Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

UNDERSTANDING MEDICAL BENEFITS:

The Explanation of Medicare Part B Benefits

JUNE GIBBS BROWN
Inspector General

APRIL 1995
OEI-01-93-00120

OFFICE OF INSPECTOR GENERAL

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services' (HHS) programs as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by three OIG operating components: the Office of Audit Services, the Office of Investigations, and the Office of Evaluation and Inspections. The OIG also informs the Secretary of HHS of program and management problems and recommends courses to correct them.

OFFICE OF AUDIT SERVICES

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the Department.

OFFICE OF INVESTIGATIONS

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil money penalties. The OI also oversees State Medicaid fraud control units which investigate and prosecute fraud and patient abuse in the Medicaid program.

OFFICE OF EVALUATION AND INSPECTIONS

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the Department, the Congress, and the public. The findings and recommendations contained in these inspection reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

This report was prepared under the direction of Mark R. Yessian Ph.D., Regional Inspector General, and Martha B. Kvaal, Deputy Regional Inspector General, Boston Region, Office of Evaluation and Inspections. Participating in the project were the following people:

Boston
Barry McCoy
Michael Sullivan
Theodore Wall

Headquarters
Thomas Noplock
Barbara Tedesco
Winnie Walker

For additional copies of this report, please contact the Boston regional office by telephone at 617-565-1050 or by fax at 617-565-3751.

EXECUTIVE SUMMARY

PURPOSE

The purpose of this inspection is to measure the effectiveness of Medicare's Part B benefits notice.

BACKGROUND

When a claim for medical insurance benefits is processed, Medicare sends a notice, the ***Explanation of Your Medicare Part B Benefits*** (EOMB), to the individual beneficiary. The EOMB informs the beneficiary what services were involved, how much Medicare paid, why Medicare made the decision it did, and what action the beneficiary can take next.

The Health Care Financing Administration (HCFA) has made and continues to make revisions to improve the EOMB. It has used focus groups and purposive interviews to evaluate EOMB effectiveness, but has not used survey questionnaires to systematically measure beneficiary understanding.

We mailed a self-administered questionnaire to a random sample of Medicare beneficiaries who had claims processed since HCFA's last major revision of the EOMB. From the respondents' answers we created an overall index and four subindexes of beneficiary understanding. Additionally, we collected and analyzed respondents' opinions about how easy or difficult it is to understand the EOMB.

SURVEY RESULTS

Medicare beneficiaries appear to understand most of the information on the EOMB.

On average, the 288 respondents we surveyed answered 72 percent of the survey questions correctly (±2.37 percent at the 95 percent confidence level). They answered, on average, 19 percent incorrectly, and they did not answer 8 percent of the questions. The percentages do not sum to 100 because of independent rounding.

Beneficiary understanding varies among different categories of information on the EOMB. It is highest with respect to basic descriptive information and lowest with respect to follow-up actions they could take in response to the EOMB.

The rate of correct answers differs among our four subindexes:

> **Basic Information:** For questions concerning basic descriptive information on the EOMB, such as who and what service it is about, respondents on average answered 83 percent correctly.

Cost Information: For questions concerning money amounts on the EOMB, such as how much Medicare approved or paid, they answered on average 71 percent correctly.

Context Information: For questions concerning the reasons why Medicare made the decision it explains on the EOMB, including understanding of key terms such as "assignment" and "deductible," respondents on average answered 68 percent correctly.

Action Information: For questions concerning what the beneficiary could do next, such as appeal rights and amounts owed, they answered on average 64 percent correctly.

The lower level of correct answers to questions having follow-up implications for the beneficiary reinforces a statement by Westat Inc., introducing the recommendations in a study it conducted on the EOMB in 1992. Westat urged priority for helping beneficiaries understand "the bottom line"—what action they should take in response to the EOMB.

Beneficiaries regard the EOMB as no more, and no less, difficult to understand than other notices they receive in the mail.

Sixty-six percent of the 281 respondents who expressed opinions characterized the EOMB as being neither easier nor harder to understand than notices such as bank statements or utility bills. Another 17 percent thought the EOMB easier; the remaining 17 percent thought it harder.

RECOMMENDATION

It is satisfying that the rate of understanding for basic descriptive information is quite high. It is of some concern, however, that the rate is lower for the subindex that bears upon matters previously identified as most important to beneficiaries—what action(s) to take next.

We recommend that HCFA build on its prior efforts and give major attention to informational items having follow-up implications for the beneficiary.

As HCFA continues to revise the EOMB it should aim to facilitate beneficiary understanding of the following items:

- what the beneficiary needs to pay out of pocket,
- how the beneficiary can get more information,
- how to appeal Medicare's decision, and
- what to do if there appears to be fraud or abuse.

COMMENTS ON THE DRAFT REPORT

We shared a draft copy of this report with, and invited comments from, the Health Care Financing Administration (HCFA) and the Assistant Secretary for Planning and Evaluation (ASPE.) We summarize their comments below, along with our responses in italics.

The HCFA concurred with our recommendation. It stated that their Medicare Summary Notice initiative includes plans for a section that will explain the actions necessary for an appeal, and a "Customer Service Information Box" that will display important information.

We appreciate HCFA's positive response. We would be pleased to work with it in the future to evaluate the effectiveness of the new summary notices, perhaps as an application of the methodology we developed in this study.

The ASPE, in comments accompanying its conditional concurrence with our draft report, stated: "...the report should not assert that beneficiaries appear to understand most of the information on the EOMB." It went on to say: "It is easily argued that Medicare beneficiaries ... find [the EOMB] very difficult to interpret based solely on the information that fewer than 50% of them handle their own Medicare paperwork."

We have revised the report to recognize more clearly the possible role that another person might play in helping the beneficiary. However, we have retained in the finding the assertion about beneficiary understanding.

Our purpose was to measure the effectiveness of the EOMB as Medicare actually uses it. In mailing the EOMB to the beneficiary Medicare accepts whatever informal support the beneficiary chooses. We accepted as representative of beneficiary understanding the answers returned by anyone responding on the beneficiary's behalf, just as Medicare accepts the informal support that friends, relatives, physicians, and representatives give beneficiaries in understanding the EOMB.

TABLE OF CONTENTS

PAGE

EXECUTIVE SUMMARY

INTRODUCTION 1

SURVEY RESULTS 5

- Overall Understanding. 5
- Subcategories of Information. 5
- Comparison to Other Notices. 11

RECOMMENDATION 12

COMMENTS ON THE DRAFT REPORT 13

APPENDICES

A: Example of an EOMB A-1

B: Sample Selection B-1

C: Analysis for Nonresponse Bias C-1

D: Survey Results D-1

E: Complete Comments on the Draft Report E-1

F: Notes F-1

INTRODUCTION

PURPOSE

The purpose of this inspection is to measure the effectiveness of Medicare's Part B benefits notice.

BACKGROUND

Medicare is the Federal program of health insurance for people aged 65 or older and for certain disabled people.[1] There are two parts to Medicare. Hospital insurance (Part A) helps pay for inpatient hospital care and for related care by a skilled nursing facility, home health agency, or similar facility. Medical insurance (Part B) helps pay for a doctor's services, outpatient hospital care, and a number of related medical services and supplies not covered by Part A.[2]

This inspection addresses only medical insurance benefits under Part B. For most people, Medicare Part B operates as an indemnity insurance program.[3] When a Medicare enrollee incurs an expense for medical care, the provider of service must submit a claim for reimbursement through one of the insurance companies that have contracted with the Federal government to act as carriers for Medicare Part B medical insurance.[4] The carrier determines if the service is eligible for reimbursement and issues the appropriate payment.

When the carrier processes a Medicare Part B claim it sends a notice, the ***Explanation of Your Medicare Part B Benefits***, or EOMB, telling the beneficiary what decision Medicare made on the claim.[5] Appendix A contains an example of an EOMB. The numbers correspond to the questions in our survey instrument.

The EOMB serves two purposes. First, it serves as a formal notice to the beneficiary of Medicare's decision. In doing so, it notifies the beneficiary of the right to appeal in the event of disagreement, and the time limit for appeal. Second, the EOMB serves as the explanation to the beneficiary of the reasons why Medicare made the decision it did.

To serve these purposes the EOMB needs to convey information to the beneficiary in four categories:

- Basic descriptive information about the provider, the medical service, when the service occurred, who was paid, and who was the beneficiary.
- Cost and financial information about the amount of money charged to Medicare, approved by Medicare, paid, and applied to the deductible and coinsurance.
- Key terms and contextual information about the reasons for Medicare's decision.

- Action information about what the beneficiary needs to do next to obtain more information, appeal Medicare's decision, pay the provider what remains due, or recognize potential fraud.

In response to criticisms that the EOMB was not effective in communicating claim information to beneficiaries, the Health Care Financing Administration (HCFA) began a series of substantial revisions to the notice, starting in 1991. By late 1992 all 33 carriers had implemented the first set of major revisions. At that time HCFA contracted with the research firm Westat to evaluate the revised EOMB.[6] Westat found that the revision was a substantial improvement over the earlier version of the EOMB. But Westat also found that beneficiaries could still be confused about what action they should take in response to the EOMB. Westat noted, particularly, that beneficiaries were confused about how much they still owed after Medicare made its payment.

Westat's methodology involved focus groups of beneficiaries and their representatives, along with purposive interviews of HCFA staff, carrier personnel, and Medicare advocates. The focus group discussions used sample EOMBs, not real claims. While HCFA was generally satisfied with the Westat report, it felt that a scientific evaluation was appropriate, using real EOMBs for a representative sample of beneficiaries.

Since the Westat evaluation, in 1993 and 1994, HCFA has continued to add enhancements to the revised EOMB. At the same time the need for clear, correct, and simple communication with beneficiaries has come to the fore. A report by the National Academy of Social Insurance in June 1993 recommended that HCFA continue to review and evaluate the efforts that have been undertaken to improve the EOMB.[7]

Customer service improvement is among the major themes to emerge from the National Performance Review. Along with other agencies, HCFA recently introduced new and more user-friendly brochures for Medicare and related programs. A more user-friendly EOMB remains a related goal.

METHODOLOGY

Data Collection

Ours was a mail survey using a self—administered questionnaire that asked the beneficiary to interpret information on the EOMB. We sent the questionnaire to a simple random sample of Medicare beneficiaries, whose selection we describe in Appendix B. The first mailing included a personal cover letter seeking the beneficiary's participation and a copy of their sample EOMB printed on yellow paper with the word "COPY" in red letters across the front, along with the questionnaire booklet. About a month after the initial mailing we sent a reminder letter, and about three weeks after that we sent a third letter with another copy of the questionnaire.

In the cover letter we addressed the beneficiary. We recognized that many people in the beneficiary population do not handle their own business affairs. The cover letter and the

instructions in the questionnaire booklet invited whomever handles those affairs to respond. The EOMB communicates effectively if it conveys information to that person and, through him or her, to the beneficiary.

In presenting our results we report them as measures of beneficiary understanding, whether the beneficiary answered the questions directly or through some other person. In a mail survey we cannot know to what extent another person may have influenced a beneficiary's responses. Nor can we assume that participation by another person reflects difficulty by the beneficiary in understanding the EOMB; it could be a matter of convenience for the beneficiary.

Our purpose was to measure the effectiveness of the EOMB as Medicare actually uses it. In mailing the EOMB to the beneficiary, Medicare accepts on its own terms whatever support the beneficiary chooses to seek. It is always possible that another person might play a role in helping the beneficiary understand the EOMB. We accepted as representative of beneficiary understanding the answers returned by anyone responding on the beneficiary's behalf, just as Medicare accepts the informal support that friends, relatives, physicians, and representatives give to beneficiaries in understanding the EOMB. We believe our survey places no more limitation on beneficiary understanding than does Medicare's mailing.

We analyzed the sample for possible age and sex bias. As detailed in appendix C, we found no evidence for response bias.

Data Analysis

Our survey included 23 factual questions that asked for specific responses corresponding to information contained on the EOMB. We counted the numbers of correct and incorrect responses to each question, along with the numbers not answered and, for seven of the questions, the numbers of "Don't know" responses. We report in Appendix D the counts and the associated percentages of 288 total responses.

Six other questions asked either the beneficiary's opinion or preference in dealing with EOMB-related matters. For these we recorded the respondent's selection among the multiple choices. We report these counts, and the associated percentages of respondents who expressed an opinion, in Appendix D.

At the end of the questionnaire we invited additional comments. These we analyzed for common threads, and for positive or negative characterization of the understandability of the EOMB.

We coded and checked all of the responses and entered them into a database file. We used

a personal computer to develop the counts and percentages that are reported in Appendix D. Additionally, we created an overall index of understanding for each beneficiary based on the number of questions answered correctly, incorrectly, or not answered. In calculating

this index we combined the raw number of incorrect answers with "Don't Know" answers and report the sum under the heading "Incorrect". This index, along with four subindexes calculated similarly to measure beneficiary understanding of specific categories of information, forms the basis for our analysis of the respondents' collective understanding of the EOMB.

We completed our review in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

SURVEY RESULTS

Medicare beneficiaries appear to understand most of the information on the EOMB.

On average, the 288 respondents we surveyed answered 72 percent of the survey questions correctly (±2.37 percent at the 95 percent confidence level). They answered, on average, 19 percent incorrectly, and they did not answer 8 percent of the questions. The percentages do not sum to 100 because of independent rounding.

Two beneficiaries had the lowest score for the overall index; they answered 4 percent (1 out of 23 questions) correctly. Two other beneficiaries answered all 23 questions correctly. Among individual questions, the lowest rate of correct answers was 43 percent for a question about understanding the words "Your total responsibility" on the EOMB. The highest rate of correct answers was 94 percent for a question about the Medicare number.

Beneficiary understanding varies among different categories of information on the EOMB. It is highest with respect to basic descriptive information and lowest with respect to follow-up actions they could take in response to the EOMB.

The rate of correct answers differs among our four subindexes:

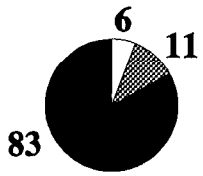
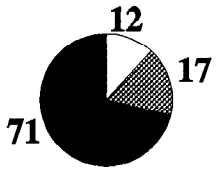
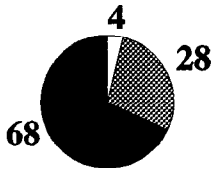
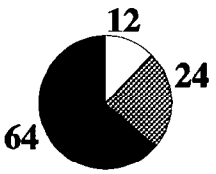
> **Basic Information:** For questions concerning basic descriptive information on the EOMB, such as who and what service it is about, respondents on average answered 83 percent correctly.
>
> **Cost Information:** For questions concerning money amounts on the EOMB, such as how much Medicare approved or paid, they answered on average 71 percent correctly.
>
> **Context Information:** For questions concerning the reasons why Medicare made the decision it explains on the EOMB, including understanding of key terms such as "assignment" and "deductible," respondents on average answered 68 percent correctly.
>
> **Action Information:** For questions concerning what the beneficiary could do next, such as appeal rights and amounts owed, they answered on average 64 percent correctly.

The lower level of correct answers to questions having follow-up implications for the beneficiary reinforces a statement by Westat Inc., introducing the recommendations in a study it conducted on the EOMB in 1992. Westat urged priority for helping beneficiaries understand "the bottom line"—what action they should take in response to the EOMB.

INDEXES

Table I below summarizes the survey results for our overall index and four subindexes of beneficiary understanding.

TABLE 1
BENEFICIARY UNDERSTANDING for the EXPLANATION OF MEDICARE PART B BENEFITS

Overall Index		Average Percent		
		Correct	Incorrect	No Answer
Includes all 23 survey questions with right/wrong answers.		72	19	8
Specific Subindexes				
Basic (?)	Includes 7 survey questions that ask for information identifying the EOMB: Provider, service, dates, claim and Medicare numbers, and who was paid.			
Cost ($)	Includes 5 survey questions that ask for information about the money amounts on the EOMB: amounts charged, approved, paid, applied to deductible and coinsurance.			
Context (✓)	Includes 5 survey questions that ask for information necessary to understanding the reasons for Medicare's decision on the claim: Explanatory notes and definitions of key terms.			
Action (⇒)	Includes 6 survey questions that ask for information bearing on actions the beneficiary could take in response to the EOMB: appeal, questions, amount still owing, and possibility of fraud.			
Shading for Subindex Pie Charts: ● Correct ▒ Incorrect ○ No Answer				
SOURCE: OIG Mail Survey, September 1994				

QUESTIONS

Basic

The subindex of basic descriptive information includes seven questions that address what service was provided, by whom, and when. Three respondents answered none of these questions correctly; 119 answered all 7 correctly. Table 2 below summarizes the results for the subindex and the individual questions.

TABLE 2: BASIC DESCRIPTIVE INFORMATION

SURVEY RESULTS FOR BASIC SUBINDEX OF 7 QUESTIONS (AVERAGE PERCENT):

SURVEY RESULTS FOR THE 7 INDIVIDUAL QUESTIONS:

Question Number	Subject of Question	Percent		
		Correct	Incorrect	No Answer
1	Date of EOMB	63	32	5
2	Claim Control Number	84	10	6
3	Who Provided the Services on the EOMB	90	5	5
4	What Kinds of Services Were Provided	82	11	7
5	When the Services Were Provided	82	8	11
12	Who Was Paid	86	6	6
23	Medicare Number	94	3	2

NOTE: Percentages may not sum to 100 because of independent rounding.

SOURCE: OIG Mail Survey, September 1994

Shading Key: Correct, Incorrect, No Answer

The highest rates of correct answers to basic questions occurred for the Medicare number (that identified the beneficiary) and the provider of service (that identified the provider.) A few of the "incorrect" respondents chose to ignore the provider listed on the EOMB and wrote in the names of their regular physicians—whom they identified as such. The small number of these, together with the circumstance that many sample EOMBs listed laboratories or other impersonal providers, suggests that the respondents truly derived their answers from the EOMB copies we sent them, as we requested in the cover letter.

In contrast, the answer to our question on the claim control number could only be obtained by a careful reading of the EOMB. Yet 84 percent of the responses to this question were correct. Respondents can recover specific and very technical information from the EOMB.

The rate of correct answers for who was paid, 86 percent, was above average for the questions in the subindex. This may reflect the direct statement (added in 1994 and placed just beneath the summary box) whether or not the provider accepted assignment.

Cost

The subindex of cost and financial information includes five questions that address the money amounts charged to, approved by, and paid by Medicare. Nineteen respondents answered none of these questions correctly; 84 answered all 5 correctly. Table 3 below summarizes the survey results for the subindex and the individual questions.

TABLE 3: COST INFORMATION

SURVEY RESULTS FOR COST SUBINDEX OF 5 QUESTIONS (AVERAGE PERCENT):

SURVEY RESULTS FOR THE 5 INDIVIDUAL QUESTIONS:

Question Number	Subject of Question	Percent		
		Correct	Incorrect	No Answer
7	Amount Charged	84	6	10
8	Amount Approved	90	1	9
11	Amount Paid	77	14	9
13	Amount Applied to Deductible	59	28	13
14	Amount of Copayment	47	35	18

SOURCE: OIG Mail Survey, September 1994

Shading Key: Correct Incorrect No Answer

The highest rates of correct answers to individual cost questions occurred for the amounts charged to Medicare and approved by Medicare. These amounts were displayed prominently in the summary box at the upper right hand area of the EOMB. They were also clearly labeled. In their comments, some respondents expressed approval for this mode of displaying information. A few went on to suggest that a slightly expanded summary box could convey almost all of the information that ordinarily interests a beneficiary on the EOMB.

The rates of correct answers to the questions about deductible and copayment amounts, 59 and 47 percent, were among the lowest in the survey. The "No Answer" rates for these two questions, 13 and 18 percent, were among the highest in the survey. The word "copayment" or "coinsurance" did not appear directly on the EOMB. The word "deductible" might appear only in a separate message telling the beneficiary that the deductible had already been met. For these questions, respondents had to figure out the answers on their own, rather than associate a clearly labeled amount on the EOMB with the subject of the question.

Context

The subindex of context information and key terms includes five questions that address the reasons for Medicare's decision and beneficiary understanding of some key Medicare terms. Ten beneficiaries answered none of these questions correctly; 62 answered all 5 correctly. Table 4 below summarizes the survey results for the subindex and the individual questions.

TABLE 4: CONTEXT INFORMATION AND KEY TERMS

SURVEY RESULTS FOR CONTEXT SUBINDEX OF 5 QUESTIONS (AVERAGE PERCENT):

SURVEY RESULTS FOR THE 5 INDIVIDUAL QUESTIONS:

Question Number	Subject of Question	Percent		
		Correct	Incorrect	No Answer
9	"Notes" on the EOMB	69	22	8
26	Understanding of "Assignment"	75	22	3
27	Understanding of "Deductible"	84	14	2
28	Understanding of "Copayment"	68	28	5
29	Understanding of "Your Total Responsibility"	43	53	4

NOTES: Percentages may not sum to 100 because of independent rounding.
Percent Incorrect includes the following percentages answering "Don't Understand":
Question 9: 0; Question 26: 14; Question 27: 3; Question 28: 17; Question 29: 4.

SOURCE: OIG Mail Survey, September 1994

Shading Key: Correct Incorrect No Answer

The lowest rate of correct answers for any of the 23 survey questions, 43 percent, occurred for the context question concerning understanding of the words "Your total responsibility."

The highest rate of correct answers for a context question, 84 percent, occurred for the question concerning the respondent's understanding of the word "deductible." The "No Answer" rate of 2 percent for this question was the lowest for all the questions in the survey.

At least as measured by percent correct, beneficiary understanding of the "deductible" was substantially higher for the general definition of the term (84 percent) than for the actual deductible amount on the sample EOMB (Question 13 had 59 percent correct.) Similarly, measured understanding of the general term "copayment" at 68 percent correct was higher than that for the actual amount on the EOMB, (Question 14 had 47 percent correct.)

But note that, for both deductible and copayment, the "Incorrect" rates are the same for general questions 27 and 28 and specific questions 13 and 14. The gain in "Correct" rates in going from general to specific reflects a decrease in "No Answers."

Action

The subindex of beneficiary actions includes six questions addressing how to obtain more information, how to appeal, and what is still owed. Eleven respondents answered none of these questions correctly; 37 answered all 6 correctly. Table 5 below summarizes the survey results for the subindex and the individual questions.

TABLE 5: BENEFICIARY ACTION INFORMATION

SURVEY RESULTS FOR ACTION SUBINDEX OF 6 QUESTIONS (AVERAGE PERCENT):

64 | 24 | 12

SURVEY RESULTS FOR THE 6 INDIVIDUAL QUESTIONS:

Question Number	Subject of Question	Percent		
		Correct	Incorrect	No Answer
6	What To Do If A Service Was Not Received	53	38	10
15	Total Providers Can Collect	54	30	17
16	Amount You Add To Medicare's Payment	69	16	16
20	Who To Contact With Questions	78	12	10
21	How To Appeal	81	15	4
22	Closing Date for Appeal	52	32	16

NOTES: Percentages may not sum to 100 because of independent rounding.
Percent Incorrect includes the following percentages answering "Don't Understand":
Question 6: 7; Question 15: 0; Question 16: 0; Question 20: 0; Question 21: 2; Question 22: 0.

SOURCE: OIG Mail Survey, September 1994

Shading Key: Correct | Incorrect | No Answer

A higher-than-average percent of respondents correctly answered the questions about who to contact for additional information (78 percent) and how to file an appeal (81 percent). Only 52 percent correctly answered the question concerning the closing date for filing an appeal. Some respondents showed a grasp of the rules for appeal by writing "six months" or the like. Yet they bypassed a clearly stated specific date to answer with a general rule that derives from a source other than the EOMB.

About half the respondents, 54 percent, answered with the correct total amount the provider can collect for the services on the sample EOMB. But 69 percent answered with the correct total amount they needed to add to Medicare's payment to meet their total responsibility. Most of the claims in the sample were assigned and one might easily guess the "Your 20%" or "Your total responsibility" amount without understanding why.

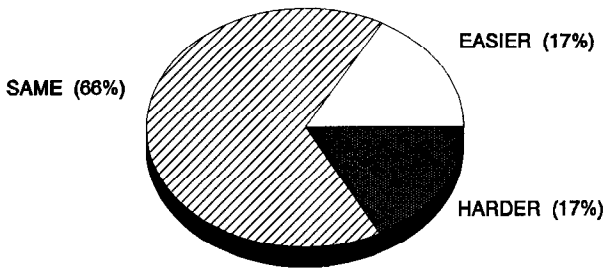
A relatively low 53 percent of respondents correctly answered what the EOMB tells them to do if Medicare paid for a service they did not receive. The EOMB was less effective at conveying this information than the answers to most of our other questions. One respondent commented that it was necessary to spend 25 minutes and read through all the information on the back of the form to find out what to do.

Beneficiaries regard the EOMB as no more, and no less, difficult to understand than other notices they receive in the mail.

Sixty-six percent of the 281 respondents who expressed opinions characterized the EOMB as being neither easier nor harder to understand than notices such as bank statements or utility bills. Another 17 percent thought the EOMB easier; the remaining 17 percent thought it harder.

One of the opinion questions on our survey invited respondents to rate the EOMB in comparison to other notices they receive in the mail, such as bank statements and utility bills. About 98 percent of the respondents (281/288) answered this question. As shown in Figure 1, a clear majority considered the EOMB about the same as other notices for ease of understanding. We estimate the precision of this survey result as ±7 percent at the 95 percent confidence level.

Figure 1: 281 Respondents Compare the Ease of Understanding Medicare's EOMB to Other Mailed Notices (Utility Bills, etc.)



Source: OIG Mail Survey, September 1994

Those who thought the EOMB was easy to understand said things such as: "In my opinion your explanations are precise and easy to understand," or "It is good now. Leave it alone." On the other hand, those who thought the EOMB now was not easy to understand offered comment such as: "The more I read about Medicare the more confused I get," or "The explanations are over-done to the point of confusion. Please simplify our lives a bit, not complicate them."

RECOMMENDATION

It is satisfying that the rate of understanding for basic descriptive information is quite high. It is of some concern, however, that the rate is lower for the subindex that bears upon matters previously identified as most important to beneficiaries—what action(s) to take next.

We recommend that HCFA build on its prior efforts and give major attention to informational items having follow-up implications for the beneficiary.

As HCFA continues to revise the EOMB it should aim to facilitate beneficiary understanding of the following items:

- what the beneficiary needs to pay out of pocket,
- how the beneficiary can get more information,
- how to appeal Medicare's decision, and
- what to do if there appears to be fraud or abuse.

COMMENTS ON THE DRAFT REPORT

We shared a draft copy of this report with, and invited comments from, the Health Care Financing Administration (HCFA) and the Assistant Secretary for Planning and Evaluation (ASPE.) We summarize their comments below, along with our responses in italics.

The HCFA concurred with our recommendation. It stated that their Medicare Summary Notice initiative includes plans for a section that will explain the actions necessary for an appeal, and a "Customer Service Information Box" that will display important information.

We appreciate HCFA's positive response. We would be pleased to work with it in the future to evaluate the effectiveness of the new summary notices, perhaps as an application of the methodology we developed in this study.

The ASPE, in comments accompanying its conditional concurrence with our draft report, stated: "...the report should not assert that beneficiaries appear to understand most of the information on the EOMB." It went on to say: "It is easily argued that Medicare beneficiaries ... find [the EOMB] very difficult to interpret based solely on the information that fewer than 50% of them handle their own Medicare paperwork."

We have revised the report to recognize more clearly the possible role that another person might play in helping the beneficiary. However, we have retained in the finding the assertion about beneficiary understanding.

Our purpose was to measure the effectiveness of the EOMB as Medicare actually uses it. In mailing the EOMB to the beneficiary Medicare accepts whatever informal support the beneficiary chooses. We accepted as representative of beneficiary understanding the answers returned by anyone responding on the beneficiary's behalf, just as Medicare accepts the informal support that friends, relatives, physicians, and representatives give beneficiaries in understanding the EOMB.

APPENDIX A

EXAMPLE

of an

EXPLANATION OF MEDICARE PART B BENEFITS

(EOMB)

Front of EOMB **A-2**

Back of EOMB **A-4**

NOTE: **The numbers written on the example correspond to questions on the survey instrument.**

THIS IS NOT A BILL
Explanation of Your Medicare **Part B** Benefits

WI-FA-00001

JAMES T KIRK
1701 W WARP DR
APARTMENT 8C
ALDEBARAN US 22222-2003

Summary of this notice dated March 31, 1994

Total charges:	$280.00
Total Medicare approved:	$171.21
We are paying you:	$137.57
Your total responsibility:	$196.89

Your Medicare number is: 123-45-6789A

Your provider did not accept assignment

Details about this notice (See the back for more information.)

Control number 0246-8135-79024

BILL SUBMITTED BY: ENTERPRISE MEDICAL GROUP
Mailing address: 1722 STARLIGHT DR VULCAN US 33333

Dates	Services and Service Codes		Charge	Medicare Approved	See Notes Below
	JEAN-LUC PICARD M.D.				
Oct 16, 1993	1 Biopsy, abdominal mass [49180-51]		$ 140.00	$ 53.01	b,c
Oct 16, 1993	1 Biopsy of urethra [53200]		+ 140.00	+ 118.20	d,e
		Total	$ 280.00	$ 171.21	**a**

Your provider(s) did not accept assignment. We are paying you the amount that we owe you. See #4 on the back.

Notes:

a This information is being sent to Medicaid. They will review it to see if additional benefits can be paid.

b The approved amount is less because this service was performed with another surgery on the same day.

c Your doctor did not accept assignment for this service. Under Federal law, your doctor cannot charge more than $ 60.96.

d The approved amount is based on the fee schedule.

e Your doctor did not accept assignment for this service. Under Federal law, your doctor cannot charge more than $ 135.93.

IMPORTANT: If you have questions about this notice, call US Medicare Carrier Part B at 999-555-1212, or toll free at 1-800-555-4567 or visit us at 1717 W. Broadway, Downtown, US 11111. You will need this notice if you contact us. To appeal our decision, you must WRITE to us before September 30, 1994 at Medicare Part B, P.O. Box 9999, Downtown, US 11111. See #2 on the back.

JAMES T KIRK

Control number 0246-8135-79024 **Your Medicare number is: 123-45-6789A**

More details about this notice

Here's an explanation of this notice:

Of the total charges, Medicare approved	$	171.21	See #4 on the back.
Your 20%	-	34.24	We pay 80% of the approved amount; you pay 20%.
The 80% Medicare pays	$	136.97	**You have already met the deductible for 1993.**
Medicare owes	$	136.97	
Plus interest for delayed processing	+	0.60	Processing of these services exceeded set time limits.
Net payment after interest	$	137.57	
We are paying you	$	137.57	Please cash the enclosed check as soon as possible.
Of the total charges	$	280.00	
Less amount exceeding charge limit	-	83.11	You are not responsible for this amount which is in excess of the Medicare limiting charge. See note(s).
Your total responsibility	$	196.89	The provider may bill you for this amount. If you have other insurance, the other insurance may pay this amount.

IMPORTANT: If you have questions about this notice, call US Medicare Carrier Part B at 999-555-1212, or toll free at 1-800-555-4567 or visit us at 1717 W. Broadway, Downtown, US 11111. You will need this notice if you contact us. To appeal our decision, you must WRITE to us before September 30, 1994 at Medicare Part B, P.O. Box 9999, Downtown, US 11111. See #2 on the back.

Important Information You Should Know About Your Medicare Part B Benefits

This part of the notice answers some questions about receiving Medicare payments. If you have other questions, see your copy of *The Medicare Handbook* or call us for more information.

1. **What should I do if I have questions about this notice?**
If you have questions about this notice, call, write, or visit us and we will tell you the facts that we used to decide what and how much to pay. Turn to the front of this notice; our address and phone number are on the bottom of the page.

2. **Can I appeal how much Medicare paid for these services?**
If you do not agree with what Medicare approved for these services, you may appeal our decision. To make sure that we are fair to you, we will not allow the same people who originally processed these services to conduct this review.

However, in order to be eligible for a review, you **must** write to us within **6 months** of the date of this notice, unless you have a good reason for being late (for example, if you had an extended illness which kept you from being able to file on time).

Turn to the front of this notice; the deadline date and our address are on the bottom of the page. It may help your case if you include a note from your doctor or supplier (provider) that tells us what was done and why.

If you want help with your appeal, or if you have questions about Medicare, you can have a friend or someone else help you. There are also groups, such as legal aid services, who will provide free advisory services if you qualify. In addition, volunteers at Medicare peer counseling programs in your area can also provide you with assistance. If you would like more information on how to get in touch with a counselor, contact us at the address or phone numbers on the bottom of the front page of this notice.

3. **How much does Medicare pay?**
The details on the front of this notice explain how much Medicare paid for these services. See your copy of *The Medicare Handbook* for more information about the benefits you are entitled to as a beneficiary in the Medicare Part B program. If you need another copy of the handbook, call or visit your local Social Security Office.

Medicare may make adjustments to your payment. We may reduce the amount we pay for services by a certain percentage (Balanced Budget Law). If your provider accepted assignment, you are not liable to pay the amount of this reduction. We pay interest on some claims not paid within the required time.

All Medicare payments are made on the condition that you will pay Medicare back if benefits are also paid under insurance that is primary to Medicare. Examples of other insurance are employer group health plans, automobile medical, liability, no fault or workers' compensation. Notify us immediately if you have filed or could file a claim with insurance that is primary to Medicare.

4. **How can I reduce my medical costs?**
Many providers have agreed to be part of Medicare's participation program. That means that they will always accept the amount that Medicare approves as their full payment. Write or call us for the name of a participating provider or for a free list of participating providers.

A provider who accepts assignment for covered services can charge you only for the part of the annual deductible you have not met and the copayment which is 20 percent of the approved amount.

If you are treated by one of these doctors, you can save money. See *The Medicare Handbook* for more information about how you can reduce your medical costs.

Generally a doctor who has not accepted assignment may not charge more than 115 percent of the Medicare approved amount for services provided in 1993 or later. This is known as the limiting charge. Contact us if assignment was not accepted, and you think your doctor charges more than the limiting charge.

Some states have laws that could further reduce your medical costs. Please see *The Medicare Handbook* published in 1993 or later for more information.

5. **How can I use this notice?**
You can use this notice to:

- Contact us immediately if you think Medicare paid for a service you did not receive;
- Show your provider how much of your deductible you have met;
- Claim benefits with another insurance company. If you send this notice to them, make a copy of it for your records.

Keep this notice for your records
Health Care Financing Administration

APPENDIX B

SAMPLE SELECTION

Our purpose was to measure the effectiveness of the EOMB, so it would be reasonable to select a random sample from some population of EOMBs. Unfortunately, no database of EOMBs exists. Claims for medical insurance benefits result in EOMBs, so we selected our sample from a population of claims.

We selected claims from HCFA's Common Working File that met the following conditions:

- The last date of service was on or after May 1, 1993. This ensures that the EOMB was issued after all the carriers had implemented HCFA's major revisions that were the subject of the Westat report.

- The last date of service was on or before December 31, 1993. The provides an 8-month sample that is large enough to average out most seasonal variations.

Implicitly, we also had a condition limiting the selection to claims that had been processed by the carriers and reported to HCFA by March 31, 1994. This was the most recent data available at the time of selection.

Following discussions with HCFA we placed no restrictions on the type of claim selected. Any claim, paid or denied, assigned or nonassigned, physician or nonphysician for any beneficiary and for any amount, anywhere in the country was eligible for selection.

Also following discussions with HCFA we planned to report the results to a precision of 5 percent at the 95 percent level of confidence. Since the key questions in our survey were binary we made the conservative assumption that responses would be evenly divided between correct and incorrect. These criteria imply a sample size of about 400.

Based upon OIG's past experience in conducting mail surveys with beneficiary populations we anticipated a response rate of about 75 percent. In order to realize 400 responses this implies a sample size of about 540. But not all claims result in EOMBs, some are suppressed by the carriers. Following discussions with HCFA we estimated about 20 percent of EOMBs would be suppressed. So we selected a sample of 675 claims in order to send out 540 questionnaires and realize 400 responses.

When we requested EOMB copies from the carriers we found that the EOMBs for 163 (24 percent) of the claims had been suppressed. Carriers have discretion to suppress the EOMB for claims that do not admit beneficiary appeal or require follow-up action. Examples include assigned laboratory claims paid at 100 percent, or claims for Medicaid

recipients. We did not mail questionnaires to beneficiaries who had not received an original EOMB during regular claim processing.

Also, we did not mail questionnaires to beneficiaries who were recorded as deceased in the Enrollment Database at the time of sample selection. The following table summarizes the sample:

TABLE B-1: SURVEY MAILING	
NUMBER OF CLAIMS	DESCRIPTION
675	Entire random sample
163	Claims with EOMB suppressed
512	Sample with EOMB sent originally
61	Deceased beneficiaries among 512 sent EOMB
451	Recipients of the survey questionnaire

The next table details our experience with the 451 surveys we mailed to beneficiaries.

TABLE B-2: MAILING RESULTS	
NUMBER OF CLAIMS	DESCRIPTION
451	Recipients of the survey questionnaire
288	Timely responses, 07/01/94-09/23/94
9	Late responses, after 09/23/94
4	Postal Service returns, undeliverable
18	Contacted OIG, could not respond
132	No contact, no response

We completed our mail survey with 288 responses, a 64 percent response rate. We counted as a respondent anyone who returned a questionnaire with at least one question answered. One respondent answered only 2 questions, 150 respondents answered all the questions, and 259 respondents answered at least 75 percent of the questions in the survey. Overall, the 288 respondents answered 7659 out of 8392 questions in the survey (29 per respondent, a 92 percent answer rate), and 131 (45 percent) offered comments.

Answer rates for individual questions varied from a low of 81 percent (231/288) to a high of 98 percent (283/288). Taking the low value of 231 as the sample size, we can conservatively estimate the measured precision of the survey results for categorical questions as slightly better than 7 percent, at the 95 percent confidence level.

The several indexes of understanding which we discuss in the text are continuous rather than categorical variables. We give the precision of these index results in the table below.

TABLE B-3: PRECISION FOR INDEXES

INDEX	MEAN VALUE	PRECISION
Overall	72	±2.37%
Basic	83	±2.57%
Cost	71	±3.20%
Context	68	±3.06%
Action	64	±3.02%

NOTES: Index values for percent correct answers.
Number of respondents = 288
Precision at 95 percent level of confidence (t = 1.96).

APPENDIX C

ANALYSIS FOR NONRESPONSE BIAS

In a survey based upon a random sample we need to consider the possibility that bias may be introduced through self-selection by the respondents. To determine whether significant differences exist in this survey we compared the two groups, respondents and nonrespondents, by age and sex. We found no difference between the groups for either variable at the 95 percent confidence level.

Analysis by Age

Calculated at July 1, 1994, the average age for beneficiaries who responded to the survey, either on their own or through a representative, was 73.5 years. By comparison, the average age for nonrespondent beneficiaries in the sample was 75.4 years, and the average age for the entire sample of 451 beneficiaries was 74.2 years.

We tested the significance of age differences between respondents and nonrespondents by using the t-test procedure in the SAS program package. The calculated t value was 1.81, which is not statistically significant at the 95 percent confidence level. We conclude that there is no difference between respondents and nonrespondents by age at the 95 percent confidence level.

Analysis by Sex

The percentage respondents and nonrespondents by sex is:

COMPARISON OF RESPONDENTS BY SEX							
	RESPONDENTS		NONRESPONDENTS		TOTAL		PERCENT RESPONDING
	Number	Percent	Number	Percent	Number	Percent	
MALE	123	43 %	57	35 %	180	40 %	68 %
FEMALE	165	57 %	106	65 %	271	60 %	61 %
TOTAL	288	100 %	163	100 %	451	100 %	64 %

We used the chi-square test to look for a difference between respondents and nonrespondents by sex. The computed chi-square value of 2.6 is not statistically significant at the 95 percent confidence level. We conclude that there is no difference between respondents and nonrespondents by sex at the 95 percent confidence level.

APPENDIX D

UNDERSTANDING MEDICAL BENEFITS SURVEY RESULTS

- The number of responses, or survey instruments returned with at least one question answered, equals **288**. The number of answers varies from question to question.

- On the survey questionnaire we referred to the notice that was the subject of this study, the "Explanation of Your Medicare Part B Benefits", or EOMB, simply as "Your Explanation." Appendix A contains a sample EOMB with answers to the survey questions marked.

- Most (23 out of 30) survey questions asked for specific information given on the beneficiary's sample EOMB, a copy of which was included with the mailing. We recorded and give here the numbers of correct and incorrect answers. For these questions we also give percentages of all the (288) responses correct, incorrect, and not answered. And for the seven of these questions that allowed a "Don't Know" answer, we give the numbers and percentages for that option.

- Questions 10, 17, 18, 19, 24, and 25 asked for the beneficiary's opinion or preference. We recorded and give here the numbers for each choice. For these six opinion questions we give percentages excluding the respondents who did not answer the question.

- Question 30 invited comments. We give here the numbers who did and did not comment.

- The sum of individual percentages may not equal 100 due to independent rounding.

UNDERSTANDING MEDICAL BENEFITS SURVEY RESULTS		
QUESTION	**NUMBERS**	**PERCENTAGES**
IDENTIFYING YOUR EXPLANATION		
1. Please write in the date of your Explanation.		
Correct	180	63
Incorrect	93	32
No Answer	15	5
2. Please write in the first control number on your Explanation.		
Correct	243	84
Incorrect	29	10
No Answer	16	6
WHAT YOUR EXPLANATION SHOWS		
3. Who provided the health care services described on your Explanation?		
Correct	260	90
Incorrect	13	5
No Answer	15	5
4. What kinds of health care services did they provide?		
Correct	236	82
Incorrect	31	11
No Answer	21	7
5. When did they provide the health care services?		
Correct	235	82
Incorrect	22	8
No Answer	31	11

UNDERSTANDING MEDICAL BENEFITS SURVEY RESULTS		
QUESTION	**NUMBERS**	**PERCENTAGES**
6. What does your Explanation ask you to do if Medicare paid for a service you did not receive?		
Correct	152	53
Incorrect	89	31
Don't Know	19	7
No Answer	28	10
WHAT ARE THE COSTS ON YOUR EXPLANATION		
7. Please write in the total amount of money that Medicare was charged for all the services on your Explanation.		
Correct	243	84
Incorrect	16	6
No Answer	29	10
8. Please write in the total amount of money that Medicare approved for all the services on your Explanation.		
Correct	259	90
Incorrect	4	1
No Answer	25	9
THE NOTES ON YOUR EXPLANATION		
9. Your Explanation may include some Notes that tell you how Medicare decided the amounts to approve for each service. Please mark the one box that most closely describes how Medicare decided the approved amounts on your Explanation.		
Correct	200	69
Incorrect	64	22
Don't Know	1	0
No Answer	23	8

UNDERSTANDING MEDICAL BENEFITS SURVEY RESULTS		
QUESTION	**NUMBERS**	**PERCENTAGES**
10. How strongly do you agree or disagree with the statement that the Notes on your Explanation are clear and easy to understand?		
Strongly Agree	130	49
Somewhat Agree	106	40
Somewhat Disagree	13	5
Strongly Disagree	14	5
No Notes	0	0
No Answer	25	--
WHAT MEDICARE PAID		
11. Please write in the total amount of money that Medicare paid for all the services on your Explanation.		
Correct	223	77
Incorrect	39	14
No Answer	26	9
12. Who did Medicare pay for the services on your Explanation?		
Correct	249	86
Incorrect	17	6
No Answer	16	6
WHAT MEDICARE DID NOT PAY		
13. Please write in the amount Medicare applied to the deductible for the services on your Explanation.		
Correct	169	59
Incorrect	82	28
No Answer	37	13

UNDERSTANDING MEDICAL BENEFITS SURVEY RESULTS		
QUESTION	**NUMBERS**	**PERCENTAGES**
14. Please write in the amount of the copayment for the services on your Explanation.		
Correct	134	47
Incorrect	101	35
No Answer	53	18
WHAT YOU OWE		
15. Please write in the total amount the health care providers are entitled to receive for the services on your Explanation.		
Correct	155	54
Incorrect	85	30
No Answer	48	17
16. Please write in the total amount you need to add to Medicare's payment in order to pay your total responsibility (even if other insurance will pay some or all of it for you).		
Correct	198	69
Incorrect	45	16
No Answer	45	16
17. Your Explanation may contain a calculation of your total responsibility. If your Explanation has a calculation, how strongly do you agree or disagree with the statement that it is clear and easy to understand.		
Strongly Agree	116	50
Somewhat Agree	88	38
Somewhat Disagree	19	8
Strongly disagree	8	3
No Calculation	0	0
No Answer	57	--

UNDERSTANDING MEDICAL BENEFITS SURVEY RESULTS		
QUESTION	**NUMBERS**	**PERCENTAGES**
USING YOUR EXPLANATION		
18. Who usually takes care of your Medicare Explanations and other health care paper work?		
I Do It Myself	121	45
A Friend or Relative	71	27
Health Care Providers	42	16
Someone Else	28	11
Don't Know/Understand	4	2
No Answer	22	--
19. What do you usually do with your Explanation when you get one from Medicare?		
Read Myself	183	66
Someone Explains	70	25
Try, No One Helps	7	3
Keep for Later	14	5
Discard	0	0
Don't Know/Understand	4	1
No Answer	10	--
APPEALING MEDICARE'S DECISION		
20. Who does your Explanation ask you to contact if you have a question about your Medicare benefits?		
Correct	225	78
Incorrect	34	12
No Answer	29	10

UNDERSTANDING MEDICAL BENEFITS SURVEY RESULTS		
QUESTION	**NUMBERS**	**PERCENTAGES**
21. What does your Explanation tell you to do to appeal Medicare's decision, if you do not agree with it?		
Correct	234	81
Incorrect	36	13
Don't Know/Understand	6	2
No Answer	12	4
22. What is the latest date you could appeal Medicare's decision on your Explanation?		
Correct	150	52
Incorrect	93	32
No Answer	45	16
SOME GENERAL INFORMATION		
23. Please write in your Medicare number.		
Correct	272	94
Incorrect	10	3
No Answer	6	2
24. How do you prefer to contact Medicare?		
Phone	231	84
Write	29	11
Personal Visit	15	5
No Answer	13	--

UNDERSTANDING MEDICAL BENEFITS SURVEY RESULTS		
QUESTION	**NUMBERS**	**PERCENTAGES**
25. How do you rate Medicare's Explanation compared to other notices you get in the mail, such as bank statements and utility bills. The Explanation is:		
Easier to Understand	48	17
About the Same	185	66
Harder to Understand	48	17
No Answer	7	--
SOME MEDICARE DEFINITIONS		
26. Please mark the one box that best matches what you understand by Medicare's word "Assignment."		
Correct	216	75
Incorrect	23	8
Don't Understand	41	14
No Answer	8	3
27. Please mark the one box that best matches what you understand by Medicare's word "Deductible."		
Correct	241	84
Incorrect	33	11
Don't Understand	9	3
No Answer	5	2
28. Please mark the one box that best matches what you understand by Medicare's word "Copayment."		
Correct	195	68
Incorrect	31	11
Don't Understand	48	17
No Answer	14	5

UNDERSTANDING MEDICAL BENEFITS SURVEY RESULTS		
QUESTION	**NUMBERS**	**PERCENTAGES**
29. Please mark the one box that best matches what you understand by Medicare's words "Your total responsibility."		
Correct	123	43
Incorrect	142	49
Don't Understand	11	4
No Answer	12	4
COMMENTS		
30. We'd appreciate your suggestions on ways to make Medicare Explanations easier to understand.		
Comments Made	131	45
No Comments	157	55

APPENDIX E

COMPLETE COMMENTS ON THE DRAFT REPORT

Comments from the Health Care Financing Administration E-2

Comments from the Assistant Secretary for Planning and Evaluation E-4

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE MAR 8 1995

TO June Gibbs Brown
Inspector General

FROM Bruce C. Vladeck
Administrator

SUBJECT Office of Inspector General Draft Report: "Understanding Medical Benefits: The Explanation of Medicare Part B Benefits" (OEI-01-93-00120)

We reviewed the subject report which presented results from the survey on beneficiary understanding of the Explanation of Medicare Part B Benefits. Our comments are attached for your consideration.

Thank you for the opportunity to review and comment on this report. Please advise us if you would like to discuss our position on the report's recommendation.

Attachment

Comments of the Health Care Financing Administration (HCFA)
on Office of Inspector General (OIG) Draft Report:
"Understanding Medical Benefits:
The Explanation of Medicare Part B Benefits"
(OEI-01-93-00120)

OIG Recommendation

HCFA should build on its prior efforts and give major attention to informational items having followup implications for the beneficiary. As HCFA continues to revise the Explanation of Your Medicare Part B Benefits it should aim to facilitate beneficiary understanding of the following items:

- What the beneficiary needs to pay out of pocket,
- how the beneficiary can get more information,
- how to appeal Medicare's decision, and
- what to do if there appears to be fraud or abuse.

HCFA Response

HCFA concurs. We have begun our initiative to redesign all beneficiary notices into one, easy to read, Medicare Summary Notice (MSN). As part of the MSN initiative, HCFA consulted with Medicare beneficiaries who provided us with feedback on the current beneficiary notices.

In response to our beneficiaries' comments, we plan to incorporate into the MSN a section that will explain the actions necessary to request an appeal. For clarity, we will include a special "Customer Service Information Box" that will display important information. To help us combat fraud, we will revise the fraud language to include examples of fraudulent activities and provide instructions if our beneficiaries suspect fraud.

The improvements described reflect our current plans and ideas. However, we will solicit more beneficiary input once we complete the draft design.

Additionally, we are currently reviewing the HCFA publications with regard to beneficiary information.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

FEB 15 1995

TO: June Gibbs Brown
Inspector General

FROM: Assistant Secretary for
Planning and Evaluation

SUBJECT: OIG Draft Report: "Understanding Medical Benefits" -
CONDITIONAL CONCURRENCE WITH COMMENTS

This inspection was intended to measure beneficiary understanding of Medicare's *Explanation of Your Medicare Part B Benefits* (EOMB). It follows changes in the EOMB made by HCFA in response to recommendations from a Westat Inc. study in 1992. It indicates that HCFA's continuing efforts to improve the EOMB are producing a more "user-friendly" form.

Throughout the report OIG refers to "communicating claim information to beneficiaries," when the survey was not limited to beneficiaries. The report notes that "[OIG] recognized that many [beneficiaries] do not handle their own business affairs" and invited whoever handled those affairs to respond. The survey results indicate that fewer than 50% of those surveyed take care of their own Medicare Explanations. Therefore the report should not assert that "beneficiaries appear to understand most of the information on the EOMB."

It is easily argued that Medicare beneficiaries, in spite of improvements to the EOMB, still find it very difficult to interpret based solely on the information that fewer than 50% of them handle their own Medicare paperwork. Further, given this information, it would be useful to analyze the data based on whether the respondent was the beneficiary or another person.

I look forward to seeing these data in the revised report.

David T. Ellwood

Prepared by: C. Colladay, 690-7770

APPENDIX F

NOTES

1. The statutory basis for Medicare is located at Title XVIII of the Social Security Act, as amended, 42 U.S.C. 1395 ff. The implementing regulations are at 42 CFR Part 400 et seq.

2. An elegant summary of the structure and operation of Medicare is contained in ***The Medicare 1994 Handbook***, published by the Health Care Financing Administration and provided to all beneficiaries.

3. Major exceptions include beneficiaries who join a health maintenance organization, those entitled to Medicaid, and those with medical benefits through the Department of Veterans Affairs.

4. The provider of service is always required to submit the claim to Medicare (to the carrier). The provider may choose to receive payment directly from Medicare for its portion of the amount due (accept assignment of the Medicare payment). Or the provider may choose to have Medicare make payment to the beneficiary (not accept assignment) and look to the beneficiary for full payment.

5. In other words the EOMB sets the stage for administrative finality. Because some claims present no issue for appeal, Medicare suppresses the EOMBs on these. Assigned laboratory claims paid in full are a common example. Currently Medicare suppresses the EOMB for about 20 percent of Part B claims.

6. *Evaluation of Revised Medicare EOMB, Final Report on Beneficiary Understanding*. Report submitted by Westat, Inc. to the Health Care Financing Administration under contract 500-92-0006, dated March 31, 1993.

7. *Medicare Claims Handling: The Consumer Perspective*. Report of a Study Panel of the National Academy of Social Insurance, Washington, DC, April 1993.