billed charges exceeded prevailing charge	130,691	32	420,021	32
Other reasons	4,777	1	30,173	2
Total	411,733	100	$1,337,650	100

[a]Billings may also equal or exceed the prevailing charge.

Analysis of most frequent procedures

We analyzed claims processed during December 1972 for the 25 services most frequently provided. These services included office and hospital visits, electrocardiograms, X-rays, lab tests, and such common surgery as a cataract removal and a prostate resection. These 25 services represented 533,849 covered services, or about half of the number of covered services included on the claims processed in December 1972, and about 40 percent of the amount of charges on the claims processed. Further, of the 411,733 services for which charges were reduced by the computer, 247,595 (60 percent) related to these 25 services; of $1,337,650 in related reasonable charge reductions during the month, $585,250 (44 percent) applied to these 25 services.

The following table shows that the frequency and rate of reductions, as well as the other characteristics of the 25 services, were generally representative of the total monthly activity, as shown on page 47.

25 Most Common Services

	Number of services on processed claims (note a)	Number	Percent reduced	Services with reduced charges: Amount charged	Amount of reduction	Percent of reduction
Assigned claims	355,218	163,232	45.9	$2,291,378	$418,381	18.3
Unassigned claims	178,631	84,363	42.2	1,187,973	166,869	14.0
Total	533,847	247,595	46.4	$3,479,351	$585,250	16.8

[a]Excludes denials and other noncomputer reductions.

Of the total reductions of $585,250, about 80 percent, or $465,843, applied to charges for office or hospital visits. Charges for surgical services were reduced $65,398, which accounted for about 11 percent of the reductions.

The table below shows, for the 25 services, the number for which charges were reduced.

Occurrences of the 25 Services for which Billed Charges Were Reduced

Percent of reduction	Total: Number	Total: Percent	Total: Average reduction	Assigned: Number	Assigned: Percent	Assigned: Average reduction	Unassigned: Number	Unassigned: Percent	Unassigned: Average reduction
Less than 5	31,457	12.7	$ 0.70	18,725	11.5	$ 0.70	12,732	15.1	$ 0.71
5.1 to 10	68,706	27.7	1.07	42,315	25.9	1.03	26,391	31.3	1.14
10.1 to 20	90,130	36.4	1.97	59,010	36.1	1.97	31,120	36.9	1.98
20.1 to 30	26,152	10.6	3.51	18,536	11.4	3.66	7,616	9.0	3.15
30.1 to 40	16,967	6.9	5.25	12,768	7.8	5.36	4,199	5.0	4.92
40.1 to 50	8,943	3.6	7.66	7,334	4.5	7.56	1,609	1.9	8.11
Over 50	5,240	2.1	11.93	4,544	2.8	11.84	696	0.8	12.57
Total	247,595	100.0	$ 2.36	163,232	100.0	$ 2.56	84,363	100.0	$ 1.98

California Blue Shield reduced billed charges more than 20 percent on about 23 percent of the services. About 26 percent of the charges for services on assigned claims were reduced more than 20 percent and about 17 percent of the charges for services on unassigned claims were reduced more than 20 percent. The charges for about 3 percent of the services on assigned claims and for about 1 percent of the services on unassigned claims were reduced over 50 percent.

Physicians or suppliers with the most reductions

We also analyzed the charges by 50 physicians or suppliers with the largest number and largest amount of

reductions for the 25 services. The number of charges by these physicians or suppliers accounted for 19,215, or about 3 percent, of the 553,849 covered services billed; 12,534, or about 5 percent, of the 247,595 services for which charges were reduced; and $40,613, or about 7 percent, of the $585,250 in reasonable charge reductions.

As would be expected, both the frequency of and rate of reductions to the charges by these 50 physicians and suppliers were higher than the frequency and rate of reductions for all the charges for the 25 services. The 50 physicians and suppliers rendered the 25 services 19,215 times. As shown below, the 12,534 services for which charges were reduced represented about 63 percent of the 19,215 services billed and the amount of the reductions ($40,613) represented 20 percent of the reduced charges for the services.

	Number of services on processed claims (note a)	Number reduced	Percent reduced	Charges reduced for services: Amount charged	Amount of reduction	Percent of reduction
Assigned claim	9,962	7,596	76.2	$118,184	$28,123	23.8
Unassigned claim	9,253	4,938	53.4	85,097	12,490	14.7
	19,215	12,534	65.2	$203,281	$40,613	20.0

[a]Excludes denials and other noncomputer reductions.

As indicated by the above table, the frequency and rate of reasonable charge reductions were much higher for assigned claims than for unassigned claims. Our study was not designed to identify the reasons for assigned claims being more extensively reduced than unassigned claims; however, such reductions suggest to us that, for the same service, the physician may be charging more on assigned claims than on unassigned claims to increase his customary charge profile without passing the higher charges on to his Medicare patients.

CALIFORNIA BLUE SHIELD'S METHOD OF DETERMINING REASONABLE CHARGES

Except as noted below, California Blue Shield followed SSA procedural requirements for establishing customary and prevailing charges. It may have departed from SSA-recommended methodology by not recognizing physician specialties in establishing prevailing charges.

According to SSA instructions, the range of prevailing charges in a locality may be different for physicians who engage in a speciality; this could lead to the development of more than one range of prevailing charges.

For certain medical procedures, such as office visits, hospital visits, injections, and extended care facility visits, California Blue Shield combines the charges of specialists and nonspecialists in establishing prevailing charges. For example, charges for office visits to general practitioners and charges for office visits to heart specialists and neurosurgeons are included in the data base for establishing the prevailing charge for an office visit in a given locality.

California Blue Shield informed us that specialty groups have argued that combining the charges of specialists and nonspecialists reduces the prevailing fee limitations for the specialists.

SSA made a limited comparison of California Blue Shield's prevailing charges with the prevailing charges established by another Medicare carrier for the same localities[1] in California.

SSA concluded that its study tends to support the argument that different specialists have different charges and that specialists' charges must be considered if reasonable charge determinations are to be realistic. For example,

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[1]As noted on page 45, another carrier processes Medicare claims for physicians' services in the nine southern counties of California except when the beneficiary is also eligible for Medicaid, in which case the claims are handled by California Blue Shield.

SSA's comparison shows that California Blue Shield's prevailing charge for an initial limited patient history in the Los Angeles area is $27 for all physicians, whereas the other carrier's prevailing charges for the same procedure in the same area are $25 for a urologist, $28 for a general practitioner, and $35 for a surgeon and an internist.

The effect of these differences in the reasonable charge methodology is that beneficiaries and physicians in the Los Angeles area are not treated uniformly.

ANALYSIS OF CLAIM REDUCTIONS APPEALED AND AMENDED AS A RESULT OF CALIFORNIA BLUE SHIELD'S RECONSIDERATION AND FAIR HEARING PROCEDURES

California Blue Shield reported that, during the period January 1 through September 30, 1972, requests were received from beneficiaries and physicians or suppliers for reconsideration of 2,102 claims and for fair hearings on 100 claims. This represents less than 0.1 percent of the claims that were denied or reduced during the period. The carrier reported that 1,879 reconsiderations and 103 fair hearings were cleared[1] during the 9-month period and that 996, or about 53 percent, of the 1,879 reconsiderations and 17, or about 16 percent, of the 103 fair hearings were resolved in favor of the claimants. The reports do not show the number of reconsiderations and fair hearings that involved disputes over reasonable charge reductions.

Complaints from beneficiaries and physicians or suppliers may be another indicator of the extent to which disputes arise over reasonable charge reductions. During September 1972, the carrier received 12,274 complaints from beneficiaries and physicians or suppliers. Only 259 of the complaints involved reasonable charge reductions. The disposition of the 259 complaints was as follows.

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[1]Requests and clearances do not necessarily pertain to the same claims because both events may not occur during the same period.

Disposition	Number of complaints
Adjusted in favor of claimant	63
Not adjusted--no fair hearing	115
Fair hearing	28
Further evaluation	53
Total	259

Thus, of the 178 reasonable charge complaints that were resolved, 63, or 35 percent, were resolved in favor of the claimant.

ASSIGNMENT OF CLAIMS

SSA reported the following assignment rates for claims California Blue Shield received during the last 4 calendar years.

	Calendar year			
	1969	1970	1971	1972
Assignment rate	80.9	80.4	80.4	78.1
Net assignment rate	79.8	79.3	79.4	77.0

Reported assignment rates not meaningful

Historically, California Blue Shield has been among the top five carriers in terms of assignment rates. As pointed out on page 45, California Blue Shield is the Medicare carrier in California for all but nine counties in the south but processes the claims for dual beneficiaries for the entire State. As a result, about 70 percent of the claims it processes are applicable to the dual beneficiaries, where the physicians or suppliers are generally required to take assignments.

As shown below, the rate of assignment of claims--excluding the dual beneficiaries' claims--computed on the basis of total claims for which the physician or supplier had an option not to accept an assignment is much lower than the assignment rates SSA reported.

	Calendar year		
	1970	1971	1972
Adjusted net assignment rate	35.9	38.4	27.7

In our opinion, the reported assignment rates of about 80 percent for California Blue Shield do not provide a meaningful indication of the medical community's current level of satisfaction with the Medicare program, especially with the program's level of payments for specific services and the promptness of payment. (See p. 11.)

Decrease in assignment rate

As shown above, excluding claims for the dual beneficiaries, there has been a decrease in the rate of assignment of claims. The adjusted net assignment rate decreased from 35.9 percent in 1970 to 27.7 percent in 1972--a decrease of about 8 points.

California Blue Shield officials advised us that the decrease in assignments in 1972 is attributable to (1) a greater degree of sophistication on the part of beneficiaries in processing their own claims and (2) physicians beginning to pass the paperwork burden of submitting claims on to the beneficiaries by not accepting assignments. These officials advised us that they do not necessarily believe that the increase in unassigned claims represents a trend on the part of the physicians to recover from the beneficiaries the amounts disallowed by California Blue Shield's reasonable charge determinations.

United States Senate
SPECIAL COMMITTEE ON AGING
(PURSUANT TO S. RES. 27, 92D CONGRESS)
WASHINGTON, D.C. 20510

September 11, 1972

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

Dear Mr. Staats:

In my letter of June 13, 1972, I requested your thoughts on the feasibility of a statistical study involving the application of the reasonable charge provisions for paying doctors' fees under the Medicare program. In response to my letter, your staff met several times with my staff to discuss this matter, and I have concluded that such a study would be possible. Therefore, I am requesting the GAO to order a review of claims paid in 1972 in the states of Idaho, New Jersey, Missouri, and California along the following lines:

Evaluate the accuracy and completeness of the Social Security Administration's statistics concerning reasonable charge reductions contained in the carriers' workbook reports.

Analyze random samples of those Medicare claims that were reduced under the reasonable charge provisions. Among the matters to be considered in the analysis would be: (1) the extent that claims are reduced by less than 5 percent, by 10 percent, 20 percent, 30 percent, 40 percent, and 50 percent and over; (2) the extent that the same medical and surgical procedures are involved in these reductions; (3) the extent that the same physicians are involved

in these reductions; (4) the extent that the claims reduced are "assignments" where the charges reduced are not supposed to be passed on to the patient; and (5) the extent that the reductions were caused by the "customary charge" limitation on the prevailing charge limitation.

Analyze the carriers' reasonable charge methodology with the view toward determining whether it is being applied uniformly and fairly.

Analyze the extent that the claim reductions are appealed and amended as a result of the carriers' fair hearing procedures.

Your cooperation in this matter would be greatly appreciated. Please keep me advised of developments as the study progresses. Thank you.

Sincerely,

Frank Church
Chairman