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MEDICARE BALANCE BILLING LIMITS: HAS THE PROMISE BEEN FULFILLED?

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED SECOND CONGRESS

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CONTENTS

Page

Opening statement of Senator William Cohen, acting Chairman ... 1

Statement of:

Senator Conrad Burns ... 8

Senator Charles Grassley ... 43

Senator Arlen Specter ... 44

Prepared statement of:

Senator David Pryor, Chairman ... 6

Senator Bill Bradley ... 7

Senator Larry Pressler ... 7

CHRONOLOGICAL LIST OF WITNESSES

David Lee, Medicare beneficiary ... 9

Stanley Lipson, Medicare beneficiary ... 11

Susan Stayn, program director, Medicare Beneficiaries Defense Fund ... 13

Carol Walton, Deputy Director, Bureau of Program Operations, Health Care Financing Administration ... 31

Carol Jimenez, director of litigation, Medicare Advocacy Project ... 45

Jack Guildroy, board member, American Association of Retired Persons ... 64

Nancy W. Dickey, M.D., member, board of trustees, American Medical Association ... 76

APPENDIX

Item 1. Written testimony from the Physician's Payment Review Commission, submitted by Philip R. Lee, M.D., chairman ... 89

Item 2. Statement of Martha McSteen, president, National Committee to Preserve Social Security and Medicare ... 94

Item 3. Written testimony from W. Howard Johnson, Rockville, MD ... 97

MEDICARE BALANCE BILLING LIMITS: HAS THE PROMISE BEEN FULFILLED?

TUESDAY, APRIL 7, 1992

U.S. Senate,
Special Committee on Aging,
Washington, DC.

The Committee met, pursuant to notice, at 9:30 a.m. in room 628, Dirksen Senate Office Building, Hon. William S. Cohen (acting Chairman of the Committee) presiding.

Present: Senators Cohen, Burns, Grassley, and Specter.

Staff present: Portia Porter Mittelman, Staff Director; Christopher C. Jennings, Deputy Staff Director; Christine V. Drayton, Chief Clerk; Bonnie Hogue, Professional Staff; Johnna Goggans, Professional Staff; Mary Berry Gerwin, Minority Staff Director; Priscilla Hobson Hanley, Professional Staff Member for the Minority.

OPENING STATEMENT BY SENATOR WILLIAM COHEN, ACTING CHAIRMAN

Senator Cohen. The Committee will come to order.

I am sorry that the Chairman of the Committee, Senator Pryor, is unable to attend this morning. He called the hearing and was planning to attend, but unfortunately was called to Arkansas to attend funeral services for Sam Walton, who died this past weekend.

Senator Pryor is very interested in this issue and we are working together on legislation to fix some of the problems that we are now seeing with the implementation of the limiting charge laws in order to protect Medicare beneficiaries against excessive medical bills. Senator Pryor wanted me to convey his strong desire to attend this morning, but all of us understand why he can't be with us.

This is a matter of tremendous importance to our Nation's 34 million elderly and disabled Medicare beneficiaries. The issue is whether or not they've been given the protection they've been promised by the law against being terrorized by high doctor bills which result from excessive overcharging.

In 1989, Congress enacted legislation to limit the amount that doctors could charge their Medicare patients over and above the Medicare-approved amount. This is generally referred to as the limiting charge. This cap was intended to protect Medicare beneficiaries from excessive out-of-pocket medical expenses.

The limiting charge is like a seatbelt. It offers protection but only if it's used. Unfortunately, it appears that what we have here is an unbuckled seatbelt just as a crash is about to occur. Many doctors are still charging their Medicare patients far more, at times even thousands of dollars more, than the billing limit allows. Many of these overcharges are probably the result of honest errors; others may be intentional. In either case, however, the Medicare patient is far too often stuck with paying a very big bill that Congress did not intend him or her to pay.

The Health Care Financing Administration has been extremely lax about enforcing the new limits on physician charges. With the exception of one small paragraph in the Medicare Handbook, which is sent only to new enrollees and not to all beneficiaries, HCFA has done nothing to notify Medicare beneficiaries about the new limits on physician fees.

Not only has HCFA failed to inform Medicare beneficiaries about the new limiting charge, but it has also routinely provided information to thousands of beneficiaries that was both erroneous and misleading.

I want to call the attention of the Committee to an example of the Explanation of Medicare Benefits form that until recently was routinely mailed to Medicare beneficiaries after they had seen a physician. Nowhere on this form does it say there is a limitation on what the physician can charge or what the beneficiary must pay.

The physician in this case billed Medicare $3,200 for surgery and related services. The Explanation of Medicare Benefits form sent to the patient states that you are responsible for a total of $2,939.84, the difference between the billed amount and the Medicare payment.

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS

REQUESTED COPY - MEP THIS IS NOT A BILL 184

HEALTH CARE FINANCING ADMINISTRATION

NY

NEED HELP? CONTACT:
MEDICARE PART B
622 Third Avenue
New York, NY 10017
Local Telephone 516-244-5
Toll Free 1-800-442-8430
Mail all inquiries to:
Medicare Part B, PO Box 2.
Peekskill, NY 10566-0991

Apr 19,1991

PARTICIPATING DOCTORS AND SUPPLIERS ALWAYS ACCEPT ASSIGNMENT OF MEDICARE CLAIM, SEE THE BACK OF THIS NOTICE FOR AN EXPLANATION OF ASSIGNMENT. WRITE OR CALL FOR THE NAME OF A PARTICIPATING DOCTOR OR SUPPLIER .

For medical services you receive on or after September 1, 1990, your doctor or the company that provides your medical services, equipment or supplies must prepare and submit your Part B Medicare claims.

Your doctor or supplier did not accept assignment of your claim (CONTROL NUMBER totalling $ 3200.00 (See item 5 on the back.)

		Billed	Approve
1Surgery	Feb 26,1991	$3200.00	$ 325.20
Approved amount limited by item 6c on back.			

Total approved amount .... $ 325.20
Medicare payment (80 % of the approved amount) .... $ 260.16

We are paying a total of $ 260.16 to you. **You are responsible for a total of 2939.84, the difference between the Billed amount and the Medicare payment. You could have avoided paying $2874.80, the difference between the Billed and Approved amounts, if the claim had been assigned. If you have other insurance, it may help with the part Medicare did not pay.**

(You have met the deductible for 1991)

Overcharges

One example of how a doctor overcharged a Medicare patient for surgery and related services.

Doctor billed .... $ 3,200.00

Medicare approved .... $ 325.20

Medicare paid
(80% of approved amount) .... $ 260.16

Medicare told patient she was liable for
(Billed amount minus
Medicare payment) .... $ 2,939.84

BUT

Doctors charges
were limited by law to .... $ 406.50

Doctor overcharged patient .... $ 2,793.50

ACTUALLY

Patient was only liable for
(Charge limit minus medicare payment) ..$146.34

Source: Medicare claims data

As the second chart shows, in this case, the new billing limit should have capped the doctor's charge at $406.50. After Medicare paid its share, the beneficiary was in fact only liable under the law for $146.34, but the form erroneously states that the beneficiary was responsible for the difference between the physician's actual charge and the Medicare-approved amount. In this case, what Medicare told the beneficiary she owed was over 20 times the amount that she was required to pay by law.

That's a tremendous difference, a potentially catastrophic difference for the Medicare beneficiary who has been ill, who has been living on a fixed income, and who has likely been socked by a multitude of out-of-pocket expenses for prescription drugs. It's difficult to understand why Medicare would go to all of the trouble of putting a specific dollar amount on this form without making certain that the amount cited was correct.

Such oversights are not only irresponsible, they are unconscionable and a source of great confusion and consternation for all Medicare beneficiaries.

If Medicare's elaborate computer system is unable to calculate and state correctly what the beneficiary actually owes, how can we possibly expect an elderly Medicare patient, who probably has never heard of a limiting charge, to catch, much less rectify this kind of an error? Too often, older people will not challenge the information of a doctor's bill, they simply will feel compelled to pay it and deprive themselves of other necessities.

Furthermore, even those beneficiaries who have known that they have been overcharged have been given little or no assistance from Medicare. In fact, in spite of the protection offered by the law, many have been advised by Medicare officials that they should go ahead and pay the bill in full. I find this both incomprehensible and reprehensible.

As we'll hear today, HCFA has finally begun to take some positive steps to correct the information it's providing Medicare beneficiaries and to improve its enforcement efforts. The question we have is why has it taken more than 2 years from the time the law was adopted to eliminate a blatantly erroneous statement on a standard form? Why has it taken so long for HCFA to issue clear instructions to its carriers that they should vigorously enforce the law? Why should Medicare beneficiaries, already among the most vulnerable members of our society, be terrorized by a faceless, computerized bureaucracy that wrongly commands them to pay thousands of dollars which they don't owe?

It's clear that HCFA has only been moved to begin addressing these problems through congressional interest, press attention and, indeed, lawsuits, so I think we have to keep the pressure on.

In addition to HCFA's responsibility to inform beneficiaries and enforce the billing limits, we must also determine why these overcharges are continuing to occur. If doctors are intentionally overcharging the patients, this must be stopped through vigorous enforcement by HCFA and the Medicare carriers.

Today, we're going to hear many explanations for why these overcharges continue to occur. The transitional formula for calculating the limiting charge is complicated and I realize the physician payment reform has made major and fundamental changes in

the way physicians are reimbursed by Medicare. This is bound to cause some confusion.

There is a need for further clarification of the law to better enforce those limiting charges and to ensure that the beneficiaries are refunded the money that they are due and it should be done in a timely fashion. The Chairman and I intend to address this problem in the legislation that we'll be introducing shortly.

The fact is, whatever the reason, whatever the explanation, the Medicare patient has been wrongly footing the bill for these overcharges and that simply is intolerable.

I want to once again thank the Chairman. While he is absent today, he and I will be working together to correct the situation that currently exists.

[The prepared statements of Senator Pryor, chairman, Senator Bradley and Senator Pressler follow:]

PREPARED STATEMENT OF SENATOR DAVID PRYOR

Good Morning. Almost 3 years ago we passed a law that would protect Medicare beneficiaries from excessive out-of-pocket costs for physician services. Today we find that despite our efforts, untold numbers of older Americans have been subjected to physician overcharges. For many of these people, who live on fixed incomes, the overcharges present a great financial hardship—one that we thought we had taken care of.

This law, enacted in 1989, places limits on the amount that physicians can bill their patients over and above what Medicare pays. We are holding a hearing today because the Health Care Financing Administration (HCFA) has dropped the ball on this important law. Both doctors and patients are often unaware of these billing limitations, and as a result, thousands of Medicare patients pay more than the law requires. Beneficiaries have received little or no protection—only confusion and misinformation. Likewise, physicians have received only criticism—not needed information or guidance.

As we will hear this morning, when beneficiaries realize they have been overcharged, they have had to struggle to obtain information from an unresponsive bureaucracy. The Aging Committee has received many reports of beneficiaries who have had to work hard to receive a refund after they had been overcharged. After he realized that he had overpaid his physician more than $2,000, Mr. Howard Johnson of Rockville, Maryland made many phone calls that went unreturned and wrote many letters that went unanswered. Repeatedly stonewalled and ignored by the Medicare system, his persistence was finally rewarded after 5 months, and he received a refund. One can only guess how many people gave up and paid the overcharge rather than battle the bureaucracy. [See chronology in Appendix, Item 3.]

People like Mr. Johnson have had to fight for what was rightfully theirs because HCFA has done little to implement the law. For example, HCFA neglected to change their forms to reflect the new limiting charges. The EOMB (Explanation of Medicare Benefits)—the only information beneficiaries routinely receive from Medicare—contained erroneous information about the amounts they owed their physicians. Unfortunately, these forms still do not include the limiting charge information. The beneficiaries who attempted to call the carriers to ask about the information on their EOMB received misinformation or no information at all.

Late this winter, more than 2 years after Congress passed the law, HCFA finally gave some meaningful instruction to the Medicare carriers. Although HCFA's efforts are a step in the right direction, we want to ensure that these limits provide the protection that Congress intended. For this reason, Senator Cohen and I plan to introduce the "Medicare Beneficiary Payment Protection Act of 1992."

Our legislation strengthens the law by requiring specific monitoring and enforcement efforts by HCFA, and by clarifying that beneficiaries are not liable for overcharges. Our bill would also give beneficiaries increased access to HCFA by creating a beneficiary advisory council to HCFA, much like the existing physician advisory council. Our legislation closely follows the Physician Payment Review Commission's recommendation that Congress make improvements to the law to ensure that limits on balance billing achieve the goal Congress intended. I am hopeful that we can work quickly to enact this legislation so that Medicare beneficiaries receive the protection they are due.

The witnesses assembled today will tell us why it is so important that HCFA effectively and fairly administer the balance billing limits. We will hear from beneficiaries who have been overcharged and Medicare advocates who have helped many receive refunds. We will also be joined by physicians and the Health Care Financing Administration. Thank you all for coming today. I look forward to hearing your testimony.

PREPARED STATEMENT OF SENATOR SENATOR BILL BRADLEY

Mr. Chairman, I am pleased you have called this hearing to look into the issue of possible overcharges of patients under Medicare. I have heard from many elderly New Jerseyans who have encountered this issue. One group was familiar with the new regulations that limit the amounts physicians can charge above Medicare rates. They have been overcharged and have tried to fight it. They have reported the overcharges to HCFA, yet nothing happens. They have advised the doctors of the new regulations; yet nothing happens. Unfortunately, for many, something does happen when the doctor reports the patient to a credit agency for collection of a bill that is incorrect in the first place. It is a battle that can't be won. They deserve our help.

Our patients who are unaware of the new regulation, the situation is worse; they simply pay the incorrect bill when it arrives. These issues illustrate some of the complex problems facing our health care system today. Legitimate attempts to control costs are met with further cost shifting that increases price for those who can afford to pay. The GAO and others have reported many problems with fraud and abuse in the Medicare system and a lack of sufficient means to confront them effectively.

I understand the complex set of regulations doctors have to contend with in dealing with Medicare. I believe that a simplified system that allows doctors to practice medicine, not become experts at paperwork, would help make our system more efficient. Yet, the issue of overcharges to our elderly citizens is a serious one, and merits our attention. I appreciate your attempts to focus attention on these problems through the Aging Committee. I look forward to learning more about these issues, and what solutions may be needed to address them.

PREPARED STATEMENT OF SENATOR LARRY PRESSLER

Mr. Chairman, I would like to thank the Chairman for conducting the hearing this morning. I appreciate the opportunity to review Medicare related programs and better understand the impact that they have on senior citizens.

Last year during the Physician Payment Reform (PPR) rule writing process we became aware of the many flaws that existed in the initial guidelines. Many Senators joined in introducing S. 1810 which would ensure proper implementation of PPR. We also attempted to resolve these problems administratively. The final regulation that went into effect on January 1, 1992 are much improved from the earlier guidelines.

However, inadequacies still exist. I hear frequently from South Dakota physicians and clinic administrators telling me of coding and other billing difficulties. These problems are being addressed both legislatively and administratively.

I feel that it is most appropriate to focus our efforts on the senior citizen. These are the individuals that Medicare is intended to assist.

The legislation that Senator Cohen and Pryor intend to introduce is designed to ensure Medicare enrollees are not paying excessive fees to physicians. This is one way to help control medical costs.

In South Dakota there are 108,000 Part B Medicare enrollees. In 1991 there were 1.3 million Medicare Part B claims processed. Fifty-one percent of these claims were processed under assignment. Medical reimbursements in South Dakota totaled nearing $293 million in 1991. Changes in the Medicare program affects many people and represent a sizable portion of total medical expenditures.

Like so many government programs, the limiting fee provisions of PPR are yet another example of Washington's "hidden secrets." Several months ago we gathered to discuss the Qualified Medicare Beneficiary Program. We learned that most of the individuals qualified for the program were not enrolled. Now we learn that many senior citizens are paying medical bills in excess of the limiting charge. This must stop. We need to educate beneficiaries and ensure that medical providers don't accept excessive payments.

The problems with PPR are numerous. The solutions are not always easy. It seems to illustrate the importance of the fact that health care reform must include Medicare and Supplemental Insurance policies.

Before calling for our first panel, Senator Burns.

STATEMENT OF SENATOR CONRAD BURNS

Senator BURNS. Thank you, Mr. Chairman.

We're all sort of saddened with the passing of Sam Walton. I had the opportunity to sit down and talk to him one time. I said, Sam, if you had some advice to a young person on how to be successful in life, make some money and hang on to it, in a line what could you tell that young person? He said, only sign checks on the back. [Laughter.]

He was a great American, a great entrepreneur and he will be missed.

As we start these hearings today, there is no doubt about it that Medicare and, of course, medical services acts as the cost of it is high on the minds because of the number of meetings that are being held here in Washington and also in our respective States. We've had a couple of meetings in our State and we still continue to discuss and see a few of those problems bubble to the top—when you talk about administrative costs, prohibitive medical liability, the health care services performed strictly for defensive means.

Then there is what we are looking at today, fraud and abuse of the Medicare system. I would imagine that if we went through all of the systems and programs in this government, we could find probably 25 percent of our outlay is tied up in fraud. We've looked at this before, Senator Cohen, as we've worked in this Committee as beneficiaries are charged for services not rendered, as durable medical equipment companies bill Medicare exorbitant amounts for the simplest items, but this is a new focus and it's called balanced billing.

We've talked to folks out in Montana about this and have found through many groups that this is not perceived to be a problem in our State of Montana. Some physicians did acknowledge that they knew of colleagues who had overbilled but only once. Once they were made aware of the regulations and the limits, they did not overcharge again. Even the carrier admits that the few times it has been detected, it has been unintentional.

I think you made a good point a while ago. They just haven't been told and the forms do not remind them of the law. I've talked with the regional office of HCFA and we've found there have been no investigations conducted of violations reported in my State related to balanced billing.

Now, perhaps it's because beneficiaries are not aware that they have been overcharged and that's possible, but if that's the case, then the numbers should be minimal.

Have you ever seen the amount of paperwork that the Government sends health care providers. If they manage to get through the 3-inch thick document explaining all the new regulations of HCFA, they are lucky, but to then try to keep up with the changes is almost prohibitive. The modifications are updated monthly, weekly and it doesn't surprise me that there aren't a lot more slipups than there already are.

If there is anything in this system that cries for reform, that is let's get through this paperwork, let's template some of this stuff and get on with the business of electronically transferring the information and also transferring the funds.

I think we need to encourage the physicians to accept Medicare. From what I understand, the letter that is sent to nonparticipating physicians who have overcharged is not only stern, it's aggravating. Perhaps more appropriate would be a warning rather than a threat. As you know, bureaucrats like to threaten.

Because in most of the offices, the physician doesn't get involved in the billing, his staff does, he may be unaware of any discrepancy whatsoever. We need to have some sort of intermediate intervention that would be less drastic than some of the sanctions that are now in force.

So, Mr. Chairman, I realize that some of the States may have some real problems with physicians who knowingly and willfully overbill on a continual basis. Fortunately, Montana is not one of those States, but I don't think any industry is free of this kind of abuse and we do need to crack down on the offenders, protect the beneficiaries, and help the physician who is doing his best within his means to provide quality health care to his patients.

I congratulate you and Senator Pryor for these hearings. I look forward to hearing from our witnesses, and hope that maybe we can find a sane and moderate solution to this.

Thank you very much.

Senator COHEN. Thank you very much.

The first witnesses we are going to hear from today will describe their personal experiences with overcharges on their medical bills. First, we're going to hear from David Lee of Sag Harbor, New York, and then Stanley Lipson of Bayside, New York and finally, we will hear from Susan Stayn of the Medicare Beneficiaries Defense Fund, a Medicare advocacy group in New York which brought a class action suit against Secretary Sullivan on behalf of Medicare beneficiaries to enforce the existing limiting charge law.

Mr. Lee, why don't you begin?

STATEMENT OF DAVID LEE, MEDICARE BENEFICIARY

Mr. LEE. Good morning, gentlemen.

My wife was taken sick about 2 years ago and over the period of 2 years, we racked up bills getting close to $100,000. Most of this was paid by Medicare. All of the hospital bills were paid by Medicare. I'd just like to throw one little aside in this. When I complained to one of the hospitals about the fact that I was still paying $800 for the room as well as paying $2,500 for the special section in which she was, they said, what are you worried about, insurance is paying for this. That bugged the hell out of me to start with.

Anyway, this one particular bill which really got my dander up was one that came from one particular doctor for $4,863. That was the billed amount. For Medicare benefits such as the form you had there, Senator, I was told that this was a $1,714.80 procedure for which I was going to get reimbursed $1,371.84, leaving a balance of $3,392.20 for me to pay.

I complained to Medicare and asked for a review. The review came back—this is supposedly English—"When two or more surgeries are done on the same day, the one with higher allowed charge is paid for 80 percent of the amount approved. The allowed charge for the other procedure is adjusted to 50 percent of the amount approved." So if you're unfortunate enough to have to have two procedures done, tough.

Medicare pays what the law allows. The claimant pays the deductible each year. After that, Medicare pays 80 percent of the allowed charge. The allowed charge is the lowest of the following: one, the actual charge for the service; two, the customary charge—this is the median charge and it falls in the middle of the highest and lowest charge the doctor made for the service during the prior 12-month period or the prevailing charge. We use the amount that three out of four doctors with the same specialty charge for this service. Congress limits the yearly increase to the change in economic index.

The first paragraph of this, as you asked, we have reviewed the amounts paid on the above claim. A trained person made a new review of your claim. This person did not take part in making the first decision. Based on this, we found the first decision to be correct. Yes, Mr. Lee, go ahead, pay the $3,300.

As you said, no where does it say, hey, doctor, 115 percent in New York State. Do a little mathematics, very simple, push three little buttons on the calculator and you've got 115 percent of the amount that Medicare allows.

Fortunately, I came across the advocacy group, Medicare Beneficiaries Defense Fund and spoke to Susan, sent her a copy of all of the papers, and in a matter of just a few short weeks, I was reimbursed for the amount which I had paid over and above the allowed amount.

I have a rough idea what's going on in the world, but I visualize little old ladies who sell their houses to pay these exorbitant bills without realizing that they don't have to pay them. The whole story here makes one think, this is what I've got to pay, sit back, swallow hard, sell what you have and manage.

I wrote a letter to Medicare, Correspondence Control and Support.

Attached, please find paperwork pertaining to procedures performed by the doctor on March 21st. The amount charge to me by the doctor and the amount reimbursed to me by Medicare do not seem to have any relationship. The charge is $4,863; the reimbursement is $1,371.84 plus $187.60 for a total of $1,714.80 of which I got $1,500. This is about one-third of the bill. Is there not a limit as to how much a doctor can charge for a specific procedure? I am naive regarding the manner by which these determinations are made and need an explanation.

I called a little while later on August 23 to an 800 number and the lady said to wait. Well, during that interim period, fortunately I heard of Medicare Beneficiaries Defense Fund and managed to take care of this. It would be so simple on these forms to stamp in red, hey, doc, 115 percent or 120 percent or whatever State you're in. It's very, very simple. The people have to know that if they don't get that message to the doctor, they have some place to go to try and get this money back.

Nobody is complaining about the fair amount paid, but we feel like we are not Medicare patients, we are Medicaid patients looking for welfare. We're not. This is the money I've been paying into Social Security since I came here in 1948. This is the money that supposedly is paying those bills.

If, in fact, the fair amount by four doctors is $4,863, why the hell is Medicare only paying $1,700? These things have got to relate to each other somewhere, Senator.

I thank you very much for the opportunity to come down here and blow my cork. Thanks very much.

[The prepared statement of Mr. Lee follows:]

TESTIMONY OF DAVID J. LEE

My wife Vera Lee suffered from Breast Cancer about 13 years ago and underwent radical surgery and large doses of radiation.

All went well for many years until gradually she began to suffer from weakness and shortness of breath. It was determined that her pericardium had hardened from the radiation and aging and that surgery was necessary. A window was cut in the pericardium and thoroscpies were performed.

About 6 months later a very bad infection appeared and more surgery was needed to remove her collar bone and top right rib. This necessitated plastic surgery, not for cosmetic reasons but to cover the area where the surgery had been performed.

I had not been checking the numbers on the invoices as I was involved in caring for my wife and learning how to run a household. Prior to her sickness I had never run the washing machine or shopped or taken care of a myriad of things which had always been done without my realization.

Anyway, when I received a check for $1,527.20 from Medicare and saw that it left a balance of $3,335.80 for us to pay, I broke into a sweat. I wrote a letter on July 8th to "Medicare Correspondence, Control & Support" and received a reply on or about October 1st stating that a second review had been done and that "The Prevailing Charge" was correct and we did in fact owe the amount stated. I sent a copy of my letter to the physicians billing service and received no reply.

At this point, I felt a great deal of frustration and sent a partial payment in silent protest hoping to stir up a contact, to no avail.

Some time in the fall I heard of an advocacy group in California who might be able to relieve my smouldering anger and possibly recoup some funds. I called them and was very fortunate in being told of the Medicare Beneficiaries Defense Fund in New York. I called them and had a long conversation with Susan Stayn who is their program director. I sent the attached letter and papers to her on December 30th 1991.

On or about January 16th, I heard from Susan who told me of her success. We had been overcharged $2,000.00 on a bill which should have been $1,072.02 not $4,063.00 and recompense was made. How many people not as persistent as I was are owed how much wonder because they haven't heard of M.B.D.F.?

Senator COHEN. Mr. Lee, we're going to come back to you with questions in a moment.

Mr. Lipson.

STATEMENT OF MR. STANLEY LIPSON, MEDICARE BENEFICIARY

Mr. LIPSON. My name is Stanley Lipson and I live in Bayside, New York. I am 68 years old.

I appreciate the committee's invitation to testify at this hearing because this limiting charge law really confuses a lot of seniors.

The way things currently work, this law is costing us more money than we should have to pay when we need medical attention. I hope my experience with a doctor's overcharge of more than $1,000 will help Congress to understand that we senior citizens find it almost impossible to obtain help when we overpay our doctors.

In January of last year, I had prostate surgery performed which my doctor billed more than $2,300. When I received my explanation of benefits statement with my check from Medicare, I couldn't believe it. Medicare approved little more than $1,100 for this service and the explanation of benefits said I owed Dr. Barbaris the difference between this bill and Medicare's payment.

According to Medicare, I owed in excess of $1,400. That's a lot of money for me. By the way, I still work part-time as a piano tuner. I'd have to tune a hell of a lot of pianos for that kind of money and that's what helped me to be as persistent as I'll explain before I go on.

Before I paid Dr. Barbaris, I wanted to make sure I really owed everything the Medicare form said I owed. I began what turned out to be a wild goose chase for accurate information and useful assistance. First, I called Social Security. I must have called Social Security 25 to 30 times at different intervals. Social Security referred me to Medicare and the Department of Fraud and Abuse.

When I called the Department of Fraud Office I was told to call my Medicare carrier. When I called Medicare, I was told to call my doctor to find out what I really had to pay. I contacted my doctor, but he said—whenever I say my doctor, by the way, that's his office—that his $2,300-plus fee was allowed under Medicare. I was getting so frustrated I just ended up paying the doctor.

Somehow I finally found out about the name of the law, the Omnibus Reconciliation Act of 1989. When I learned that it had gone into effect in 1991, I called my doctor again. I was told that they found out about his new limiting charges on January 26, 1991 and then entered his new fees in the computer. Since my surgery was performed on January 7, I had missed out. I was out of luck by more than $1,000.

I told my doctor that no law goes into effect on the 26th of a month when it was passed 2 years earlier. Besides, I said, the law goes into effect when it becomes law, not when one discovers the law. The doctor insisted that he was in the right.

I again tried calling Medicare or Social Security, I don't remember which. I asked to speak to a supervisor. When asked why, I said I wanted to speak to someone familiar with the Omnibus Reconciliation Act. The person asked me to hold, then she came back and again asked me why. I told her I thought I had been overcharged by a doctor and wanted verification. After holding for some time, I was told she had checked on the overcharge and I was correct. I asked her to send me a letter to that effect. I was left holding again. Finally, she said her supervisor said they are not allowed to do that.

I made more calls to find out where I could get a copy of the Omnibus Act. I was told any large library would have it, not so. I was planning to see the doctor and needed some documentation as to what I was building my case on. I found out that I would have to go to a special place that was a depository where U.S. Government documents are held.

Then I heard New York State had a stricter balance billing law which the State Department of Health is supposed to monitor. That run-around was even worse, no information at all. One phone led to a referral of another phone number and so on.

I started all over again. I called my Medicare carrier and was told to write to a special correspondence office in Peekskill, New York. I had written there twice already and received no reply. I asked for the Peekskill phone number, but was told it is a private number and only can be reached by writing. I pleaded to talk to a supervisor and was told to be patient since it takes 3 months to get a reply from that office.

I told the Medicare carrier representative I had waited 3 months twice already and received no answer. I said, please help me. She told me to hold. When the representative returned, she said, Medicare had only received one letter from me and that was in the process of being answered. It never happened, I never got a reply.

I did not know where else to turn. I had nothing to show for my dozens of calls and written requests for information or assistance from Social Security and Medicare. I heard about Medicare Beneficiaries Defense Fund in New York City and called as a last attempt to get back my $1,000-plus.

They asked me for the pertinent facts and my doctor's name and phone number. I had a check for $1,062.80 in 3 days. I can't emphasize enough how important it is for the Government to enforce this law actively. I think doctors know about their legal limits. Most subscribe to medical journals as well as the American Medical Association to keep them informed. Disciplinary action should be taken against those who are supposed to be monitoring doctors' charges as well as Medicare, who are keeping the lower echelon of employees in the dark about the law.

Steep fines for doctors who overcharge would help. Educating the public as to their rights and recourse is also essential. I began to feel after all this that it is possible, you don't have to have a ski mask, you can have a scalpel and do the same thing to people.

Senator COHEN. Thank you very much, Mr. Lipson, for your testimony. We'll come back to you in a moment.

Ms. Stayn.

STATEMENT OF SUSAN STAYN, PROGRAM DIRECTOR, MEDICARE BENEFICIARIES DEFENSE FUND

Ms. STAYN. My name is Susan Stayn and I am the Program Director at Medicare Beneficiaries Defense Fund, a nonprofit organization that promotes and protects the rights of older and disabled adults on Medicare.

In the last 6 months, we at MBDF have helped more than 200 Medicare beneficiaries in 18 States to understand the limiting charge law and obtain refunds from their doctors where appropriate. We are grateful to Senator Pryor and Senator Cohen for inviting us to share our experiences as a direct services Medicare advocacy group with the Committee.

The limiting charge law was intended to reduce the amount elderly and disabled Americans spend on medical care by allowing physicians to charge no more than a fixed percentage above Medicare's approved charge for their services. Unfortunately, the Health Care Financing Administration's failure to enforce this law properly is undermining the good intentions of Congress.

As you heard from two of our clients, Medicare beneficiaries are paying thousands of dollars in out-of-pocket health care expenses they cannot afford and should not be paying. Beneficiaries' lack of information about the law is one part of the problem. We have spoken to more than 1,000 senior citizens in New York City and only a tiny percentage have heard about the law. Even those aware of the law are unsure of how it applies to their individual cases. When they seek help from their Medicare carrier, satisfactory answers are extremely difficult to obtain. Phone lines are frequently busy, letters often lost, and responses received are usually, in fact, unresponsive.

Educating beneficiaries alone will not solve the problem. Active enforcement of the limiting charge law is badly needed. Many doctors require that patients pay up front before services are provided. Other doctors ask beneficiaries to sign waivers under which the beneficiary agrees to pay for all services that Medicare does not cover.

Unless there is a reasonable basis for believing that Medicare does not cover the service, these waivers are illegal. However, judging by the cases we have handled, many beneficiaries do not know that the signed waivers are unenforceable. Many pay their doctors' full charges promptly because they are primarily concerned with getting the ongoing care they need.

Medicare patients who overpay for medical care frequently find themselves caught between the Medicare carrier and their doctors. Beneficiaries who successfully contact Medicare are often told to resolve apparent overcharges with their doctors. Doctors, in turn, often advise that Medicare has underpaid for the services. Unfortunately, beneficiaries who have paid thousands of dollars out of pocket find no further recourse from Medicare available.

Elderly and ill patients on Medicare do not want to confront their doctors whom they trust and depend on for further care and they should not have to. Probably everyone here has a parent, older relative, or friend who has been ill. These patients simply want to improve their well-being and worry that challenging their bills could adversely affect the quality of care they receive.

Many seniors are accustomed to paying their bills on time. Leaving thousands of dollars in outstanding expenses pending takes a major emotional toll on them. Moreover, even we who are equipped to assist beneficiaries in obtaining refunds for overcharges are encountering significant obstacles.

Eight of MBDF's clients are or were cancer patients at Memorial Sloan-Kettering Hospital in New York City. Collectively, these eight patients have more than $80,000 in Sloan-Kettering bills, of which Medicare has approved a small percentage. Our clients supplied us with their bills and asked us to contact Sloan-Kettering on their behalf. We provided Sloan-Kettering with a release from the patients and asked for an explanation of the hospital's charges. Even with the beneficiaries' written permission in hand, the hospital has continued to be uncooperative. Several of the cases are still unresolved.

Active enforcement of the limiting charge law is urgently needed so that older and disabled Americans on Medicare can obtain the medical care they need. The Health Care Financing Administra-

tion has made some recent corrective gestures, but to date, these have been insufficient.

First, at a minimum, beneficiaries need accurate information regarding limiting charges on their explanation of benefit forms. I would like to submit for the record a copy of the proposed new EOMB which MBDF obtained from a Medicare carrier in New York last week. HCFA removed some but not all of the misleading language.

Copy

This is not a bill

Explanation of Your Medicare Part B Benefits

NEW YORK, NY 10012-1605

Summary of this notice dated March 19, 1992		
Total charges:	$	2450.00
Total Medicare approved:	$	1363.49
We are paying you:	$	1093.46

Your Medicare Number is:

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

Claim Control Number 92044-0502-39-000

You received these services from your provider: FRANCIS X MENDOZA, Mailing Address:
159 E 74th St, New York, NY 10021

Services and Service Codes	Dates		Charge		Medicare Approved	Note
Repair of Shoulder (23420)	Jan. 16, 1992	$	1985.00	$	1363.49	a
Partial Removal, Collarbone (23120-51)	Jan. 16, 1992	+	465.00	+	0.00	b
	Total	$	2450.00	$	1363.49	

Difference between charges & total amount approved		
	$	2450.00
	—	1363.49
	$	1086.51

Your provider(s) did not agree to accept our approved amounts. If these services had been assigned, you could have saved $621.51. We are paying you directly for the amount that we owe you. Your provider(s) can bill you for these services. (See #4 on the back of this notice.)

Notes:

a The approved amount for this procedure is based on the Medicare fee schedule.

b Medicare does not pay for this service because it is part of another service that was performed at the same time. You cannot be billed separately for this service.

(continued on next page)

IMPORTANT: If you have questions about this notice, call Medicare Empire Blue Cross and Blue Shield at (516) 244-5100 (toll free 1-800-442-8430) or see us at 622 Third Avenue, New York, N.Y. You will need this notice if you contact us.
To appeal our decision, you must WRITE to us before SEP. 19, 1992 at Medicare Part B, P.O. BOX 2280, Peekskill, NY 10566-0991. See #2 on the back. (000-0001371)

In this example, Medicare approved less than $1,400 for a doctor's total charge of $2,450. The new Medicare statement tells the beneficiary, "if these services had been assigned, you could have saved $621.51." It goes on to say, "Your provider can bill you for these services." It is unclear to me from this form, let alone to an elderly or disabled Medicare patient, what the beneficiary truly owes. To be clear and accurate, the form should list the precise limiting charge for the services. Without this corrective action, it appears that beneficiaries in 1992 will still be advised in writing to pay their full doctor's charges, even when the fees exceed the legal limits.

Second, and perhaps more importantly, Medicare carriers still refuse to assist beneficiaries with obtaining refunds for overcharges. Over the course of the last few days, MBDF has made more than a dozen attempts to call Medicare carriers in New York State. We presented apparent overcharge cases based on real beneficiaries' records. Every time but one, the Medicare carrier staff advised that it could not assist with obtaining a refund. The responses ranged from, "It's not my department" to "You'll have to pursue the matter with the doctor yourself." Even the most helpful representative advised me that only after I unsuccessfully pursued the matter with the doctor would Medicare review the matter and possibly write to the doctor.

In closing, MBDF recommends the following four steps. One, the EOMB should list the precise limiting charge. Two, if a doctor overcharges, the Medicare carrier should send the doctor a copy of the EOMB with a letter requesting a bill adjustment or refund if appropriate. The beneficiary should be informed on the EOMB that the doctor has been notified of the overcharge and the doctor is expected to adjust the bill within 30 days. Three, a technical amendment to the law should be passed to provide explicitly that beneficiaries who are overcharged are entitled to refunds, regardless of whether the overcharges are repeated or intentional. Four, the HCFA should monitor doctors' compliance with requests for bill adjustments and refunds and impose sanctions against doctors who intentionally and repeatedly violate the law.

Older and disabled adults cannot and should not shoulder the burden of enforcing this law.

I appreciate the committee's time and attention and I welcome your questions.

[The prepared statement of Ms. Stayn follows:]

STATEMENT OF
MEDICARE BENEFICIARIES DEFENSE FUND
TO THE
SENATE SPECIAL COMMITTEE ON AGING

Diane Archer, Executive Director
Susan Stayn, Program Director

Medicare Beneficiaries Defense Fund is a non-profit organization dedicated to promoting and protecting the rights of the elderly and disabled on Medicare. Over the last six months, we have assisted more than 200 clients in 18 states with understanding and enforcing federal and state limits on physician charges to Medicare beneficiaries. Our attempts to enforce the limiting charge law have convinced us that the law needs substantial revision in order to be effective.

The limiting charge law was intended to reduce and limit the resources that elderly and disabled beneficiaries on Medicare spend on vital health care by limiting a doctor's charge to a fixed percentage of Medicare's approved charge for his or her services. Medicare informs doctors of the limiting charge for individual procedures they commonly perform. Because Medicare applies a complex set of reimbursement policies whenever doctors perform multiple procedures, however, doctors often exceed their limiting charges without necessarily realizing they are doing so.

Unfortunately, the federal government has taken virtually no steps either to inform beneficiaries about the limiting charge law or to enforce the law. Moreover, the limiting charge law places an undue burden on beneficiaries to ensure that they are not overpaying their physicians. As a result, the limiting charge law provides little benefit for hundreds of thousands of Medicare beneficiaries across the country.

In order to clarify the breadth of the overcharge problem that many of our clients face, we offer two examples of beneficiary overpayments that have yet to result in complete refunds. Both cases involve cancer patients who are being treated at Memorial Sloan-Kettering Hospital in New York City.

Mrs. S received medical services at Sloan-Kettering for which she was billed $6700. Medicare approved $2855 for the services. She paid the hospital charges in full for fear that if she did not do so she would not receive necessary follow-up and life-sustaining treatment from her physicians. When she learned about the limiting charge law, she approached the Sloan-Kettering billing department and requested a refund of all payments that exceeded the limiting charge for the services she received. The Sloan-Kettering billing department refused, claiming that the doctors had not overcharged and that Medicare had underpaid for the services she received. When Mrs. S called Medicare for assistance, Medicare confirmed that Sloan-Kettering had unlawfully overcharged her for her physicians' services but that Medicare would not help her to obtain a refund and, indeed, do anything whatsoever to assist her.

Mrs. S then turned to Medicare Beneficiaries Defense Fund for assistance. We have been working on Mrs. S's case -- and requesting refunds from Sloan-Kettering -- for two months. To date, we have succeeded in reducing her bills by almost $1500; based on her Explanation of Medicare Benefits ("EOMB") forms, however, we believe that she has been overcharged by an additional $1900. Sloan-Kettering continues to assert that Medicare did not pay as much as it should have for Mrs. S's physician services even though Mrs. S did not receive any additional benefits when she sought a review of her Medicare payments. We are still working to encourage Sloan-Kettering to comply with the limiting charge law and to issue an appropriate refund to Mrs. S. If Sloan-Kettering refuses to cooperate with us, however, the current statutory scheme contains no means of requiring Sloan-Kettering to provide Mrs. S with the refund she is due.

Sloan-Kettering billed Mr. T more than $35,000 for his cancer treatment. Medicare approved less than $10,000. While Mr. T suspected that he had overpaid the hospital, he received so many bills from Sloan-Kettering that he could not calculate the appropriate limiting charge for his treatment. Afraid to contact the hospital directly for fear of alienating his doctors, he called us for assistance.

After reviewing the sea of bills he received, we, too, could not determine how to calculate the precise amount of his overpayment. We contacted Sloan-Kettering for assistance. Although we had all of Mr. T's papers and were simply asking for a clarification of his bills, the physician billing department refused to speak with us until it obtained a complex written release from Mr. T. After Mr. T hand delivered this written release, however, Sloan-Kettering continued its refusal to make a reasonable effort to help us understand its specific charges for Mr. T's treatment.

Despite this lack of cooperation, we were able to determine that Mr. T's bill contained several obvious overcharges, for which we demanded a refund. In response, Sloan-Kettering has thus far reduced its charges to Mr. T by approximately $10,000. Although we believe that our client has still paid Sloan-Kettering several thousand dollars in excess of the legal charge limits, Mr. T simply does not have the energy to continue fighting the hospital in light of his terminal condition. So, too, our client does not want us to report this matter to Medicare or the Office of the Inspector General for fear of jeopardizing his care and his relationship with his doctors. But even if he permitted us to report Sloan-Kettering, we wonder whether either agency could determine whether it was appropriate to take action on his behalf given the complexity of his bills.

These examples illustrate three problems with ensuring that beneficiaries do not overpay their doctors under the limiting charge law: 1) beneficiaries often lack adequate information to know whether and to what extent they have been overcharged; 2) beneficiaries fear confronting their doctors over the limiting charge law because doing so could jeopardize vital medical relationships; and 3) Medicare carriers and the Health Care Financing Administration ("HCFA") are not adequately enforcing the law. We address each problem in turn.

1. <u>Lack of information</u>

Many beneficiaries still do not know about the federal charge limits. We have addressed more than 1000 beneficiaries in the last six months, but only a tiny percentage even knew there are legal limits on their doctors' charges. Even those aware of the charge limits, moreover, do not know how to apply the law and thus cannot calculate how much their doctors may charge them under the law. Obtaining accurate limiting charge information is difficult and sometimes impossible.

Even with limiting charge information, beneficiaries often have no way of determining whether their doctors have charged them for specific services that Medicare does not cover and for which beneficiaries do not have to pay. We have handled a number of cases in which doctors charge separately for several procedures and Medicare only approves a portion of the doctor's charges. The Explanation of Medicare Benefits form explains that some billed procedures are incidental to other procedures and therefore are not separately reimbursable. In these cases, it is impossible for a beneficiary to know whether the doctor improperly charged for the purported incidental procedure or whether Medicare erroneously denied payment.

For example, a doctor might charge separately for setting a broken arm and for putting a cast on the arm. However, Medicare only pays for setting the arm because the cost of the cast is included in the bone setting fee. In this example, the doctor might innocently claim that he did not exceed legal charge limits because he billed the proper limiting charge for both the setting and the cast. If Medicare allowed the doctor to bill patients for each of these procedures, he would be correct. Medicare does not, however, permit doctors to bill separately for the casting fee. Without assistance, beneficiaries would not know that their doctors have overcharged them in this class of cases.

We believe that this information problem could be addressed, in part, by a redesigned Explanation of Medicare Benefits form that clearly states the maximum amount a doctor may charge for the procedures he or she has performed. Supplied with this information by Medicare, beneficiaries could more easily protect their rights under the limiting charge law by requesting a refund for the specific overcharge stated on the EOMB.

Even this solution, however, is inadequate because it burdens beneficiaries with handling adjustments of their bills and obtaining refunds when they have overpaid. Doctors in New York, for example, often ask beneficiaries to sign waivers under which the beneficiary agrees to pay for all services that Medicare does not cover. Unless there is a reasonable basis for believing that Medicare does not cover the services, these waivers are illegal and unenforceable. In most cases, however, beneficiaries who sign such waivers erroneously assume they are liable for all physician charges.

Even if the physician does not obtain a waiver, it is unrealistic to assume that sick and elderly beneficiaries have the knowledge and expertise to challenge physician overcharges under the law. If they have paid up front, they will have difficulty obtaining a refund. If they have not paid up front, they will often face collection agency notices. In either case, most beneficiaries will simply pay whatever their doctors charge. Accordingly, for the limiting charge law to work, the statute should contain some enforcement mechanism other than beneficiary demands.

2. Beneficiary fear of confronting their doctors

The second problem with the limiting charge law as it currently operates is that the law pits patients against their doctors. Many Medicare beneficiaries are not physically or emotionally equipped to confront their doctors about overcharges. For most elderly and disabled persons, their doctors are their lifelines. They would not consider jeopardizing that relationship by questioning their doctors' bills, let alone referring overcharge complaints to the Inspector General.

In addition to Mrs. S and Mr. T, we have six clients who either were or are cancer patients at Sloan-Kettering. They are entirely dependent upon receiving treatment at Sloan-Kettering. As indicated in our discussion of Mrs. S and Mr. T, however, the patient billing department at Sloan-Kettering appears not to recognize the limiting charge law, at least with regard to our clients. Often their doctors' charges are three to ten times higher than Medicare's approved payments -- in other words, the charges are as much as 1000% higher than the amount Medicare recognizes. But even our clients who live on small fixed incomes would rather scrape up the money to pay the hospital than report the hospital for investigation. Their lives are on the line.

To make matters worse, many doctors obligate their patients to pay up front, long before the patients know their doctors' limiting charge. Some doctors even refuse to file Medicare claim forms until the patient pays the bill in full. And patients who must revisit their doctors are often led to believe that their doctors will refuse to continue treating them if they do not pay up.

A practical solution to this problem would be for Medicare to program its computers to compare the amount billed against Medicare's approved charge. When the billed amount exceeds 120% of Medicare's approved charge, Medicare carriers should send doctors a copy of the EOMB (which they do not currently receive), along with a letter notifying them that they have charged in excess of their legal limit and instructing them to refund the overcharge to the beneficiary. Medicare should further notify the beneficiary on the EOMB that it has contacted the doctor and instructed the doctor to refund the overcharge. We believe that the overwhelming majority of doctors would correct overcharges and issue refunds once notified. If the beneficiary does not receive a refund within thirty days of this notice, Medicare should refer the physician to the Office of the Inspector General for investigation and possible prosecution under the statute.

3. Government's failure to enforce the limiting charge law

To date, HCFA has failed to enforce the limiting charge law when notified of doctor overcharges. HCFA currently maintains that the law does not entitle beneficiaries to a refund when they overpay their doctors. At the same time, however, HCFA concedes that beneficiaries do not owe their doctors more than the limiting charge. To our mind, if it is illegal for a doctor to overcharge a patient, and the beneficiary does not owe the doctor more than the limiting charge, the patient must be entitled to a refund.

HCFA and the Medicare carriers' enforcement of the limiting charge law on a case by case basis is critical to making the law work. If the law is designed to protect beneficiaries from paying more than 120% of Medicare's approved charge, the government must require doctors to refund all amounts patients pay in excess of the legal charge limit. Anything less makes the limiting charge law an empty promise.

Doctors may unwittingly overcharge their patients because they do not know what Medicare will ultimately approve for their services. Indeed, this is frequently the case for surgeons performing complex procedures. Under HCFA's current interpretation of the statute, however, doctors who unintentionally exceed their charge limits have not violated the law and do not owe their patients any refund for their

overcharges. This interpretation plainly ignores the spirit and intent of the limiting charge law. These doctors should not be subject to sanctions, but they should not be able to charge more than the legal limit for their services.

We believe that Congress should pass a technical amendment to the limiting charge law expressly stating that beneficiaries are entitled to refunds in all cases in which doctors' exceed their legal limits. The government should obligate doctors to refund overcharges within thirty days after the date they receive notice of an overcharge from Medicare. If a doctor disputes the overcharge within the thirty-day period, the government should be obligated to resolve the dispute within thirty days, after which the doctor should be obligated to issue any remaining refund to the beneficiary.

A doctor who fails to make a refund within the enumerated time limits should be subject to sanctions such as civil money penalties and/or exclusion from the Medicare program. This proposal is analogous to the regulatory structure governing doctors charges for procedures which Medicare deems unreasonable and unnecessary.

In closing, we would ask that you recognize the difficult position of the beneficiary when considering revisions to the limiting charge law. Under the current system, beneficiaries must pay for the mistakes of both their doctors and the Medicare program. If their doctors do not adequately complete the claim form or if Medicare erroneously processes their claim -- as it all too often does according to HCFA statistics -- beneficiaries are not adequately reimbursed and overpay for physician services. For the limiting charge law to work properly, beneficiaries should not be liable for either their doctors' or Medicare's mistakes.

We are grateful that you have given us the opportunity to provide testimony on this subject.

Senator COHEN. Thank you very much, Ms. Stayn. Thank all of you for your testimony this morning.

I must say, in looking at this form that is sent out, "Explanation of Medicare Benefits," were I not a member of the Committee, I would have no idea what they were talking about.

Mr. LEE. It takes about 2 years.

Senator COHEN. How long, Mr. Lee, have you been dealing with Medicare? That's not a way of finding out your age.

Mr. LEE. It took about 2 years before I became cognizant of how this thing works and I still really don't know. One of the things I should point out—I don't know if this is self-preservation or what—I had no problems with the local doctors whose offices do their own billing. I find that most of the problem, as far as I was concerned, was with hospitals where they have physicians' billing services. I don't know whether the doctor actually sees what is billed, whether he gets a piece of what the physicians' billing service collects from the patient. There may be some slippage there. I'm not saying there is a scam. If there is not a scam, then there is a hell of a lot of carelessness involved that has to be straightened out.

I had another one that I haven't even brought to Susan's attention. It was an ambulance ride from Southhampton Hospital to New York. I couldn't get the local volunteer ambulance; they were out on another couple of calls.

The man came with the ambulance and asked for my credit card on which he put $715. I sent the bill in to Medicare, which again I point out is not welfare type thing, it's my money they're giving back to me, and was told it's a $300 ride, we'll give you $240. I don't know if this is covered by this limitation or if it's just for physicians' services.

This is really taking advantage of somebody who is in a rather precarious position and you're not going to say, hey, I'm going to try somebody else. I just can't afford to pay another $400 for an emergency ride into New York.

Those are some of the things and I started to go through some of the other doctor bills and I have a stack about this high, and I find that mostly it is where there is somebody other than the doctor's office doing the billing. The other ones are right to the penny where they've taken a calculator evidently and multiplied it by 115 percent, and that's what we got billed for.

Senator COHEN. This form, this "Explanation of Medicare Benefits," is really quite confusing. It says, for example, "Participating doctors and suppliers always accept assignment of Medicare claims. See back of this notice for an explanation of assignment." Then down below in bold print, it says, "You are responsible for a total of $2,939.84, the difference between the billed amount and the Medicare payment. You could have avoided paying $2,874.80, the difference between the billed and approved amounts if the claim had been assigned." How could you have avoided the payment of that—theoretically, by picking a "participating doctor" or "physician?"

Mr. LEE. Yes. We have to go shop around.

Senator COHEN. So, you've got to shop around. Maybe I should explain how this all came to be.

We have a situation where if you are a "participating doctor," you basically agree to accept the Medicare reimbursement as pay-

ment in full. That's not quite accurate. It's not payment in full because you're still responsible for 20 percent, so payment in full means payment except for the 20 percent which is your co-payment.

About 52 percent of all the physicians in this country are "participating physicians." They accept Medicare reimbursement as full payment minus 20 percent. The patient is responsible for the 20 percent.

Other doctors, who are not participating physicians but who nonetheless accept Medicare patients, may accept assignment on a case-by-case basis. They are called "nonparticipating physicians." Historically, they have been reimbursed by Medicare for the approved Medicare amount, but have held the patient responsible for the full amount of the actual charge. It could be $1,000, $2,000, $5,000, whatever the physician wanted to charge.

Congress then decided to put limits on what physicians could charge Medicare patients. In all fairness, if you're going to participate in this program, there have to be limits. We had a previous limitation called the "maximum allowable actual charge," the so-called MAAC, which we changed in 1989 in the Omnibus Reconciliation Act.

I was amused, Mr. Lipson, that you were sent to find the Omnibus Reconciliation Act. If you found it, please tell me if you could ever figure out what was said in it because we can't, so I'm not sure that would have been much help to you had you found that document which you couldn't locate at the local library.

Nonetheless, in 1989, we made changes in the law saying, wait a minute, we're going to change the Medicare system to put a limit on the amount nonparticipating physicians can charge, and we're going to do this over a 3-year period. We're going to say that nonparticipating physicians are still going to be bound by the limits that Medicare imposes, but we'll allow you 25 percent the first year over and above the Medicare approved amount, 20 percent the second year and in 1993, it will drop down to 15 percent over and above the Medicare-approved amount charge. That's the limiting charge, or balance billing limit.

The problem is that HCFA has been sending out a notice which reflects the old law in that it states that the beneficiary is responsible for the full difference between what Medicare has reimbursed and what the physician has charged. That is what is so irresponsible about the current situation.

I said today on a program on which Mr. Lee and I appeared that it's like pouring new wine into old bottles, corrupting the new wine. Congress has enacted legislation to protect Medicare beneficiaries against excessive medical bills and we should not be putting them in a situation of having to pay these charges which are not legally due.

Further, not only are they often required to pay up front, but according to HCFA, the law is so ambiguous that we are not sure that we have the legal right to seek a refund from the physician for the charge. So the burden of obtaining a refund for any amount he or she may have paid now is placed upon the Medicare beneficiary.

Number one, he or she was not obligated to pay in the first instance. Two, HCFA maintains the law is so ambiguous that it needs clarification that there is a legal obligation on the part of that physician to reimburse the patient for any amount he or she may have overpaid.

Further, the patient should not be placed in the position of demanding a refund from his physician. Patients often have a very difficult time challenging physicians because they are viewed as authority figures. The patient may also want to seek further medical attention from that physician and therefore doesn't dare to raise any question, objection or criticism.

The burden of collecting a refund should not rest with the beneficiary. Ms. Stayn, your recommendations, I think, are quite clear and right. The burden rests with the Government. HCFA and the Medicare carriers are the ones who should be negotiating with the physician, not the Medicare beneficiary.

I'm not sure I have any more questions for Mr. Lee. Mr. Lipson, in this whole process, how did you ever find out about the Medicare law itself? Mr. Lee, you seem to be more familiar than others perhaps but did you ever get the Medicare Handbook that is put out by HCFA?

Mr. LEE. No, I've never seen that. I did hear about an organization similar to Susan's organization in California and I called them and was told about Susan's advocacy group. Of course I got wonderful treatment from them.

One of the things I think is a problem is the problem we had in New York State. The people who make the laws have wonderful intentions, the people who promulgate the rules based on the laws that were passed frequently don't seem to know what the hell the people who made the laws had in mind when they made the laws because there's a lack of relationship between what you do and what finally comes out of the other end of the printing machine.

There is a need for oversight before it is allowed to become public that this is what the law is meant to do. Somebody should look over it again and say, that's not what we passed.

Senator COHEN. First of all, the problem is that this Medicare 1991 Handbook is not sent to all Medicare beneficiaries, only to new enrollees. As a matter of fact, it's not sent to the physicians either. So, Mr. Lipson, there may be some intentional overbilling on the part of some and we'll find out—we've got an Inspector General's investigation underway to give us more information on that—but it's more likely that there's a good deal of confusion because the physicians who are "nonparticipating" don't have access to necessary information either. Some, however, may be taking advantage of the system and we'll find out about that as the evidence unfolds.

Nonetheless, it seems to me that the Government has a responsibility to make it clear to all physicians, participating and nonparticipating, and to all Medicare beneficiaries, exactly what they are entitled to charge and what the obligation of the beneficiary is to pay. We have not done that. That's the purpose of this hearing, to seek recommendations from people who have been afflicted by the confusion in the law.

I'd point out that on this Medicare Handbook, it says, "Don't be confused, there's a printing error in this handbook. The blue titles on the charts on pages 32 and 33 have been erroneously transposed." So not only is it difficult enough to get through the handbook but it says, don't be confused, we've got some errors on the inside as well.

Mr. LEE. I think a great step forward is being made, Senator, by the media picking up, the program we did this morning, picking up what's going on in here today. I think this is going to go quite a distance toward straightening this thing out because people just did not know that there were limitations.

Senator COHEN. Mr. Lipson, can I just ask you one question. How much time elapsed between your first inquiry to your physician and the receipt of the refund that you finally got?

Mr. LIPSON. Close to a year.

Senator COHEN. So you had to come up with that thousand dollars?

Mr. LIPSON. Oh, yes. As a matter of fact, they told me, yes, that I had signed this agreement which they sent to me, but and it's very interesting, they highlighted this and said, "You may contact Medicare for the approved amount of the surgical procedure." They told me I was notified ahead of time. When I called Medicare, they told me I had to get the information from my physician, they couldn't do that.

By the way, I first heard about this in a newsletter called "Personal Finance." There were two sentences about this and this aroused my curiosity even more. To begin, at this stage in life, I found out many years ago you don't trust these hallowed banks, insurance companies, you can't trust anybody, so I tried to find out if I was being charged correctly to begin with, not knowing about this law.

When I found out about that thing, what it mentioned in the newsletter, that's when I started again, then I gave up. Then I happened by chance encountered somebody telling me, one of my friends, had an office procedure done and nobody puts anything over on his wife. They tried to bill him more than he was entitled to. By coincidence, it was another urologist in the same group practice that I had been involved with.

When I called them up and I tried to be tactful, I said, you know, perhaps you made an error on the computer. They said, oh, no, it wasn't. This was the biggest joke of all. I received the Medicare Beneficiary Newsletter which stated what this was all about and when I called up, nobody knew anything about it. It says here, "Nonparticipating physician performed knee surgery in a hospital, the prevailing charge"—and it goes on, the whole thing telling that, so here I have it from them and nobody knows. So I let it lie again. Every time, it was just eating away at me. I just knew I was right.

Senator COHEN. Ms. Stayn, you talked about doctors who insist upon or demand that beneficiaries sign waivers. In your judgment, is there evidence that should be taken into account that this is an intentional practice on the part of those physicians who demand waivers, knowing that they are not only unenforceable but illegal?

Ms. STAYN. I don't know if that necessarily means it is an intentional violation. In our experience, most doctors do comply with the law once we send them a copy of the law and inform them of the apparent overcharge. However these physicians give out the waivers, we believe, to protect themselves. As I explained, these waivers are illegal if they don't give a reasonable basis for believing that Medicare will not cover the services.

Senator COHEN. You claim that the hospital you've been dealing with was unwilling to help the beneficiary calculate the correct cost. Could you give us a little more explanation of that?

Ms. STAYN. Sure. Mr. Lee's wife was treated at Memorial Sloan-Kettering. That was one of our earliest cases at Memorial Sloan-Kettering. The hospital billing department was generally cooperative at that time. As several other clients came to us with complaints about Memorial Sloan-Kettering, the hospital has become significantly less cooperative. They have asked us to submit written releases from the patients allowing the hospital to provide information concerning billing, which we have done as requested, but even after we have submitted those, the hospital continues to insist, in one case, for example, that the beneficiary should continue to appeal the matter with Medicare. The hospital continues to insist that Medicare has underpaid for the services. They also have given us the answer that they are looking into it, but when asked what exactly are you looking into, we could not get a satisfactory response. It's just been delay after delay.

Senator COHEN. Do you think that when there is a refund that is due that interest should be paid on that?

Ms. STAYN. Sure. I think that the priority here is to get the refund of the overcharged amount. Other sanctions may be possible if it was an intentional and repeated violation of the law.

Senator COHEN. There are sanctions available. One sanction would be to exclude that particular physician or hospital from the Medicare program up to a period of 5 years. There is a civil penalty that is also available, a sum of $2,000. I think something on the intermediate level might give an incentive to refund the money quickly, for instance, the imposition of an interest charge.

One final question before I yield. Have you found that overcharges tend to occur more in the hospital setting as opposed to the physician's private offices?

Ms. STAYN. We've received cases on both fronts. I would say that we have had several at Memorial Sloan-Kettering and several other hospital billing departments. In those cases, the quantities involved are usually much more significant, but we have had cases at individual doctors' offices.

If I could, I just wanted to underline one point that Mr. Lee mentioned which is that the issue of resources to enforce the law is critical. When beneficiaries call Medicare, they need to get information clearly and accurately. They can't just get a busy phone line. When our office calls, we get the same thing. That's why we believe it's critical that on the explanation of benefit form, the beneficiary should be able to see the precise amount of the limiting charge.

Senator COHEN. Could I also suggest, as long as we're engaged in the education of the public in terms of what the beneficiary is enti-

tled to, that rather than going around in a circle that those who are watching or listening might also think of calling their Congressman or Senator. Most of us have offices spread out throughout our States and a quick call to our district offices will get the information and assistance to you very quickly.

Senator Burns.

Senator BURNS. Thank you, Mr. Chairman. I have just a couple of questions.

Mr. Lipson, I have a couple of questions for you but first, Mr. Lee, you hit the nail right on the head. This Congress will pass a law, and I would venture to say that none of us will get involved in the rulemaking and those rules are never brought back to Congress and reviewed before they are finally put into effect. I think we'd have a lot of changes in all areas that the government gets into. I wish you'd make that clear every time, every place you go. I happen to believe in that very, very strongly.

If you want to get into another fight, you can get over in the public lands policy and everything else and we turn some person out here that in government is living proof that the "Peter Principle" works, so I want to congratulate you on that.

Mr. Lipson, I want to congratulate you for just staying in there and being tough and finally getting your money back. When you contacted your doctor, was the doctor or the organization aware of this balanced billing, were they aware that they had violated the law?

Mr. LIPSON. My surgery was on January 7, they told me that they were notified on January 26 and immediately put it on their computer as of then.

Senator BURNS. Ms. Stayn, I have some questions for you. How many such complaints do you receive? Do you have any idea how many complaints you handle a year?

Ms. STAYN. As I said, we've received over 200 inquiries about the limiting charge law in the past 6 months alone. I believe that partly because of the recent media attention we've been receiving more inquiries in the last couple of months.

Senator BURNS. Are you a national organization?

Ms. STAYN. We handle cases from across the country, yes, but we primarily provide direct services to beneficiaries in New York City.

Senator BURNS. How do people find you or how do you find your clients?

Ms. STAYN. We deliver presentations to senior citizen centers as well as to senior advocates. The Department of the Aging and State Office for the Aging know about us because we work with them on Medicare cases. We specialize in Medicare, and we've built our reputation on that.

Senator BURNS. How are you funded?

Ms. STAYN. We're funded privately through foundations and contributions.

Senator BURNS. Thank you very much. That's all the questions I have.

Thank you, Mr. Chairman.

Senator COHEN. Thank you, Mr. Lipson, Mr. Lee, and Ms. Stayn for coming before the panel this morning. I think it's going to be very helpful in alerting all Medicare beneficiaries of the nature of

the problem that exists and hopefully, we'll be able to adopt some changes in the law which will clarify the responsibilities of the governmental agencies.

Thank you very much.

Next, we are going to hear from Carol Walton, the Deputy Director of the Bureau of Operations in the Health Care Financing Administration.

STATEMENT OF CAROL WALTON, DEPUTY DIRECTOR, BUREAU OF PROGRAM OPERATIONS, HEALTH CARE FINANCING ADMINISTRATION

Ms. WALTON. Mr. Chairman and members of the Committee, I am pleased to be here today to discuss the Health Care Financing Administration's efforts to monitor limiting charges.

Limiting charges are an important feature of the Medicare physician participation program. Participating physicians agree to accept assignment on all claims and nonparticipating physicians, on the other hand, may accept assignment on a claim by claim basis or they can charge in excess of the Medicare fee up to a limit specified in law.

In 1991, assignment was accepted on 81 percent of claims and 88 percent of the Medicare physician dollars. This leaves 19 percent of the claims and 12 percent of the physician dollars that are unassigned and subject to the limiting charges.

The Medicare charge limits are not new, having been around in some form since 1984. In 1987, we had the maximum allowable actual charge, the MAAC system, that provided limits that were specific for every physician, for every procedure in the country. The MAACs were exceedingly cumbersome and complicated to calculate, to explain and to administer.

The new limiting charges that were enacted as a key part of the physician payment reform replaced the MAACs. There is a 3-year transition period to the new charge limits which began in 1991. During the transition years of 1991 and 1992, the charge limits are still computed using the individual MAACs as well as a decreasing percentage limit. In 1993, the charge limits are simplified and are simply a straight percentage of the fee schedule.

There's been much discussion regarding the extent to which the statute protects beneficiaries from excess charges. We believe that Congress intended that physicians should not charge beneficiaries more than the limiting charge, and beneficiaries are not responsible for paying physicians in excess of the limiting charge. If overcharges occur, carriers ask the physicians to rollback their charges.

While the statute provides us no direct means of requiring physicians to refund excess charges, we have recently instructed the carriers that are not already doing so, to ask the physician to make a refund to the beneficiary.

Let me describe some of our monitoring activities. Each year the carriers send all physicians the limiting charges for each of the procedures that they perform and a letter that explains the limiting charges. Every 6 months, the Medicare carriers review the unassigned claims and identify potential violations of the limiting charges. When violations are identified, the physicians are notified

in writing of the overcharges. Intensified monthly monitoring is used for physicians who continue to overcharge.

When carrier monitoring identifies egregious cases; that is, physicians who knowingly and willingly on a repeated basis overcharge, these physicians are referred for sanctions and civil money penalties that are specifically provided in the law.

The most recent monitoring period for the carriers was July through December 1991. They sent, for this period, 7,200 warning letters, or 1.8 percent of the nonparticipating physicians. In that same time period, second warning letters from the intensified monitoring, went to 373 physicians, and carriers referred 7 physicians to the Office of the Inspector General for sanctioning.

The monitoring data indicate a high level of compliance by physicians to the charge limit. The carriers have found that most of the violations were unintentional billing or coding errors, and I think that the billing errors are not remarkable considering the enormous changes that Medicare physician payment has gone through in recent years.

In 1993, the monitoring process will change to a claim-by-claim review because the limiting charge will no longer be physician specific but simply 115 percent of the fee schedule.

We've recently taken some steps to improve our monitoring and to provide better information to both physicians and beneficiaries. We have recently provided carriers with nationally consistent instructions to improve their responsiveness to beneficiary inquiries. When a beneficiary inquires, we have directed the carriers to provide the beneficiary with a specific charge limit for an individual physician and a particular procedure.

If the information cannot be provided on the phone, it must be made available within 2 days of the inquiry. I believe there are only four carriers today that are not able to give that information on the phone.

Carriers have also deleted from the EOMB the confusing statement regarding beneficiary liability which did not account for the limiting charge restrictions. Language is also being added to the back of the EOMB this month that describes the limiting charge restrictions.

Beginning this summer, we will phase in annotating the EOMB when the limiting charge is exceeded. Physicians will also be notified when their charges exceed the limit. This change will be effective for all EOMBs by the end of this year.

While our monitoring experience indicates that physicians have largely complied with the limiting charges, we recognize the need to be vigilant. We believe our monitoring efforts will be even more effective when the limiting charge transition provisions are complete this January and our plans to do the concurrent review are fully in place.

Thank you.

[The prepared statement of Ms. Walton follows:]

STATEMENT OF

CAROL WALTON, DEPUTY DIRECTOR
BUREAU OF PROGRAM OPERATIONS
HEALTH CARE FINANCING ADMINISTRATION

Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss the Health Care Financing Administration's efforts to monitor and enforce charge limitations. The limits restrict the amount that nonparticipating physicians can charge beneficiaries above the Medicare fee.

BACKGROUND

Limiting charges are an important feature of the Medicare physician participation program. Participating physicians agree to accept the Medicare-approved charge for services as payment-in-full for all beneficiaries. Nonparticipating physicians, on the other hand, may accept assignment on a case-by-case basis, or they can charge in excess of the Medicare amount up to the limit specified in law. In 1991, assignment was accepted on 81 percent of claims and 88 percent of Medicare physician dollars.

Medicare charge limitations for nonparticipating physicians are not new, having been around in some form since 1984. Since 1987, the maximum allowable actual charge (MAAC) system provided limits that were specific for every physician and every procedure in the country, based on the individual physician's historical charge patterns. Consequently, the MAACs were exceedingly cumbersome and complicated to administer and monitor.

The limiting charges were enacted as a key part of the 1989 physician payment reform legislation to replace the MAACs. The three-year transition to the new charge limits began in 1991. In 1991, nonparticipating physicians could not charge more than 125 percent of the Medicare prevailing charge (primary care services had a 1991 limit of 140 percent). The limit is no more than 120 percent of the fee schedule amount in 1992 and will be reduced to 115 percent of the fee schedule amount in 1993.

However, during the transition years of 1991 and 1992, the charge limits are still computed using individual physician MAACs, as well as a percentage limit. In 1993, the charge limits are simplified because they are tied solely to the fee schedule and no longer are physician specific.

There has been much discussion regarding the extent to which the statute protects beneficiaries from excess charges. We believe that Congress intended that physicians should not charge beneficiaries more than the limiting charge. We do not believe that beneficiaries are responsible for paying physicians in excess of the charge limit. If overcharges occur, carriers ask physicians to rollback their charges. While the statute provides the Federal government with no direct means of requiring physicians to refund excess charges, we have recently instructed carriers who were not already doing so to ask physicians to make refunds to the beneficiary.

MONITORING AND ENFORCING CHARGE LIMITS

Let me describe our activities to monitor and enforce limit charges.

Medicare carriers play an essential role in administering the limiting charge restrictions. Each year, as part of the participating physician enrollment, carriers send to each physician the limiting charges that will apply for the following year for all procedures they perform.

Since 1984, the carrier monitoring process has been in place. Every six months carriers review unassigned claims on a postpayment basis to identify potential violations of the limiting restrictions. When potential violations are identified, physicians are notified in writing of the overcharges. Intensified monthly monitoring is used for physicians who continue to overcharge.

In addition, beneficiary complaints regarding physicians' charges trigger an immediate review of potential limiting charge violations.

When carrier monitoring identifies egregious cases, that is, physicians who knowingly and willfully, and on a repeated basis, bill charges in excess of the limiting charge, these physicians are referred to the Department for sanctioning. The sanctions and civil monetary penalties are specifically provided for in the law.

During the monitoring period for July through December 1991, carriers sent warning notices about potential charge limit violations to approximately 7200 physicians, or approximately 1.8 percent of all nonparticipating physicians.

For that same period, carriers sent a second warning letter to 373 physicians when intensified monitoring revealed that billed charges continued to exceed the limiting charge. Of these, carriers referred 7 cases to the Department because of continued violations.

These carrier monitoring data indicate a high level of compliance by physicians to the charge limit restrictions. Carriers have found that most initial violations were unintentional billing errors or misunderstandings, and physicians have willingly made refunds when notified of the error. These billing errors are not remarkable considering the enormous changes that physician payment has undergone in recent years.

In 1993 the monitoring process will significantly change from a retrospective review to a concurrent, claim-by-claim review. This is because the limiting charge will no longer be tied to individual physician's historical billings; rather the limit will be solely tied to the new physician fee schedule amounts.

Carriers will then be able to review limiting charges at the time claims are processed and notify physicians of possible limiting charge violations. We believe this will be much more effective than current postpayment monitoring of physician overcharges.

IMPROVING THE BENEFICIARY AND PHYSICIAN INFORMATION

We are taking steps to provide limiting charge information to both beneficiaries and physicians.

We have recently provided carriers with nationally consistent instructions to improve their responsiveness to beneficiary inquiries. When a beneficiary inquires, carriers must provide the beneficiary with the specific charge limit for the individual physician and particular procedure involved. If information cannot be provided immediately, it must be made available within 2 days of inquiry.

Our carriers are implementing an improved and more accurate Explanation of Medicare Benefits (EOMB) form. The EOMB shows beneficiaries what services were covered by Medicare, what charges were approved, and how much of the annual deductible has been met.

Carriers have deleted from the EOMB the confusing statement regarding beneficiary liability, which did not account for limiting charge restrictions. Language is also being added to the back of the EOMB to describe the limiting charge restrictions.

Beginning this summer, we will phase in annotating the EOMB when the limiting charge is exceeded. Physicians will also be notified when their charges exceed the limit. This change will be effective for all EOMBs by the end of the year.

We have also updated the Medicare Handbook and continue to revise our informational pamphlets and guides to make the limiting charge restrictions more understandable.

Medicare's Physician Participation Program

Although limiting charges protect beneficiaries from excessive billing, we encourage beneficiaries to use participating physicians to reduce out-of-pocket expenses.

Information about assignment and participating physicians is included in the Medicare Handbook, the Guide to Health Insurance for People with Medicare, and eventually on every EOMB. Beneficiaries can obtain the geographic-specific Medicare-Participating Physician/Supplier Directory free of charge from their carrier, Social Security offices, state and area offices of the Administration on Aging, and in most hospitals.

The Medicare participating physician program is successful. In 1992, the number of Medicare participating physicians reached a record high, topping 52 percent. These participating physicians account for about 73 percent of Medicare physician spending. Clearly, the participating physician program offers substantial financial protection for Medicare beneficiaries.

CONCLUSION

We believe that physicians should not charge beneficiaries more than the limiting charge. While our monitoring experience indicates that physicians have largely complied with the limiting charges, we recognize the need to be vigilant in identifying potential violations of charge limits. We believe that our monitoring efforts will be even more effective when the limiting charge transition provisions are completed in 1993, and our plans to do concurrent review are implemented.

We are ready to work with members of the Committee and advocacy groups to protect the financial interests of Medicare beneficiaries.

Senator COHEN. Director Walton, thank you very much for your testimony.

I might point out at the beginning that under the Committee's rules, testimony is required to be submitted at least 48 hours in advance of the hearing and we did not receive your statement until 7 o'clock last evening, so I hope that's not an indication of the kind of lack of responsiveness that many of the beneficiaries have had in dealing with either carriers or HCFA itself.

You indicated that this is a problem that is not confined to beneficiaries in the lawsuit filed by Medicare advocacy groups who are testifying today but one which affects Medicare beneficiaries nationwide. I agree, and even though you estimate that 19 percent of the Medicare claims are unassigned, and therefore subject to these limiting charge rules, that's 19 percent of 55 million claims. That's about $4 million in Medicare payments so whenever there is an overcharge, that could mean a significant loss of money. So the fact that it's only 19 percent doesn't in any way suggest that it's not a major problem. Do you agree with that?

Ms. WALTON. I would agree with that.

Senator COHEN. What methods do you have now to inform Medicare beneficiaries about the changes in the program? I've seen the Medicare Handbook but of course that doesn't go to existing beneficiaries, it goes to new enrollees.

Ms. WALTON. New ones, yes.

Senator COHEN. How do they get updated, the ones who are currently in the program—Mr. Lee, Mr. Lipson, or their wives, and others who have been in the program for years but have no knowledge whatsoever about "limiting charges." What are you doing to alert them?

Ms. WALTON. Effective this month, we're putting on all EOMBs an explanation of limiting charges. It's preprinted on the back and it explains them. I think what is the most important is, as I noted, starting this summer we will actually annotate the EOMB when a limiting charge is exceeded. We will explain that we believe there has been an error because there is an overcharge and that the beneficiary should contact the physician for a refund. There won't be situations where beneficiaries needed to know and were not informed once the revised EOMB is out there.

Senator COHEN. You raise a good point. One, why can't there be an update, a simple method, for example, of sending out a flyer with a Social Security check that goes out monthly to say, here are the changes in the law. This is a new procedure and you should be aware of it? Wouldn't that be a fairly inexpensive way to inform beneficiaries of changes?

Ms. WALTON. It used to be. Right now, better than 65 percent of the Social Security checks are direct deposit, so we have a $4 or $5 million postage bill for a direct mail. It could be done but it is a $4 or $5 million postage bill.

I do think that the general explanation on the back of the EOMB is a good way to notify folks who are currently using Medicare.

Senator COHEN. So what you're saying is the new forms are going to delete this statement, "You are responsible for a total of?"

Ms. WALTON. Already have. That's done.

Senator COHEN. How come it took 2 years to arrive at that position?

Ms. WALTON. Well, I would have to say it's something we just missed. That's language that's been on the form for about 10 years, and certainly it's incorrect only in a small portion of cases where there was an overcharge, and we just missed it. Not only HCFA missed it, but on two occasions last year—January 28, 1991 and June 5, 1991—I met with about 12 beneficiary groups to review, to discuss and to plan a new EOMB and on both occasions, we talked about the format, the items on it, and indeed, limiting charge was discussed. There was interest in arriving at the time when the limiting charge annotation could be on the EOMB but all of us missed that "You're responsible for." It was simply an oversight and when it was brought to our attention, we deleted it. I apologize for that.

Senator COHEN. As I understand it then, this new Explanation of Medicare Benefits will, in fact, state what the individual is responsible for under the law?

Ms. WALTON. Yes. What we're going to phase in is indeed putting on the EOMB precisely what the overcharge is and precisely what the difference would be that the beneficiary is responsible for.

Senator COHEN. HCFA will calculate what the overcharge was and not put that burden upon Mr. Lee or Mr. Lipson?

Ms. WALTON. That is correct. That is the plan.

Senator COHEN. Do you think it's fair to require the Medicare beneficiary who has had to come up with the money up front—since many of these nonparticipating physicians demand payment at the time of service and then tells the patient to get reimbursement from Medicare—to shift the burden to the patient to go back to the physician or hospital and say, "You overcharged me, I want my money back." Or should that be done by either HCFA itself or the carriers? Why not put the burden on the carrier to go to the doctor and keep the patient out of it. One of the most sensitive relationships you can have is the physician-patient relationship and patients want to have at least some sense that they have a mutual bond or trust or faith in their physician. If the patient is challenging the fee that's being charged, it's going to put a different tone on that relationship and I think most patients, most beneficiaries will say, I don't want to challenge my doctor.

Ms. WALTON. I agree that many beneficiaries might not want to challenge the fee or might be too shy, but I would also say that on an unassigned claim, the business relationship is between the beneficiary and the physician. Certainly, if it's an error in the claim which most of the situations I have seen are, if the beneficiary is comfortable dealing with the physician directly, that's the fastest way to have a billing error fixed.

What we have told our carriers and advised everyone is anytime a beneficiary is uncomfortable or would prefer not to go directly to the physician, if there's been an error or an overcharge, to contact the carrier. I hope and I would think probably a mixed approach would work well.

Senator COHEN. Let me just pick up on one thing you just said. You said, whenever there is a nonparticipating physician, the relationship really is between the beneficiary and the physician. That's not exactly true. As long as that physician is seeking to put his or

her hand into the pocket of the Federal Government, that puts the Federal Government as the intermediary it seems to me.

If the physician says, I don't want to deal with Medicare, you're on your own with me, your private health insurance, that's one thing. But to the extent the "nonparticipating physicians" are in fact participating by getting the reimbursement from Medicare, it seems to me that changes the relationship. It's not a private matter, it's a public matter.

Ms. WALTON. But they don't get their reimbursement from us. We pay the unassigned claim, but the beneficiary obviously is the conduit, I would agree.

Senator COHEN. Do you think we need changes in the law to make it clear that a hospital or physician that overcharges is required to refund that amount?

Ms. WALTON. Well, I do think that the intent of the law is clear that the physician should not overcharge, but I think there is some ambiguity and I think there is some agreement that there's ambiguity on the refund. I think technically speaking a clarification would be helpful, yes.

Senator COHEN. Isn't it kind of absurd to say, however, that you really can only charge the following amount and if you charge over that, frankly, if you do it consistently, you may be subject to penalties, but even if you overcharge, there is nothing that requires you to refund the amount?

Ms. WALTON. That could be one interpretation of the law. I think that there are some ambiguities that allow people to differ on how they interpret it.

Senator COHEN. HCFA, as I understand it, currently monitors the compliance of this balanced billing or limiting charges by looking at a random sample over a 6-month period, is that right?

Ms. WALTON. Yes, but it's not entirely random. They take the 10 most frequent procedures and then also sample randomly from 15 other procedures. We try to hit a bunch of them.

Senator COHEN. Right, but you're not surveying everybody?

Ms. WALTON. No, sir.

Senator COHEN. If you discover the overcharge, it's not made until months after the beneficiary has already paid, so we're talking about as much as 6 months to a year after the beneficiary has fine-tuned pianos to come up with $1,000 to pay the physician. Do you think there's a better way of monitoring the overcharging than the current method of waiting for 6 months to examine a sample on a semirandom basis?

Ms. WALTON. Yes, I definitely look forward to doing it on a claim-by-claim basis. I think it is a far better way.

Senator COHEN. Prescreen those. In other words, whenever you're dealing with unassigned claims or nonparticipating physicians, do you think there should be a prescreening on a 100-percent basis as recommended.

Ms. WALTON. That's our plan. We plan to have that in place for all unassigned claims by this January, and we're going to start phasing it in this summer.

Senator COHEN. Would it be difficult for the carriers to do this next year?

Ms. WALTON. Well, nothing in Medicare is easy and straightforward. It's a large program, it's extremely complex. Just figuring out which services are subject to the limiting charge is going to take thousands of hours. There are exceptions all through it, but the kinds of complications that were there with the MAAC and present during this transition period of 1991 and 1992 are truly gone starting in January 1993.

Certainly, we still have to figure out what physicians charge, but a straight 115 percent of the fee schedule amount is the kind of systems work that we can do within our budget and do it, I think, very effectively.

Senator COHEN. So you're going to have 100 percent prepayment screening?

Ms. WALTON. Yes, sir.

Senator COHEN. Starting in 1993?

Ms. WALTON. Yes, starting this summer, but totally in place by January.

Senator COHEN. Do you have any estimate as to what degree these overcharges are in fact occurring? Is this something that is being blown out of proportion or is it something that is serious on a nationwide basis? Is it confined to New York City or New York?

Ms. WALTON. No, I'm pretty sure it's not confined.

Senator COHEN. We know it's not a problem in Montana, but anyplace else?

Ms. WALTON. I think it is not a large problem. I know that the Office of the Inspector General has done a study and we do not yet have their findings, but they did tell us that overall the magnitude of the problem was small.

Senator COHEN. You indicated before that there were some 7,200 warning letters that went out?

Ms. WALTON. Yes, sir.

Senator COHEN. I assume that most of those close to 7,000 responded immediately because you said there were 373?

Ms. WALTON. Yes, 373, right. What we have found in the past is that well over half of those will be coding errors or confusion and well over 70 percent will respond right away and you have to prod a few others. It doesn't necessarily mean they were overcharging but I think that perhaps they are just irritated to get another letter from the government. Yes, virtually everyone responds quickly and appropriately.

Senator COHEN. About how much time elapses between the warning letter to the physician stating that there has been an inappropriate overcharge and the actual refund taking place? Do you have any idea?

Ms. WALTON. I don't.

Senator COHEN. Do you think we should, as part of the clarification of the law, impose interest penalties upon physicians who have engaged in overcharging inadvertently or otherwise?

Ms. WALTON. This is one citizen's personal opinion. I would say because of the cases I have seen, where there are so many inadvertent or coding errors, it would not be a good idea or appropriate.

Senator COHEN. But who should bear the inconvenience? The person who has to wait a year to get a refund while the doctor says, well, you're not entitled to this, it's not our problem? Who

should bear the responsibility when you've got a law which requires a payment of this and no more, and there's an overpayment? You can say it's inadvertent or a mistake, but who should bear the interest on that?

Ms. WALTON. In a claim-by-claim process, I would see it happening quite quickly and I would think that the only time you would get into a long delay is if there was a very large challenge by the physician. In those situations, I could see that you might want to think about interest for one party or another. I think what I see us doing would be happening on a fairly quick time frame and there would not be extraordinary delays. I think the physician community, when you point out an error, like virtually all Americans, they move to make it right.

Senator COHEN. The AARP is going to be testifying shortly and they've got a suggestion. I'm going to read it to you. They suggest that Medicare send a notice to the physician stating that the billing limits have been exceeded. The physician would then have an opportunity to respond in case a billing error had occurred.

If no billing error occurred, the physician would be responsible for demonstrating to the carrier that a refund to the patient had been made within a specific time frame. If the physician fails to respond, he'd be referred to the Secretary for a determination to be made as to whether he knowingly, willfully, and repeatedly overcharged, in which case, the full sanctions could be applied. Would you agree with that recommendation?

Ms. WALTON. I'd have to think it through to make sure exactly how it would work. I guess we would not be delaying payment of the first claim from the beneficiary, we would not want to do that, and we would be notifying, I would assume, the beneficiary and the physician at about the same time and giving an opportunity for the physician to perhaps correct an imperfect claim or something like that. You would need to just tell the beneficiary that process was going on because what you need to avoid is very large administrative costs.

It sounds like it could be worked through. Let's put it that way. I think that if you look at these ideas, we need to leave enough administrative flexibility that you really can work through the problem and iron out wrinkles. For instance, we want to avoid sanctioning or refund letters for very small amounts of money—the 13 cents refunds and things like that—so I would encourage you to keep a little administrative flexibility so we can try to be efficient.

Senator COHEN. Assuming a letter goes out to Dr. X stating that he or she has overcharged and a refund of *x* amount is due. Should that refund go to the patient? Should it go to the carrier? Where should the refund go?

Ms. WALTON. I think the refunds need to go directly to beneficiaries.

Senator COHEN. Here is the problem. Once again, you're putting the beneficiary in the position of now receiving a check from the doctor who says, oops, I overcharged you, here's the money that I owe you. That puts the beneficiary in an awkward position in terms of going back to that physician again.

I would like to see the beneficiary taken out of the process as much as possible and have it go either through HCFA or through

the carrier so you don't put an elderly person in the position of one, having to challenge a doctor, and two, being put in the position of getting the refund directly so that it looks as if the physician was caught doing something that was inappropriate and the whistle was blown by the beneficiary himself or herself.

Ms. WALTON. As you think through this, one thing that came to my mind is there is a refund provision now that's from the physician directly to the beneficiaries for the medical necessity denials. I'm going to say that's 1842(l) and if I'm wrong, someone can correct that. That works well from the point of view of the beneficiaries. The physicians certainly are not overly fond of that provision but to the best of my knowledge, I have never had a beneficiary complain about that. That's a direct refund to the beneficiary, so you might want to look at that.

Senator COHEN. I'm just trying to get at the problem, where we shift the burden to the beneficiary to make the challenge to the doctor or the hospital, it puts them in a very awkward position.

Ms. WALTON. No, not the challenge, the challenge can go from HCFA if the Medicare carrier directly writes to the physician. I was just trying to make the refund go direct.

Senator COHEN. In terms of the refund itself going directly to the beneficiary, I still would like to have either HCFA or the carrier involved so that you would at least insulate the beneficiary from the position of having to appear, one, to challenge and then two, to get the money back directly. I think it imposes some burdens upon the physician-patient relationship. It's just a personal judgment on my part.

I will yield to Senator Grassley.

STATEMENT OF SENATOR CHARLES GRASSLEY

Senator GRASSLEY. Mr. Chairman, first of all, I have a long statement that I'm just going to insert in the record.

[The prepared statement of Senator Grassley follows:]

STATEMENT OF SENATOR CHARLES E. GRASSLEY

Thank you, Mr. Chairman.

I also want to thank the ranking member, Senator Cohen, for his interest in this topic.

As several of our witnesses will point out, Medicare physician charge limits were an important component of physician payment reform which the Congress enacted with OBRA 1989.

The idea was to improve equity among physicians, reduce the growth in Medicare part B expenditures, and protect beneficiaries. The beneficiary protection was to be provided through limits on physician charges.

For many Medicare beneficiaries, these charge limits are very important. They can mean the difference between affordable physician costs and unaffordable physician costs.

Therefore, it is important to get some clarification on what is really happening with respect to Medicare physician charge limits.

So far, as far as I can tell, the evidence that physicians are evading the charge limits seems to be anecdotal. One of our witnesses cites some 400 complaints. But in a system which processes claims which number in the millions in any given year, 400 is really not many.

On the other hand, there appears to be some confusion among carriers, and certainly among physicians and beneficiaries about what the rules are. So it is certainly conceivable that errors could be much more widespread and numerous.

I have received some materials from insurance people who have encountered problems similar to those which will be discussed today at this hearing. The

amounts involved are not quite of the amounts which will be cited today by the Medicare beneficiaries who will testify, but nevertheless they are significant for someone retired on Social Security.

From some of the testimony which will be presented today, it would appear that the Health Care Financing Administration could have done more to inform carriers, physicians, and beneficiaries about the charge limits.

Mr. Chairman, and Senator Cohen, I believe that the hearing you have convened today is on a very important topic, and will certainly support your efforts to improve compliance with the law.

Senator GRASSLEY. The second thing would be to complement you for holding these hearings to find out why congressional intent is not being followed and to make sure and impress upon the bureaucracy that it be followed.

Lastly, I would just simply say that I want to help continue to work with you on this issue as well as Senator Pryor to see if we can get to the bottom of it.

Senator COHEN. Thank you, Senator Grassley.

Senator Specter.

STATEMENT OF SENATOR ARLEN SPECTER

Senator SPECTER. Thank you, Mr. Chairman.

I join my colleague, Senator Grassley, in complementing you on scheduling these hearings.

My State, Pennsylvania, is one of six States which does not have the problem of balanced billing because our State law prohibits physicians from billing Medicare beneficiaries in excess of what Medicare pays for. But this certainly is a very serious national problem. I look forward to working with you on it.

Thank you.

Senator COHEN. I've got a copy here of a publication called "Medicare Matters," issued by the HCFA Regional Office, in which the Medicare carriers discuss the rules that govern limiting charges for unassigned claims. In the text, it says, "Even though a doctor or supplier does not accept assignment, there are limits on the amounts that he or she can actually charge."

As you know, the Committee has investigated some of the durable medical equipment suppliers who bill Medicare patients for supplies and equipment that are far above the amounts an item would cost in a supply catalog. As a matter of fact, it was Senator Heinz, Senator Specter's predecessor on this Committee, who initiated the major investigation into this.

The question I have is, are there currently limiting charges imposed on suppliers or is this just an error in the text of the article itself?

Ms. WALTON. No, I don't believe there are limiting charges on supplies. I think that the Part B services have a variety of different things. For the physician services, there are limits on the unassigned claims. For some of the services, for instance, the laboratory service, there is mandatory assignment and for some of them, I'm thinking perhaps orthodontics, prosthetics and the supplies and equipment, there aren't limits on unassigned claims.

Senator COHEN. The question I have is twofold. One, the alert that goes out from the HCFA office says that even though a doctor or supplier does not accept assignment, there are limits. That is incorrect, is it not?

Ms. WALTON. On supplies, I believe that is.

Senator COHEN. So that should be stricken?

Ms. WALTON. Yes, that should be corrected.

Senator COHEN. Or, are you recommending there should be limits on suppliers?

Ms. WALTON. If that's a regional office bulletin, I'm pretty sure they're not making a policy recommendation. It's more likely an error.

Senator COHEN. I'm asking whether you would make a recommendation that there should be limits on suppliers?

Ms. WALTON. No. I'm not making that recommendation. I think that assignment is quite high in this area and I think that works well.

Senator COHEN. Director Walton, thank you very much for appearing. We will examine your testimony on what HCFA is doing to correct some of the errors in the past and we'll monitor it very closely.

Thank you very much.

Ms. WALTON. Thank you.

Senator COHEN. Our next witness this morning is Ms. Carol Jimenez, Director of Litigation of the Medicare Advocacy Project in Los Angeles, a Medicare advocacy group that brought the lawsuit against Health and Human Services to enforce the limits. Ms. Jimenez, welcome to our hearing.

STATEMENT OF CAROL JIMENEZ, DIRECTOR OF LITIGATION, MEDICARE ADVOCACY PROJECT

Ms. JIMENEZ. Good morning, Mr. Chairman and members of the Committee.

I'm Carol Jimenez, Director of Litigation of the Medicare Advocacy Project in Los Angeles, commonly known as MAP.

MAP is an independent, nonprofit organization that assists almost 5,000 individual clients and presents educational programs to an additional 10,000 persons annually. As part of MAP's work to address systemic problems, I'm lead counsel for plaintiffs in a lawsuit entitled *Williams* v. *Sullivan*. The *Williams* case is a nationwide class action which challenges HCFA's failure to implement the limiting charge in a manner that protects Medicare beneficiaries.

Despite the clear intent of Congress to protect Medicare beneficiaries from excessive out-of-pocket costs, due to HCFA's inactions, most beneficiaries are not even aware of the limiting charge. In 1991 alone, 55 million unassigned claims for physician services were processed involving $3.92 billion. Even if a small percentage of unassigned claims contain overcharges, the number of beneficiaries and the amount of dollars involved are enormous.

The limiting charge statute makes it illegal for a physician to bill in excess of the limiting charge. Common sense as well as legal principles tell us that a person who is charged an illegal amount does not have to pay it. It follows that a physician who has overcharged a beneficiary must return the unlawfully collected portion. Although many physicians may not like the law, they agree with MAP's analysis.

Well into 1991, MAP was receiving many inquiries from beneficiaries who could not afford to pay the difference between the amount charged by the doctor and the amount approved by Medicare. Many of these cases turned out to be limiting charge violations. In many ways, HCFA has made it difficult for beneficiaries to obtain information and has even affirmatively misinformed beneficiaries about the limiting charge, including the following.

HCFA has not sent any information regarding the limiting charge to beneficiaries. Carriers have routinely told beneficiaries either that they had never heard of physician charge limits or that such limits exist but beneficiaries are still required to pay the full billed amount. The EOMB forms affirmatively state that the beneficiary is responsible for the difference between the billed amount and the Medicare-approved amount, even if the billed amount exceeds the limiting charge.

This pattern of preventing access to information and providing incorrect information presents almost insurmountable hurdles to beneficiaries trying to control their medical costs. When a beneficiary is advised by the agency that administers Medicare that he or she must pay the full billed amount, how can that beneficiary protect against overcharges?

MAP contacted HCFA about its concerns and received no response. With no other recourse, on January 9, 1992, MAP and other groups filed the *Williams* case. The relief we seek includes revising the EOMB so that it correctly informs beneficiaries how much may be charged for each particular claim and including a flyer concerning the limiting charge with Social Security checks.

HCFA has advised us that our demands are reasonable. However, just 10 days ago, I received a letter from HCFA that states, "The agency believes the actions they have taken since the statute's enactment comport with its obligations to enforce the statute." This recalcitrant attitude makes it clear that we cannot rely on HCFA's recent actions to ensure that beneficiaries are protected from excessive balance billing.

MAP certainly does not want to dissuade HCFA from its recent efforts. However, HCFA's actions to date have been deficient, in part, in the following respects. In its recent directives to carriers, HCFA still takes the position that it does not have any authority to demand that a physician refund any overcharge or adjust a bill that contains overcharges.

HCFA has directed carriers to suppress the beneficiary responsibility language on the EOMB. However, the EOMB still incorrectly advises the beneficiary that if the claim had been assigned, he or she would have saved the difference between the billed amount and the Medicare-approved amount, even if the billed amount exceeds the limiting charge. MAP still has not seen any proposed EOMB language to inform the beneficiary of the true amount for which he or she is responsible on each particular claim.

Technical amendments to the limiting charge statute should be enacted to preclude any argument by HCFA that the statute does not give HCFA the authority to protect beneficiaries from physician overcharges. We suggest the following: Specifically state that a beneficiary is not responsible for any actual charge in excess of the limiting charge; specifically that if a nonparticipating physi-

cian received payment in excess of a limiting charge, such excess amount be refunded; and specifically state that the Secretary shall enforce, not simply monitor, the limiting charge.

Any technical amendments to the statute must also make clear that they merely clarify existing law rather than change it. Otherwise, it might make it exceedingly difficult for Medicare beneficiaries who have been overcharged from January 1991 through the time of the technical amendments to obtain a refund or adjustment on their account.

MAP thanks the Committee for its interest in protecting Medicare beneficiaries. We hope that through this Committee's interest and actions, the limiting charge will have the effect Congress intended to protect beneficiaries from excessive out-of-pocket medical costs.

[The prepared statement of Ms. Jimenez follows:]

TESTIMONY OF THE

MEDICARE ADVOCACY PROJECT, INC.

Before The

SENATE SPECIAL COMMITTEE ON AGING

IMPLEMENTATION OF THE MEDICARE LIMITING CHARGE

Submitted by:

Carol Jimenez
Director of Litigation

April 7, 1992

INTRODUCTION

The Medicare Advocacy Project (MAP) is an independent non-profit advocacy organization that provides free educational, counseling and legal services to Medicare beneficiaries in Los Angeles County. Our professional staff and volunteer counselors assist almost 5,000 individual clients and present educational programs to an additional 10,000 persons annually.

In addition, through state and federal administrative and legislative advocacy, litigation and research, MAP works to address systemic problems, to ensure that the benefits provided by Medicare are indeed made available to the Medicare population in California and the United States.

MAP has substantial experience and expertise on the subject of physicians' charges under Medicare. MAP has assisted many beneficiaries concerned about physicians' charges, has frequently provided technical assistance to advocacy organizations from all parts of the country, and has led seminars both locally and nationally regarding this issue.

I am MAP's Director of Litigation, and lead counsel for Plaintiffs in Williams v. Sullivan, Eastern District of California Case No. CIV-S-92 040 DFL JFM (filed January 9, 1992). The Williams case is a nationwide class action which challenges HCFA's failure to implement the limiting charge in a manner that protects Medicare beneficiaries. Unfortunately, despite the clear intent of Congress to protect Medicare beneficiaries from excessive out-of-pocket costs, most beneficiaries are not even aware of the limiting charge, due to HCFA's actions and inactions.

MAP wants to stress at the outset that it does not believe that the majority of physicians who do not accept assignment are exceeding the charge limits. Furthermore, given HCFA's conflicting signals on the issue, most of those that do overcharge are probably not doing so intentionally.

MAP hopes that this testimony will provide the Committee with an objective analysis of and insights into real-life issues regarding the limiting charge, as well as some legislative remedies to protect beneficiaries.

NUMBERS OF BENEFICIARIES AFFECTED

Based upon data contained in the Physician Payment Review Commision's (PPRC) 1992 Report to Congress, in 1991 alone, 55 million unassigned claims for physicians' services were processed, involving $3.92 billion dollars. Even if a small percentage of unassigned claims contain overcharges, the actual number of beneficiaries and amount of dollars involved are enormous.

CURRENT LAW PROTECTS BENEFICIARIES FROM PAYING MORE THAN THE LIMITING CHARGE: A SUMMARY AND ANALYSIS OF THE LAW

Under the limiting charge law (Section 1848(g)(1) of the Social Security Act), Medicare beneficiaries are not obligated to pay physicians' charges that exceed the limiting charge. MAP strongly believes that the law itself does protect beneficiaries from having to pay overcharges.

THE LAW

Section 1848(g)(1) of the Social Security Act prohibits a non-participating physician from charging an actual charge in excess of the limiting charge.

In 1991, the limiting charge was capped at 125% (or 140% for "evaluation and management" services) of the nonparticipating prevailing charge. (Social Security Act, Section 1848(g)(2)(A).) As a practical matter, if calculated correctly, the Medicare approved charge is almost always the same as the prevailing charge for nonparticipating physicians. Therefore, in almost all cases, the limiting charge is exceeded if a physician's charge is more than the percentage cap (125% or 140%) of the Medicare approved charge.

In 1992, the limiting charge is a maximum of 120% of the new fee schedule amount (which generally is the Medicare approved amount.) In 1993 and thereafter, the limiting charge is reduced to 115% of the Medicare approved amount. (Social Security Act, Section 1848(g)(2)(B).)

Carriers send a list of limiting charges to each nonparticipating physician. For 1991, this was done during the first quarter of the year, and for 1992 and thereafter, Section 1848(h) of the Social Security Act mandates that this be done before the beginning of each year.

ANALYSIS

Both the statute and the regulation make clear that a physician may not charge in excess of the limiting charge. Such a charge violates the law. As discussed in more detail below, common sense as well as legal principles tell us that a person to whom an illegal payment is charged does not have to pay it. It follows that a physician who has collected money from a beneficiary illegally must return the unlawfully collected portion.

MAP is not aware of any other area of law in which a person is obligated to pay a charge or perform an act which is illegal. For instance, many states have usury laws which protect consumers against usurious rates of interest. If a person is charged a usurious rate of interest, the person does not have to pay the interest that exceeds the legal limit. As another example, it is not uncommon for a contract to contain an unlawful provision, although the rest of the contract may be lawful. In such cases, basic contract law provides that the contract is void as to the part of the contract that is unlawful and is valid as to the remainder that is lawful. Similarly, if a physician's charge exceeds the lawful limiting charge, the amount that exceeds the limiting charge would be void and uncollectible, relieving the patient from any responsibility to pay that part of the bill.

Yet another example is the Medicare requirement that physicians who accept assignment accept the Medicare approved amount as payment in full. Like the limiting charge law, neither the statute nor the regulations regarding assignment explicitly state that participating physicians who collect more than the Medicare approved amount must refund any overpayment. Nevertheless, as evidenced by the Medicare Carriers Manual (the informal policy manual promulgated by HCFA for the carriers to use in applying Medicare law), HCFA clearly has interpreted the

assignment provisions as requiring physicians to refund any overpayments by beneficiaries. (*See* Medicare Carriers Manual Section 7553.) If the statute and regulations on assignment -- which are silent regarding beneficiaries' liability for charges in excess of the Medicare approved amount and physicians' liability for refunding any overpayments -- protect beneficiaries, then the limiting charge provision must also protect beneficiaries.

The legislative history of the limiting charge supports this analysis. House Report No. 101-247 regarding the Omnibus Budget Reconciliation Act of 1989 entitles the limiting charge "*Beneficiary protection against excessive balance billing*" and states that: "The Committee bill also contains a provision designed to protect beneficiaries against excessive balance billing." It could not be more clear that the purpose of the limiting charge is to protect beneficiaries against excessive charges.

HCFA'S FAILURE TO IMPLEMENT THE LIMITING CHARGE NECESSITATED THE *WILLIAMS* CASE.

Well after the limiting charge became effective, MAP and other advocacy groups were receiving many inquiries from beneficiaries who could not afford to pay the difference between the amount charged by their doctors and the amount paid by Medicare. Many of these cases turned out to be limiting charge violations; but the beneficiaries would never have known about that protection if he or she had not sought assistance from MAP or a similar organization. Furthermore, people attending MAP's educational presentations were, almost without exception, formerly unaware of the limiting charge.

Through investigation of individual claims, MAP learned of the many ways in which HCFA made it difficult for beneficiaries to obtain information and even affirmatively misinformed beneficiaries about the limiting charge:

(1) HCFA representatives advised us that HCFA had not sent any mailing or enclosed any information regarding the limiting charge with other information sent to beneficiaries.

(2) Until last week, carriers would only disclose the limiting charge for a particular claim if the beneficiary wrote a letter requesting such information; in California, the carriers' staff advised that it would take approximately one month to respond to such a written request.

(3) Beneficiaries from southern California and from other parts of the country informed MAP that their local carriers told them either that they had never heard of physician charge limits, or that such a law existed but that beneficiaries were still required to pay the full billed amount.

(4) Newsletters distributed by various HCFA Regional Offices contained the identical article about limiting charges; apparently the information was taken from a Fact Sheet distributed by the HCFA Office of Program Operations. (See Attachment 1.) In these articles, HCFA stated that "Beneficiaries who think they have been billed more than the limiting charge may still be required to pay the full billed amount. Failure to do so may cause the doctor or his office to send the bill to 'collection' and could affect the patient's credit rating." The fact that an account may be sent erroneously to a collection agency does not make the beneficiary liable for payment!

(5) The Explanation of Medicare Benefits ("EOMB") forms for claims in which the physician clearly has exceeded his limiting charges state that the physician does not accept assignment; but they do not mention that there is any limit on the amount that the physician may charge. In fact, the EOMBs affirmatively state that the beneficiary is responsible for the difference between the billed amount and the Medicare approved amount, with a dollar figure filled in by the carrier.

For example, in one EOMB, dated March 18, 1992 (even after HCFA claims it changed the EOMB), for surgery performed on April 9, 1991, the physician charged $6762.50 and Medicare approved $3136.50. Medicare paid $2509.20 (80% of the approved amount). Using the Medicare approved amount as a guide, the physician may not charge more than $3920.63 (125% of the approved amount for services rendered in 1991). **Yet the EOMB explicitly states that:**

> **"You are responsible for a total of $4103.30, the difference between the Billed amount and the Medicare payment. . . . You could have avoided paying $3476.00, the difference between the Billed and Approved amounts for all covered services, if the claim had been assigned."** (See Attachment 2.)

These statements are incorrect! Under the law, the beneficiary is responsible for a total of $1411.43, not $4103.30, and would have avoided paying only $784.13, not $3476.00, if the claim had been assigned.

As the facts unfolded, MAP reached the inescapable conclusion that the failure to protect beneficiaries from overcharges was a systemic problem, a result of HCFA policy, and not the result of mistakes by one or two carriers.

This pattern of preventing access to information and providing incorrect information presents almost insurmountable hurdles to beneficiaries trying to control their medical costs. When a beneficiary is advised by the agency that administers Medicare that he or she must pay the full billed amount, how can that beneficiary protect against overcharges?

As reflected in the PPRC's 1992 Report to Congress, HCFA has taken the position that the law does not protect beneficiaries because it does not state explicitly that (a) beneficiaries are not liable for charges in excess of the charge limit or that (b) physicians must refund any overpayments by beneficiaries. Therefore, HCFA has concluded, physicians are not obligated to refund any overpayments or adjust accounts that contain overcharges.

This interpretation of the law is absurd. It makes no sense that although a charge is illegal, a refund need not be issued; it is inconsistent with HCFA's interpretation of the law regarding assignment, as discussed above; and it lacks credibility in light of HCFA's plans to include limiting charge information on the EOMB at some point in the future.

In the past, HCFA has also argued that, as a practical matter, it was simply too difficult to calculate the limiting charge to include on EOMB forms. Certainly, if HCFA and its Part B carriers can put on the EOMB form a statement that the beneficiary is "responsible for a total of $____, the difference between the Billed amount and the Medicare payment," it can not argue that it is overly burdensome to provide the correct dollar amount for which the beneficiary is legally responsible. Moreover, we do not understand why it should take more than two years from the time the law was passed to make this change on the EOMB form. It took only a few months for carriers to calculate and notify physicians of particular limiting charges; there should be no further delay in notifying beneficiaries of this protection.

On October 9, 1992, MAP and several other advocacy groups wrote to Gail Wilensky, then Administrator of HCFA, regarding our concerns about HCFA's failure to implement the limiting charge. We asked that HCFA make some changes in its implementation of the limiting charge law in order to provide beneficiaries the financial protection intended by the law. We did not receive any response, not even a form letter saying "we're looking into it."

With no other recourse, on January 9, 1992, MAP, the National Senior Citizens Law Center and the Medicare Beneficiaries Defense Fund filed the nationwide class action entitled Williams v. Sullivan, on behalf of all Medicare beneficiaries who, since January 1, 1991, have received medical care from a physician who did not accept assignment. The relief we seek includes revising the EOMB so that it correctly informs beneficiaries how much may be charged for each particular claim; providing specific limiting charge information by telephone rather than requiring a written request; and enclosing with Social Security checks or Processing Center statements a flyer concerning the limiting charge.

HCFA'S RECENT ACTIONS TO IMPLEMENT THE LIMITING CHARGE ARE NOT SUFFICIENT TO PROTECT BENEFICIARIES

Ever since we filed the Williams case, HCFA has advised us that our demands are reasonable and that HCFA is taking steps to implement the relief we seek. However, just ten days ago, I received a letter from HCFA that states: "the agency believes the actions they have taken since the statute's enactment comport with its obligations to enforce the statute." This recalcitrant attitude makes it clear that we cannot rely on HCFA's recent actions to ensure that beneficiaries are protected from excessive balance billing.

MAP certainly does not want to dissuade HCFA from any efforts to protect beneficiaries from out-of-pocket medical costs. However, HCFA's actions to date are deficient in the following respects:

(1) In a February 27, 1992 memorandum to Associate Regional Administrators for Medicare, regarding Beneficiary Protection Under The Limiting Charge Rules, HCFA still takes the position that it does not have any authority to demand that a physician refund any overcharge or adjust a bill that contains overcharges. "Inquiry staff must be able to explain that . . . the carrier has no legal authority to demand restitution or adjustment on a bill from a physician . . . ." (February 27, 1992 Memorandum, page 3.) Furthermore, HCFA clearly has responsibility for

operation of the Medicare program (42 U.S.C. Section 1395kk). Such responsibility includes compelling someone who charges more than the Medicare statute allows to refund the overcharge.

(2) In some areas of the country, carriers have begun to suppress the language on the EOMB that previously stated that "You are responsible for a total of $____, the difference between the billed amount and the Medicare payment." However, such EOMBs still advise the beneficiary that "If these services had been assigned, you could have saved $____." The stated dollar amount is the difference between the billed amount and the Medicare approved amount, which implies that the beneficiary is responsible for the full billed amount even though it exceeds the limiting charge. All of the incorrect information must be suppressed.

(3) MAP still has not seen any proposed language to inform the beneficiary of the true amount for which he or she is responsible on each particular unassigned claim. This must be included in the EOMB for the average beneficiary to be able to determine how much he or she owes the physician. It is not sufficient to describe the limiting charge law on the back of the EOMB.

(4) Given the length of time that beneficiaries have been given wrong information, something must be done to alert beneficiaries that, since January 1, 1991, they may have paid too much. To date, HCFA has not indicated any action that would allow beneficiaries to obtain the protection against excessive balance billing that has been their legal right for the last year and a half. MAP suggests including a flyer about the limiting charge with Social Security checks and Processing Center statements.

LEGISLATIVE RECOMMENDATIONS

Technical amendments to the limiting charge statute should be enacted to preclude any argument by HCFA that the statute does not give HCFA the authority to protect beneficiaries from physician overcharges.

Specifically, MAP suggests the following:

(1) The statute should specifically state that a beneficiary is not responsible for any actual charge in excess of the limiting charge.

(2) The statute should specifically state that if a non-participating physician receives payment in excess of the limiting charge, such excess amount must be refunded.

(3) The statute should specifically state that the Secretary shall enforce (not simply monitor) the limiting charge.

Any technical amendments to the statute must make clear that they simply clarify existing law, and do not change it. HCFA should have no room to argue that technical amendments show that its prior interpretation, i.e., that the current law simply does not protect beneficiaries, was correct. Such a position would make it exceedingly difficult for Medicare beneficiaries who have been overcharged since January 1, 1991 to obtain a refund or adjustment on their account.

CONCLUSION

MAP thanks the Committee for its interest in protecting Medicare beneficiaries. We hope that through this Committee's interest and actions, the limiting charge will have the effect Congress intended -- to protect beneficiaries from excessive out-of-pocket medical costs.

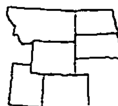
* * * * * * *

ATTACHMENT 1

HEALTH CARE FINANCING ADMINISTRATION

DENVER REGIONAL

FACT SHEET



Region VIII

LIMITING CHARGE AND NON-ASSIGNED CLAIMS

If a non-participating doctor or supplier does not accept assignment on an individual basis, the Medicare beneficiary must pay the doctor or supplier directly. The beneficiary is responsible for the full billed amount. The doctor or supplier must fill out the claim forms and send them to Medicare and any Medicare payment on the claims will go directly to the beneficiary. Although a non-participating doctor may not accept assignment, there are limits on the amount that he or she can actually charge. This limit is known as the "limiting charge," and it replaces the Maximum Actual Allowable Charge (MAAC), which limited physician charges to Medicare beneficiaries in years prior to 1991.

In 1991, the limiting charge is determined by comparing the provider's 1990 MAAC for the billed service to the 1990 area prevailing rate for non-participating physicians for the same service. (The area prevailing rate is the most common rate charged in the area for the particular service.) From this comparison, a percentage of difference is obtained. This percentage, up to a maximum of 140% (for physician evaluation and management services) or 125% (for most other physician services) is multiplied by the 1991 area prevailing rate for non-participating physicians for the service to determine the actual limiting charge.

In some instances when this calculation is discussed, the term "approved amount" is used, such as the "limiting charge is up to 125 percent of the approved charge." However, the approved amount in the determination of the limiting charge refers to the 1991 non-participating physician area prevailing rate. This use of the term "approved" amount should not be confused with the Medicare reasonable charge determination. Currently, the reasonable charge (of which Medicare pays 80 percent) is the lowest of the provider's actual charge, their customary charge for the service, or the prevailing rate for the service.

For instance, a doctor may bill $29.52 for an office call. Medicare compares the actual, customary and prevailing charges and determines that the reasonable charge is $20.27 (based upon the customary charge in this example). Of that amount Medicare pays 80 percent or $16.21. In determining the limiting charge, Medicare looks at the physician's 1990 MAAC for the service ($35.00), subtracts from it the 1990 non-participating physician

area prevailing rate ($24.00) to obtain the amount of difference ($11.00). The difference is divided by the 1990 area prevailing rate ($24.00) to obtain the percentage of difference (46%). Assuming the service is subject to the 40 percent maximum, the percentage of difference is lowered to the 40 percent and that figure is multiplied by the <u>1991</u> non-participating physician area prevailing rate ($26.00), giving us the resulting limiting charge of $36.40. (Note that if the percentage of difference was lower than the maximum--the 40% or 25%, the <u>actual</u> percentage would have been multiplied by the 1991 rate.) The doctor has not in this instance violated his limiting charge as his billed amount does not exceed the limiting charge.

Currently, the information on the Explanation of Medicare Benefits does not allow the beneficiary to compute the limiting charge. However, this information is being added in the future. In addition, the limiting charge will be computed under a similar process in 1992. However in 1993, the limiting charge will be based on a flat 115 percent of the fee schedule rate.

If any beneficiaries think they have been billed more than the amount allowed based on the limiting charge, they are still required to pay the full billed amount. Failure to do so may cause the doctor to send the bill to "collection" and could affect the patient's credit rating. Physicians who knowingly charge more than the limiting charge are subject to severe sanctions. Beneficiaries should report suspected violations of the limiting charge to their local Medicare carrier. The carrier will initiate the sanction process, if appropriate. *

Some physicians require their patients to sign an agreement that the patient will not obtain payment from the Medicare program for the physician's services. The physician may be planning to charge Medicare patients more than the limiting charge. The physician has not committed an offense by merely obtaining an agreement from the patient not to use his or her Medicare coverage. However, Medicare is not bound by the agreement the patient has signed. If the patient decides to disregard the agreement he signed with the physician and complains to the local Medicare carrier that the physician has failed to submit claims to Medicare, or if the patient submits the claim to Medicare directly, then the physician may be subject to civil and monetary penalties despite the signed agreement from the patient.

A Part A provider (like a skilled nursing facility or hospital) that requires a Medicare beneficiary, as a condition of treatment, to agree not to request Medicare payment, violates its Medicare participation agreement under Section 1866(a) of the Social Security Act and is subject to termination and exclusion from the Medicare program. Violations such as these should be reported to the local Medicare intermediary.

MEDICARE MATTERS

Health Care Financing Administration

San Francisco Regional Office September 1991 Volume 91/3

LIMITING CHARGE AND NON-ASSIGNED CLAIMS

If a doctor or supplier does not accept assignment, the Medicare beneficiary must pay the doctor or supplier directly. The doctor or supplier may request payment at the time the service is rendered. The beneficiary is responsible for the full billed amount. The doctor or supplier must fill out the claim forms and send them to Medicare. Even though a doctor or supplier does not accept assignment, there are limits on the amount that he or she can actually charge. This limit is called the "limiting charge," and it replaces the Maximum Actual Allowable Charge (MAAC), which limited physician charges to Medicare beneficiaries in years prior to 1991.

In 1991, the limiting charge for physician evaluation and management services cannot exceed 140% of the Medicare prevailing charge for non-participating physicians. For most other physician services, like surgery, the upper limit is 125% of the non-participating prevailing amount. This non-participating prevailing amount should not be confused with the Medicare "reasonable" or "allowed" charge on which Medicare payment is based. The reasonable charge (of which Medicare pays 80 percent) is the lowest of the provider's actual charge, their customary charge for the service, or the prevailing rate for the service. Therefore, if a physician's actual or customary charge is less than the non-participating prevailing, the limiting charge can be more than 125% of the approved charge. The limiting charge is determined by comparing the provider's 1990 MAAC for the service to the 1990 prevailing rate for non-participating physicians. From this comparison, a percentage difference is obtained. This percentage, up to the 125% or 140% maximum, is multiplied by the 1991

WHAT'S INSIDE?

Hugh Downs Stars in New Medicare Video 3
HCFA Publications. 3
Medicare Participating Physician/Supplier Directory (MEDPARD). . . 4
SSA Toll-Free Telephone Number Change. 4
The Who, What and Where of Medicare 4
Desk Guide 5

prevailing rate for non-participating physician to determine the limiting charge. You must keep all of these factors in mind when determining if a limiting charge has been violated.

For example, a doctor may bill $29.52 for an office call (an evaluation and management service). Medicare only approves $14.40. You might incorrectly assume that the doctor has violated the limiting charge because 140% of the $14.40 is $20.16. In fact, in this example, the non-participating area prevailing for this service is actually $24.00. The $14.40 is the physician's customary charge. Since the customary charge is lower than the non-participating prevailing, the customary charge is Medicare's allowed amount. Assuming that the doctor is subject to the maximum limit, 140% of the $24.00 is $33.60. Therefore, in this example, the doctor has not violated his limiting charge.

Billed--
$29.52

Approved--
$14.40
(Reasonable based on customary)

Prevailing--
$24.00
(Non-participating)

Limiting Charge--
$33.60
(140%, limited to max)

While in most cases the non-participating prevailing charge is the basis for Medicare's reasonable charge allowance and therefore the basis for the limiting charge, this is not always the case, as the above example illustrates. In addition, the Medicare EOMB does not reflect either the basis for the allowed amount or the limiting charge for a particular service. This makes it difficult to make a determination that the limiting charge has been violated. Upcoming changes to Medicare's payment system and the Explanation of Medicare Benefit (EOMB) will make it much easier for beneficiaries to understand Medicare allowed amounts.

Beneficiaries who think they have been billed more than the limiting charge may still be required to pay the full billed amount. Failure to do so may cause the doctor or to send the bill to "collection" and could affect the patient's credit rating. Physicians who knowingly charge more than the limiting charge are subject to severe sanctions. Beneficiaries should report suspected violations of the limiting charge to the Medicare carrier which processed the claim(s) in question. The carrier is responsible for initiating the sanction process, if appropriate.

In order to circumvent Medicare's limiting charge, some non-participating physicians require their patients to sign an agreement that the patient will not obtain payment from the Medicare program for their services. Under current Medicare policy, the physician has not committed an offense merely by obtaining an agreement from the patient not to submit a claim to Medicare. However, Medicare is not bound by the agreement the patient has signed.

The patient still has every right to submit a claim to Medicare. If the patient decides to disregard the agreement he signed with the physician and complains to the local Medicare carrier that the physician has failed to submit claims to Medicare, or if the patient submits claims to Medicare directly, then the physician may be subject to civil and monetary penalties despite the signed agreement from the patient. We are continuing to review the legality of these agreements.

A Part A provider (like a hospital or skilled nursing facility) that

requires a Medicare beneficiary as a condition of treatment, to agree not to request Medicare payment, violates its Medicare Participation agreement under Section 1866(a) of the Social Security Act and is subject to termination and exclusion from the Medicare program. Violations such as these should be reported to the appropriate Medicare fiscal intermediary.

HUGH DOWNS STARS IN NEW MEDICARE VIDEO

Hugh Downs of ABC's "20/20" stars in "Medicare in Simple Terms", a new HCFA videotape, that tells viewers how and where they can get Medicare information or assistance. HCFA Administrator, Gail Wilensky, Ph.D., introduces the 10-minute program which features Mr. Downs.

Mr. Downs uses a news show format and presents information through a series of interviews. He elicits the kinds of Medicare facts that are available to beneficiaries through the nationwide 800 number for the Social Security Administration and the statewide 800 numbers for the Medicare carriers.

The video also explains the law that requires doctors and suppliers to file Medicare claims, and the function of the Peer Review Organizations (PROs) and how they can be contacted. If you would like to borrow the "Medicare in Simple Terms" video, please let us know. If you do not wish to view the video but would like to learn more about this law and the PROs, please see our May and August 1990 issuances of Medicare Matters which features articles on these subjects.

HCF. PUBLICATIONS

The following is a list of HCFA publications that have been or are expected to be updated this year.

- 1991 Medicare Handbook (Please note there was an error in the first biannual distribution. The titles for the Part A and Part B benefits reference charts on pages 32 and 33 are switched.)

  The handbooks that will be distributed in the second biannual distribution have been corrected. The cover is slightly different. (There is a double line across the bottom of the cover.)

- Guide to Health Insurance for People with Medicare

- Common Q's & A's about Medicare

- Hospice Benefits Under Medicare

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56-746 O - 92 - 3

ATTACHMENT 2

MEDICARE PAYMENT

FOR HEALTH INSURANCE - SOCIAL SECURITY ACT
Transamerica Occidental Life Insurance Company
P.O. Box 54905, Los Angeles, CA 90054-0905

51-44
119

TO THE ORDER OF

DATE Mar 18, 1992
BENE
HIC
CCN
SEQ ****105

PAY $*2509.20**

NOT VALID IF OVER $10,000
VOID 6 MONTHS FROM ISSUE DATE

THE CONNECTICUT NATIONAL BANK
HARTFORD CONNECTICUT

Freddie Wright

⑈540393201⑈ ⑆011900445⑆ 3098⑈

DETACH CHECK ABOVE AND CASH IT PROMPTLY

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS
THIS IS NOT A BILL

665****105
01

HEALTH CARE FINANCING ADMINISTRATION

Mar 18, 1992
Need help? Contact:
TRANSAMERICA OCCIDENTAL LIFE INSURANCE
1149 South Broadway
P.O. Box 30540
Los Angeles, CA 90030-0540
Phone: 213 Area: 748-2311
Other Areas: 1-800-675-2266

Participating doctors and suppliers always accept assignment of Medicare claims. See the back of this notice for an explanation of assignment. Write or call us for the name of a participating doctor or supplier or for a free list of participating doctors and suppliers.

For medical services you receive on or after September 1, 1990, your doctor or the company that provides your medical services, equipment or supplies must prepare and submit your Part B Medicare claims.

Your doctor or supplier did not accept assignment of your claim(s) totalling $6762.50. (See item 4 on back.)

		Billed	Approved
1 Surgery Approved amount limited by item 5c on back.	Apr 09, 1991	$ 5290.00	$ 2509.20
1 Surgery Approved amount limited by item 5c on back.	Apr 09, 1991	$ 1322.50	$ 627.30
1 Inpatient Service(s) Medicare does not pay for these charges because the cost of the care before and after surgery is part of the approved amount for the surgery. Your doctor cannot charge more than the Medicare charge limit for the surgery.	Apr 09, 1991	$ 150.00	$ 0.00

This is Page 1 of 2 Pages.

Medicare Claim No. Claim Control No.

YOUR EXPLANATION OF MEDICARE BENEFITS

READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS
THIS IS NOT A BILL.

665****105
01

HEALTH CARE FINANCING ADMINISTRATION

Mar 18, 1992

Need help? Contact:
TRANSAMERICA OCCIDENTAL LIFE INSURANCE
1149 South Broadway
P.O. Box 30540
Los Angeles, CA 90030-0540
Phone: 213 Area: 748-2311
Other Areas: 1-800-675-2266

Total approved amount. $3136.50
Medicare payment (80% of the approved amount) $2509.20

We are paying a total of $2509.20 to you on the attached check. Please detach and cash it as soon as possible. If you have other insurance, it may help with the part Medicare did not pay.

You are responsible for a total of $4103.30, the difference between the Billed amount and the Medicare payment (this includes services that Medicare does not cover - shown as '$0.00' in the approved column).
You could have avoided paying $3476.00, the difference between the Billed and Approved amounts for all covered services, if the claim had been assigned.

(You have met the deductible for 1991)

If you need to call, may we suggest that you avoid the peak hours from 11:00 a.m. through 1:30 p.m..

IMPORTANT: If you do not agree with the amounts approved you may ask for a review. To do this you must write to us before Sep 18, 1992. (See item 1 on the back.)

DO YOU HAVE A QUESTION ABOUT THIS NOTICE? If you believe Medicare paid for a service you did not receive, or there is an error, contact us immediately. Always give us the:

Medicare Claim No. Claim Control No.

Senator COHEN. Thank you very much.

Mr. Guildroy is a Board Member of the American Association of Retired Persons. We'll be happy to hear your testimony.

STATEMENT OF JACK GUILDROY, BOARD MEMBER, AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. GUILDROY. Mr. Chairman, Senator Grassley, I am Jack Guildroy from Port Washington, New York and from Augusta, Maine, a member of the AARP Board of Directors.

Senator COHEN. In which order would that be?

Mr. GUILDROY. If it were July, I would say Augusta, more specifically Three Corner Pond.

Thanks for this opportunity to testify on the enforcement and monitoring of the Medicare limiting charge. While the beneficiary financial protections in the 1989 legislation are less well known than the fee schedule and volume controls, they're a key component of that legislation, the third leg of a three-legged stool.

The centerpiece of these protections, the balanced billing limit, is not being implemented as Congress intended. An increasing number of beneficiaries claim they are being overcharged for physician services, even though limits on balanced billing have been in effect since January 1991.

AARP has received nearly 400 letters from beneficiaries relating to balance billing overcharges. They've not received satisfactory responses from carriers. We hear complaints most often about the carriers' inability to clearly explain the limiting charge, to help determine whether an overcharge has occurred, or to provide assistance in getting a refund. Many carriers claim they've received no guidance from HCFA on how to monitor or enforce the limiting charge. We know of two cases where carrier staff told beneficiaries they didn't even know that limits on balanced billing exist.

Many of these problems are due to the serious lack of information provided to carriers, to physicians, and to beneficiaries. The lack of information provided to carriers is particularly troublesome. HCFA did not give carriers guidance on how to enforce compliance with this beneficiary protection or what information to make available to physicians and beneficiaries. Carriers in turn, have not helped physicians adequately in calculating their own limiting charge.

AARP is very pleased that HCFA has begun to take some steps to help carriers clarify their role in enforcing the limiting charge. Further technical refinements to the law are necessary, including the need to enforce claim-by-claim compliance with the limiting charge; clarification that physicians are required to refund any excess charges to beneficiaries; and authority for HCFA to take a range of appropriate enforcement steps if a beneficiary is not repaid.

Let me briefly explain these recommendations. With respect to the claim-by-claim monitoring, the payment reform law not only establishes a limit on beneficiary liability, it also directs the Secretary to monitor the actual charges of nonparticipating physicians. HCFA has not interpreted this to mean that it has ultimate responsibility for identifying balance billing violations, nor does it in-

terpret the law to mean that it is required to screen each claim for balance billing compliance.

AARP believes that the intent of Congress is clear. Monitoring and enforcement of the balance billing limit should ultimately rest with the Secretary through HCFA and its carriers.

The second issue deserving consideration is beneficiary refunds. Until the February notice to carriers, it was left completely up to the beneficiary to seek repayment. That notice implies that carriers can request that a refund be made but doesn't provide enforcement authority. HCFA claims that the law does not give it that authority. AARP believes that carriers should have the authority to require physicians to pay beneficiaries the amount in excess of the limiting charge; carriers should be required to tell physicians in writing each time the limiting charge has been exceeded.

A third issue is the means of enforcing payments to beneficiaries once an overcharge has been detected. The law establishes authority for sanctions in the event that a nonparticipating physician knowingly and willfully bills on a repeated basis for services in excess of the limiting charge but HCFA has not interpreted the law to mean that it also may take intermediate steps to insure routine compliance with the balanced billing limits.

AARP believes HCFA should have the clear authority to take an intermediate enforcement step. The sanctions in current law are so severe that they may rarely or never be enforced. Intermediate sanctions can be very effective. We've included one suggestion for such intermediate sanctions in our written testimony.

A fourth step is to ensure that carriers, physicians, and beneficiaries have adequate information about balance billing limits. The most logical method for communicating this is the EOMB. It's critical that next year's EOMB contain balance billing information.

AARP believes in order for the Medicare limiting charge to provide beneficiaries with effective financial protection, it must be implemented as Congress intended. We believe that the refinements discussed in our testimony would vastly improve enforcement and monitoring and make the limiting charge a real protection for beneficiaries.

We appreciate the opportunity to testify today, and look forward to continuing to work with this Committee and the Congress on all aspects of the implementation of physician payment reform.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Guildroy follows:]

STATEMENT

of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

on

THE ENFORCEMENT OF THE MEDICARE LIMITING CHARGE

Presented by

JACK GUILDROY

AARP Board of Directors

Good Morning. My name is Jack Guildroy and I am from Port Washington, New York. I am a member of the Board of Directors of the American Association of Retired Persons (AARP). I am pleased to have the opportunity to appear before the Committee today to discuss the need for effective monitoring and enforcement of the Medicare limiting charge.

Let me begin by commending you, Senator Pryor, as well as Senator Cohen and the members of the Committee, for holding this hearing. Your continued leadership and advocacy on behalf of Medicare beneficiaries is greatly appreciated.

My remarks today focus on enforcement and monitoring of the Medicare limiting charge -- or "balance billing limit" as it is commonly called -- that was enacted as part of the OBRA'89 physician payment reform law. This limit on the amount a nonparticipating physician can bill Medicare patients in excess of what Medicare pays is -- along with other beneficiary financial protections -- one of the key components of the physician payment reform package.

AARP strongly supported the adoption of beneficiary financial protections -- including the limiting charge -- as part of physician payment reform. We firmly believe that the Part B system should be equitable for both beneficiaries and physicians.

The Association also believes that one of the greatest achievements of the payment reform law is the balanced package of improvements it provides for the Medicare Part B program: a more equitable fee schedule for physicians, a means to address the rate of increase in Part B program spending, and the strong framework of beneficiary financial protections. The Congress deserves a great deal of credit for crafting a package of improvements that represents the concerns of all those with a stake in a more effective Medicare program -- from providers to beneficiaries.

Maintaining this balance is integral to the overall success of payment reform. Simply put, beneficiary protections without fair payment to physicians would lead to erosion of the Part B program, and changes in physician reimbursement without a lack of control over volume would lead to further program costs. That is why it is imperative that all of the components central to payment reform be implemented as Congress intended. Unfortunately, this has not been the case with one of the beneficiary protections -- the Medicare limiting charge.

Despite the fact that limits on balance billing have been in effect since January, 1991, there has been a disturbing increase in the number of beneficiaries reporting overcharges by physicians. Following the publication of recent articles about the limiting charge in the AARP Bulletin and The New York Times, the Association received nearly 400 letters from beneficiaries relating occurrences of overcharges for physician services, or requesting assistance or information about the balance billing limits.

Even more disturbing than the number of beneficiaries claiming that they had been overcharged is the lack of response these beneficiaries have received from Medicare carriers.

Although carriers are the entities responsible for administering the Medicare program at the state level, most of the beneficiaries who have contacted us have received little or no assistance from their carriers. The most frequent complaints centered around the carrier's inability to help determine whether an overcharge had actually occurred, to provide a clear

explanation of what the limiting charge was for a particular service, or to provide assistance in recouping an excess payment. Some carriers even provided blatantly wrong information in response to beneficiary inquiries.

Many of the Medicare carriers have claimed that they received no guidance from the Health Care Financing Administration (HCFA) on how to monitor or enforce the limiting charge provision of the law. In at least two specific cases which we know of, carrier representatives told beneficiaries from Little Falls, New Jersey and Wilmington, Delaware that they did not even know that a limit on balance billing existed.

A significant part of the problem surrounding the enforcement of balance billing limits can be attributed to the serious lack of information provided to physicians, beneficiaries and carriers. To our knowledge, carriers did not provide physicians with adequate assistance in calculating their own limiting charge, and the newly revised Explanation of Medicare Benefits (EOMB) form, issued by HCFA for use in 1992, lacks the information necessary to determine whether there has been an overcharge for a service. Compounding the problem, HCFA's distribution of the 1991 Medicare Handbook to beneficiaries, which contained a brief explanation of the limiting charge, was delayed by several months because of a printing error and many beneficiaries never received a final copy.

HCFA's failure to provide information to carriers was particularly troublesome. The original carrier manual transmittal sent by HCFA in September, 1990, did not provide carriers with guidance on how to calculate the limiting charge for a service, what information to make available to physicians and beneficiaries about the limiting charge, or how to enforce compliance with this beneficiary protection. It merely outlined the six-month sample method carriers were to use to monitor compliance with the limiting charge. This sample method is identical to one used to monitor the old Maximum Allowable Average Charges (MAACs).

Without adequate information and guidance, carriers were left to interpret their responsibilities under the law. This often led to further problems. We are aware of two specific cases in which carriers erroneously informed beneficiaries that they were liable for the entire amount of a nonparticipating physician's bill -- regardless of whether the limiting charge had been exceeded.

As a result of a serious lack of monitoring and poor information, we have witnessed a steady increase in the number of beneficiaries claiming that they have been overcharged, as well as an increasing level of frustration among physicians and beneficiaries over the lack of assistance provided by the carriers.

In response to the widespread complaints about its apparent failure to enforce the limiting charge, HCFA has begun to take some steps to improve the situation. In February, the agency issued a transmittal which should help carriers clarify their role in enforcing the limiting charge. The transmittal requires that carrier staff receive training so that they can answer questions about the limiting charge; provide actual limiting charge amounts upon request; and provide assistance to beneficiaries reporting potential overcharges.

While the Association is pleased that these steps are being taken, we believe that further technical refinements to the law are necessary if the limiting charge is to be enforced as Congress intended. The specific enforcement issues which AARP believes warrant particular attention include: the need to examine, as part of the claims filing process, claim-by-claim compliance with the limiting charge; clarification that in the event of an overcharge physicians are required, by law, to provide refunds to Medicare beneficiaries; and the authority for HCFA to impose intermediate sanctions in cases where the limiting charge has been exceeded but the beneficiary was not repaid. Our testimony examines each of these issues in further detail.

Identifying Occurrences of Excess Balance Billing

The balance billing limits established by the physician payment reform law went into effect in January, 1991, and are being phased-in over three years. In the first year, the limit for most services was originally the lesser of the physician's MAAC or 25 percent of the prevailing charge. However, a change in the original payment reform legislation resulted in a greater the lesser of the MAAC or 40 percent of the prevailing charge. For 1992, the limiting charge is the lesser of 20 percent of the fee schedule for nonparticipating physicians or the percentage by which the 1991 limiting charge for a service exceeds the 1991 prevailing charge. In 1993 and all subsequent years, the limiting charge will be 15 percent of the fee schedule.

In addition to establishing the actual balance billing limit for each year, the payment reform law requires monitoring physician compliance with the law. Section 1848(g)(6) requires that the actual charges of nonparticipating physicians be monitored to look for, among other things, changes in the amount of balance billing. Unfortunately, the current method of monitoring physician compliance with the balance billing limits takes neither that provision of the law into account nor the overall intent of the statute to limit individual beneficiary liability.

Instead of monitoring balance billing compliance by examining the actual charges of physicians, carriers review a random sample of filed claims every six months -- the same method used to monitor the old MAACs. This means that compliance is monitored only twice a year and a significant number of claims with billing errors may go undetected. As a result, the identification of excess billing is left primarily to beneficiaries.

Part of the problem lies in the interpretation of the law. The statute both establishes a limit on beneficiary liability and directs the Secretary to monitor the actual charges of non-participating physicians. HCFA, however, has not interpreted this to mean that it has ultimate responsibility for identifying balance billing violations. Nor does the agency interpret the law to mean that it is required to screen each claim for balance billing compliance.

AARP believes that the intent of Congress is clear -- monitoring and enforcement of the balance billing limit should ultimately rest with the Secretary through HCFA and the carriers. Beneficiaries were not intended to be the principal enforcers of this protection. Further, we believe that it was the intent of the Congress, in drafting this provision, that all Medicare claims be examined as part of the monitoring process. This is well established in Section 1848(g)(6), which requires the actual claims of nonparticipating physicians to be monitored by the Secretary for compliance with the limiting charge.

To complement effective claim-by-claim monitoring of balance billing compliance by carriers, physicians and beneficiaries must have accurate information on the current balance billing limit, how the limit is applied, and how to determine whether the limit has been exceeded. One logical method for communicating this information is through the EOMB form.

While AARP disagreed with the decision not to include balance billing information on the 1992 EOMB form, we understood that the current mix of the old maximum allowable average charge (MAAC), the prevailing charge and the fee schedule used to determine the balance billing limit made the inclusion of this information on the 1992 EOMB form cumbersome. However, it will cease to be problematic in 1993 when the limiting charge is a simple 15 percent of the fee schedule. For 1993, we are strongly urging that the EOMB, issued by the carriers to Part B beneficiaries, include the balance billing limit and any amount that exceeds that limit.

Beneficiary Refunds

A second issue which remains unresolved is beneficiary refunds. In the event that a physician exceeds the limiting charge, it has been left up to the Medicare beneficiary to seek repayment. HCFA has maintained that the physician payment reform law does not actually give it the authority to require providers to refund excess charges to beneficiaries.

The February 27, 1992, transmittal from HCFA to its regional offices instructs carriers to send a letter to physicians who exceed the limiting charge. The letter is to state the amount of the limiting charge and the amount of adjustment that should be made. This letter is to be sent automatically when a beneficiary reports an overcharge to the carrier in writing. However, in those cases where a beneficiary reports an overcharge to the carrier through a telephone call, it is left up to the beneficiary to request that a notification letter be sent to the physician.

AARP believes that carriers should be given the authority to require that physicians repay to the beneficiary any charges which exceed the limiting charge. We also believe that, consistent with the intent of Congress that limiting charge compliance be monitored on a claim-by-claim basis, carriers should be required to automatically notify physicians, in writing, each time the limiting charge has been exceeded.

Intermediate Sanctions

Another issue that requires further clarification is the means of enforcing repayment of beneficiaries once an overcharge has been detected. The statute clearly establishes authority for sanctions in the event that a nonparticipating physician "knowingly and willfully" bills on a repeated basis for services in excess of the limiting charge. The sanctions included in the law are specific and quite severe -- either civil monetary penalties or exclusion from the Medicare program for up to five years. HCFA has not interpreted the law to mean that it may also take intermediate steps to ensure routine compliance with the balance billing limits.

AARP believes that claim-by-claim monitoring of compliance as well as authority for HCFA -- through the carriers -- to require repayment to beneficiaries, will dramatically improve the effectiveness of the balance billing protection. However, in the event that a physician does not comply with the refund requirement, we believe that HCFA should have the clear authority to take an intermediate enforcement step. Full sanctions, as they are currently described in the law, are rarely employed if we rely on experiences in other areas. Thus, even the sentinel effect of full sanctions is minimized.

A possible intermediate enforcement step would be to require the Secretary to automatically send a letter of notification to a physician if balance billing limits have been exceeded. The physician could be provided with an opportunity to respond to the notification in case a billing error had occurred. If the physician did not respond to the initial carrier notification or could not provide evidence that a refund had been made to the beneficiary, the Secretary would then be required to issue a second letter of notification. This notification would inform the physician that an overcharge had occurred and require that a refund be provided to the beneficiary within a designated time period.

HCFA could be given the authority to require that physicians provide carriers with written notification, including a copy of the refund check, that the amount in excess of the limiting charge had been refunded to the beneficiary. If the physician did not respond to the second notification, or refund the beneficiary by the end of the designated time period, the existing sanctions could be levied. Since the question of the beneficiary's repayment would still be left unresolved, we believe that any monetary penalties levied should be increased by an amount equal to the balance billing overcharge. This amount should be refunded to the Medicare beneficiary.

Conclusion

For the Medicare limiting charge to provide beneficiaries with effective financial protection, it must be implemented as Congress intended. In many respects the law provides clear guidance for how the elements of this protection are to be administered. But in other areas, HCFA's interpretation of the statute has been inconsistent with the intent of the statute and further legislative clarification would be useful.
AARP believes that the refinements to the monitoring and enforcement requirements of the Medicare limiting charge discussed in the testimony would vastly improve enforcement and make the limiting charge a much more effective protection for beneficiaries.
We appreciate the opportunity to testify today and look forward to continuing our work with the Committee and other members of Congress on this effort and other issues of concern to older persons.

Senator COHEN. Thank you, Mr. Guildroy.

Ms. Jimenez, you indicated in your statement that you don't believe that the majority of physicians who don't accept assignment are exceeding these limiting charges intentionally, that this is something that may be done unintentionally or inadvertently given the conflicting signals that HCFA has sent out and the complexity of the changes in the law. Is that your assessment?

Ms. JIMENEZ. Yes, that's correct. We have had a 100 percent success rate in obtaining refunds or adjustments on patients' accounts when we deal with it. Given that kind of response from the physician community, it's hard for us to say that their violations are intentional. However, they still need to be addressed.

Senator COHEN. Let me ask both of you to respond to this. Were you at all satisfied with the testimony that was given by the Director here just a moment ago in terms of the steps that HCFA is going to take beginning as early as this summer to notify Medicare beneficiaries of what is required to be paid and what would be excessive?

Ms. JIMENEZ. Ms. Walton testified, I believe, that this summer they are going to start phasing in a new EOMB with the exact limiting charge. I don't understand why it needs to be phased in. Since the statute's enactment, beginning in 1991, HCFA has advised physicians what each physician's limiting charges are. In 1991, it sent it out a little bit late but it did send it out. For 1992, it sent it out in the fall of 1991.

Clearly, the information is already in the system. I'm not a computer expert but it seems to me if it's already in the computer system, it could be hooked up with the EOMB and there is no need to wait an additional 8 months, when we've already waited a year and a half.

Senator COHEN. Mr. Guildroy.

Mr. GUILDROY. My guess is, Mr. Chairman, that I was more satisfied this morning than I would have been a year or two ago. I think there is progress. On the other hand, I feel that HCFA's interpretation of the present law leaves something to be desired. AARP does not agree with the HCFA interpretation and unfortunately, it seems to me, legislation may be needed.

Senator COHEN. Has HCFA made any attempt to contact your organization for recommendations or interpretations?

Mr. GUILDROY. Yes. HCFA, I'm told, has met with our staff from time to time and I think that's very helpful. May I say that I hope that before the final EOMB for 1993, for example, is set in concrete that there be some kind of discussion with beneficiary organizations like AARP.

Senator COHEN. You mentioned you had 400 letters complaining of overcharges. What did the organization do? Did you investigate to see whether they were intentional, unintentional?

Mr. GUILDROY. What we did in order to get these?

Senator COHEN. You said you'd received 400 letters?

Mr. GUILDROY. Yes.

Senator COHEN. What was the followup; what did you do, the organization?

Mr. GUILDROY. The followup was to refer as many of these persons as possible to their carriers. We also happen to have a thriv-

ing group called MMAP, Medicare-Medicaid Assistance Program, of volunteers and coordinators throughout the country who help persons in need of such information to do something. So we have tried, as best we can, to reach out to our membership through our volunteer leadership.

Senator COHEN. Could I ask your reaction to the proposal that every claim be screened before payment to the nonparticipating physicians? Does that create any problems for you in terms that it might delay the payment to the beneficiary?

Ms. JIMENEZ. As I already said, the information is already in the system. I think that if the system is used properly, it shouldn't cause any delay and I wholeheartedly support it. I also think that simultaneously with the EOMB, a letter should be sent to every physician who has overcharged.

Senator COHEN. Mr. Guildroy, do you agree with that?

Mr. GUILDROY. I do.

Senator COHEN. Let me ask you another question as to whether or not I'm being overly sensitive about this. I think it's very difficult for patients to challenge overcharges. If I were practicing law, for example, and had limitations imposed on what I could charge for a particular type of service, and one of my clients said, I think you overbilled me by *x* amount, I might have less than a kind relationship with that particular client. It would probably be a former client.

I assume there is nothing more sensitive than a physician-patient relationship. The last thing a patient wants to do is to challenge what a doctor is charging him. They will do it but they don't feel comfortable, to say the least, particularly some of the more elderly and frail individuals, who may not have sufficient information and who hesitate to be aggressive on it.

Is that something that should be challenged by HCFA or the carrier as opposed to the individual?

Ms. JIMENEZ. There are a couple of different aspects to it. I think, initially, when there is an overcharge, the beneficiary should not be put in the middle. HCFA had sent a directive to carriers to implement some changes by the end of March and we did some checking around the country last week, calling different carriers to see if this was being implemented.

The worst we got was, "we don't know about a limiting charge" and when we specifically used the word, "it doesn't apply"; the best we got was, "yes, this is the limiting charge, you need to speak to your doctor about it." It puts the beneficiary in a very awkward position. However, on the other end, I don't think that it's a problem for the refund to go directly to the beneficiary.

Mr. GUILDROY. Mr. Chairman, may I give a concrete example of what you're talking about? Someone very near and dear to me felt that she was overcharged. The important thing, from my perspective and from her perspective, is that her treatment was marvelous, was outstanding. That must be kept in mind.

On the other hand, she felt that there was an overcharge and she sent a letter to her physician, a letter which I happened to see which, in my opinion, was a very gentle letter, asking, simply raising the question. Just to give an example of the sensitivity that exists frequently between doctor and patient, the reaction was that

the physician called her, introduced himself, did not ask her who she was, and simply said, "if you have any problem with the billing get in touch with our attorney."

Senator COHEN. What did she do?

Mr. GUILDROY. She hung up. She was just overwhelmed. She felt like calling him back and decided prudently not to do so.

Senator COHEN. Senator Grassley, do you have any questions?

Senator GRASSLEY. I do not have any questions of this panel, Mr. Chairman.

Senator COHEN. I think that's all the questions I have. I have more and I will ask you to submit them for the record, but I want to thank both of you for testifying this morning.

Ms. Jimenez, your efforts in bringing the lawsuit, I think have contributed to public understanding of what is involved here. You heard Senator Burns express a good deal of frustration. We can pass all the laws that we like and then 2 or 3 years later find out that they have not been implemented, much to the detriment of the very people we've been trying to serve.

So thank you and congratulations on your work.

Ms. JIMENEZ. Thank you, Senator.

Senator COHEN. Our final witness or panel I should say is Dr. Nancy Dickey, a member of the Board of Trustees from the American Medical Association, Richmond, Texas.

STATEMENT OF NANCY DICKEY, M.D., MEMBER, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION

Dr. DICKEY. Mr. Chairman and members of the Committee, my name is Nancy Dickey and I'm a practicing family physician from Richmond, Texas.

I'm certainly aware of the fact that my patients frequently have both medical and economic needs. As a member of the Board of Trustees of the American Medical Association, I can tell you that physicians share many of the same concerns raised today about the problems of compliance and enforcement of the limiting charge requirements.

Without trying to downplay the validity of these problems, we know that situations where physician charges exceed limiting charge amounts are isolated and furthermore, they can arise through no intention or fault on the part of the physician. Noncompliance is the exception.

However, as is becoming clear, and certainly was pointed out very well this morning, compliance is not as simple a task as it should be. For example, physicians do not receive limiting charge information from Medicare carriers for all of the services that they provide. Also, until 1993, the possibility of limiting charge differences between physicians for the same service will continue, so different physicians, different parts of the country, different services will have different limiting charges for them.

Problems with new coding and other payment policies are also causing problems during the first year of the new physician payment system. Mr. Chairman, the AMA is committed to aiding physicians in meeting their legal responsibilities. We actively are continuing efforts to assist physicians in complying with the law.

To address the confusion, we support administrative changes and educational initiatives to ensure that the limiting charge mandate is understood by all and administered in a fair and equitable manner. We urge dissemination of complete and accurate information, explaining the limiting charge obligations by sending the explanation of Medicare benefits form to both the beneficiaries and physicians. Access to this essential information in an understandable format, which may require more than just the definition, is the first step to protect the rights of the beneficiaries and to inform physicians of the limits.

Adequate notice and opportunity for physician-carrier interaction must be maintained. Where there are questions, such as coding adjustments or carrier-physician communications, there needs to be the next step to start deciding whether this was an intentional charge or a misunderstanding of some kind. Carriers and physicians have got to work together to ensure that direct billing to beneficiaries does not knowingly and willfully exceed the charges allowed by the law.

All reasonable efforts should be made to ameliorate billing problems prior to resorting to enforcement mechanisms. Care has to be taken in the monitoring process to ensure that the physician understands why a charge limit may have been exceeded and how to respond to such a situation.

The complexity of the situation, I have to thank Senator Burns for his comments earlier about the immense detail of the law and how very difficult it is for some offices to get straight what the charges may be, have got to be recognized and physicians and beneficiaries have to be treated equitably if disputes arise.

Given the opportunity to identify whether it was an error or whether it was an overcharge that should simply be refunded, I think will disallow most of the situations that you've heard about this morning.

We commend you for this opportunity to address the issue. Physicians are sensitive to both the medical and the economic needs of our patients. For this reason, the AMA urges physicians to accept assignment for all claims from patients with incomes below 200 percent of poverty. Also, where there are occasional violations of the limiting charge requirements, we urge physicians to reimburse patients for the amount collected in excess of what is allowed by law.

In light of the whole Medicare program with its over half a billion Part B claims, and the very high assignment rate, the problem of charges above the limiting amount is relatively small in scope. However, as said by others this morning, from the viewpoint of both the patients and the physicians, it's a problem that needs to be addressed.

The American Medical Association agrees that intentional and repeated violations must be sanctioned and stopped. Even occasional overcharges ought to be addressed, but the enforcement mechanism should not be so heavy-handed that it serves as an obstacle to care for the elderly and the disabled. To this end, we'd be pleased to sit down with you, HCFA, the AARP and the others who were represented here today to develop a mechanism that will be both flexible and fair to all.

I thank you for the opportunity to address the Committee and I'll be happy to answer any questions.

[The prepared statement of Dr. Dickey follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Special Committee on Aging
United States Senate

Presented by

Nancy W. Dickey, MD

RE: CHARGE LIMITS FOR MEDICARE BENEFICIARIES

April 7, 1992

My name is Nancy Dickey, MD. I am a family physician practicing in Richmond, Texas and also a member of the Board of Trustees of the American Medical Association (AMA). With me is Bruce Blehart of the Association's Division of Federal Legislation.

The AMA is aware of issues being raised at this hearing and in other forums concerning isolated problems with compliance and enforcement of the limiting charge requirements. We are pleased to testify concerning proposals and advocacy efforts aimed at better enforcing the law. The AMA takes an active role in getting information to physicians, and has been consistent in publicizing information about Medicare fee limits since their inception in 1984. Most recently, we have met with representatives of the Health Care Financing Administration (HCFA) to discuss actions that will enable more effective enforcement, and our publication efforts and outreach activities are ongoing.

While we acknowledge that there are situations where physician charges exceed limiting charge amounts, these situations are isolated and they can arise through no intention or fault on the part of the physician. During the almost eight full years of rigid fee controls, the HCFA data demonstrates that non-compliance is the exception.

While the AMA historically has opposed legislation to limit physician fees (the 1984 Medicare freeze on physician fees; the replacement of this freeze with Maximum Allowable Actual Charge (MAAC) limits in 1987; and the subsequent limiting charge program that went into effect in 1991), we are committed to aiding physicians in meeting their legal responsibilities. We actively are continuing efforts to enable physicians to comply with the law. However, as is becoming clear, this is not as simple a task as it should be. Also, the stakes for physicians are not small. Under the law, physicians found in violation of these economic controls face the potential of severe penalty.

<u>Recommendations for Limiting Charge Enforcement</u>

It is important to realize that the limiting charge program is still being phased-in, and this replacement for the MAAC continues some of the anomalies of the MAAC program through this year. Limiting charges for 1992 are the lower of 120% of the payment schedule amount for nonparticipating physicians or the percentage difference between the MAAC and the prevailing charge for the service in 1991. This information is annually calculated by Medicare carriers, but not for all services that a physician may provide. Just as beneficiaries have problems in dealing with carriers, and they at least still have access to "800" telephone service, physicians frequently receive inadequate information and have a difficult time in just getting information.

Until 1993, when the limiting charge will be a flat 115% of the payment schedule amount, the possibility of limiting charge differences between physicians for the same service will continue. Problems with new coding and other payment policies also will be more frequent in this first phase-in year of the new Medicare physician payment system.

There is confusion about the limiting charge program. To address this, we support administrative changes and educational initiatives to ensure that the limiting charge mandate is understood by all and administered in a fair and equitable manner.

We urge Medicare to disseminate, as soon as practicable, complete and accurate information explaining limiting charge obligations to both physicians and patients. The most effective means to accomplish this will be through Medicare carriers routinely providing this information on the Explanation of Medicare Benefits ("EOMB") form. This form should be provided to both beneficiaries and physicians. (Currently, the form goes only to the patient.) The AMA fully supports access to this essential information as the appropriate remedy to protect the rights of beneficiaries and to inform physicians of the charge limit.

Complete follow-up information, such as can be set forth on the EOMB, is essential for the limiting charge program to be understood by beneficiaries and physicians. The physician should be in a situation where he or she knows of instances where there is the potential for violation. This is especially important in instances where the carrier, for some reason, modifies the coverage (or "downcodes") for the service and the physician's charge does not match the new coverage determination (<u>e.g.</u>, payment reductions for multiple procedures, including multiple

surgeons). Information for the physician also is needed for infrequently provided services where it would be unlikely that the carrier previously had provided the necessary information.

We are concerned, however, that any new regulatory mechanisms for enforcement and monitoring must continue to be fair. Due process safeguards must apply to the physicians involved in any enforcement process. (Currently, the Medicare manual directs carriers to monitor a sample of claims which must include the ten most frequently performed procedures in the physician's specialty plus an additional 15 procedures selected at random. Physicians with violations of the charge limit exceeding $300 must be notified by letter. The $300 limitation can be reached on a single claim or by adding smaller violations from several claims. After the physician notification, carriers are required to monitor the physician intensively for three months. If violations persist, a second letter must be sent before the case is referred to the Office of the Inspector General.)

The current process provides adequate notice and opportunity for the physician to work with the carrier and rectify any problems. Adequate notice and opportunity for physician/carrier interaction must be maintained. Where there are questions, such as a coding adjustment, carrier/physician communication should be the first step. Carriers and physicians must work together to ensure that any direct billing to beneficiaries does not knowingly and willfully exceed the charges allowed by law.

All reasonable efforts should be made to ameliorate billing problems prior to resorting to enforcement mechanisms. Care must be taken in the monitoring process to ensure that the physician understands why a threshold may have been exceeded and how to avoid future mistakes. If a three month monitoring period ensues, the carrier should be required to document communications between itself and the physician regarding any problems during that time period.

An initial non-punitive approach is especially necessary in light of the likelihood for confusion with 1992 limiting charge calculations retaining elements of the previous MAAC system. Moreover, even physicians who are normally familiar with Medicare billing may be confused by very recently instituted billing procedures involving new codes for evaluation and management services and global fees for surgical procedures. Accordingly, regulators must work with an understanding of the complexity of the system and assurances that physicians will be duly notified of problems and treated equitably if disputes arise.

<u>Assignment of Medicare Claims</u>

We recognize that efforts need to be made to assure protection for beneficiaries in financial need. We also recognize that situations where limiting charges will even apply are the exception and not the rule. First of all, our policy is clear that physicians should take assignment in all instances where the patient is under 200% of the poverty level. The result is that well over 80% of Medicare claims are assigned.

This fact, coupled with the "participating physician" program, points to the situation where a Medicare beneficiary can easily find a physician who will submit claims on an assigned basis. This is underscored by the Department of Health and Human Service's March 25, 1992, announcement that a record 52.2% of the nation's physicians have agreed to serve Medicare patients as "participating physicians." Where an assignment is taken, the patient is responsible for the deductible (if any) and the coinsurance amount, which may be covered by a medigap policy. Also, physicians are obligated by law to attempt to collect this coinsurance amount. While recognizing that there is a valid role for patient cost-sharing, physicians should be allowed to consider patient needs and routinely waive this collection requirement without penalty.

<u>Conclusion</u>

While the problem of charges above the limiting amount is relatively small in scope, the AMA agrees that intentional and repeated violations must be sanctioned and stopped. While even occasional overcharges need to be addressed, enforcement mechanisms should not be so heavy handed that they serve as an obstacle to care. The AMA urges that enforcement mechanisms remain flexible and fair, and that the statutory standard of proof required to show a violation be carefully and consistently applied.

Senator COHEN. Thank you, Dr. Dickey, very much for your testimony.

As you've heard from the prior witnesses, there is a gap between what the law is and the notification that goes out to beneficiaries. This Medicare Handbook, for example, doesn't go out to the current beneficiaries, but new enrollees. So, many people are not even aware of the changes that were adopted as recently as 1989.

What about the physicians? What does the AMA do in terms of alerting physicians about the changes in the law? Do you have a program whereby you mail out copies of the law, summaries of it? I assume you may have an attorney here advising you. Exactly how does the AMA treat this?

Dr. DICKEY. I'm accompanied by Mr. Blehart from our Federal Legislation Division. Indeed, we try very hard to notify physicians. However, there is not an organized mechanism of being sure that every change is mailed to every physicians' office, rather, that communication comes in the form of our publications to physicians, of practice management workshops which are offered on a repeated basis and encouragement of physicians to send themselves or their staffs to understand the changes and how they impact them, and continued updates in the form of newsletters and electronic communications to be sure physicians are aware that there are changes either anticipated or immediately coming about.

Nonetheless, much like Medicare beneficiaries, physicians can indeed remain less than completely informed about the changes or how it may impact them. In fact, as you heard the testimony earlier, the MAAC charges didn't even arrive in some physicians' offices until 3 or 4 weeks after they should have been implemented in 1991. This year, when we had the new ARBRVS payment changes as well as a conglomeration of either a percentage of the MAAC or 20 percent, depending on which was the lower number, it could become a massively frustrating effort for a physician's office.

In my office it might be 30 to 50 charges a day, depending on the number of patients that I saw and the number of procedures I did and office staff attempting to decide which billing rate applied to which ones. So many times, I think we would be benefitted greatly by receiving the limiting charge information, seeing whether it was a misinterpretation on our part, something we could perhaps appeal to the carrier, or whether it was simply a miscalculation and we should refund that money to our patients prior to letters and communications that suggest that we are intentionally terrorizing our patients.

Senator COHEN. When there is an error made and a refund due, should there be a specific timeframe in which that refund should be made before interest is charged or should interest be charged at all? We're trying to get away from the more severe sanctions which could exclude someone from the Medicare program or a $2,000 civil fine. How about something intermediate saying a refund is due in such and such a time frame and the interest will be due retroactively or whatever. Is that something the AMA would support?

Dr. DICKEY. I think we could live with some kind of an interest sanction for those cases where it was repeated, where there was no discussion about whether or not there were differences in the billing errors. So long as I'm appealing the carrier interpretation, I'm

sure that I should be penalized for a difference of opinion until we decide who is going to end up winning that argument.

However, in cases where physicians appear to be blatantly dragging their feet and keeping their beneficiaries' money when it should have been refunded to them, I think that we would be happy to see an interim kind of sanction that served as a notice to physicians and at the same time was far less onerous than the $2,000 monetary penalties.

Senator COHEN. In your statement, you recommended that a copy of the Explanation of Medicare Benefits go to the physician as well as to the beneficiary. Would that help clarify what the obligations of the physicians are?

Dr. DICKEY. Oh, absolutely. In fact, it would allow us to begin communication either to immediately refund the amount to a patient or if it was indeed one where I thought perhaps the carrier had misinterpreted or I should provide additional information to defend my charges, I could get that information before a patient came into my office and was concerned about the letter they'd gotten suggesting I had overcharged.

Senator COHEN. Have you had a chance to look at the 1992 annual report that's issued by the Physician Payment Review Commission?

Dr. DICKEY. Yes, I have.

Senator COHEN. Do you agree with those recommendations?

Dr. DICKEY. Some of them.

Senator COHEN. Tell me the ones you don't agree with?

Dr. DICKEY. Oh, goodness.

Senator COHEN. Do you want me to go through some of them for you?

Dr. DICKEY. Sure. Which ones do you want to hear about?

Senator COHEN. I think the ones that will support a number of statutory changes in clarifying that beneficiaries shouldn't be held liable for the charges that exceed the limiting charge. Do you agree with that?

Dr. DICKEY. Right.

Senator COHEN. Physicians that exceed the limiting charge should be required to make refunds to beneficiaries. I assume you agree with that?

Dr. DICKEY. Yes.

Senator COHEN. They also contend that detection of the limiting charge violation is difficult and because the monitoring for compliance isn't current but rather kind of an ex post facto type of analysis, that there ought to be a screening of all unassigned claims in advance. Do you agree with that as well?

Dr. DICKEY. Yes.

Senator COHEN. What is it you disagree with?

Dr. DICKEY. I have to admit that I have a whole stack of information here, so for fear that I would say yes, Senator, and then find out that I'd misread.

Senator COHEN. What you can do is submit to me or you can do it now?

Dr. DICKEY. I think that we do have to recognize, as has been pointed out, that this will become much clearer in 1993 when we're talking about a flat 15 percent. There will continue to be concerns

about whether carriers are able equitably to put this information on the EOMB forms, so long as they have to look at individual MAAC charges which may be less than the 20-percent limiting charge, and therefore, I think while philosophically we're in favor of the phasing in beginning this summer, in terms of actual ability for that to work, I have questions and concerns.

My experience in interacting with the carriers is that it's just as frustrating for beneficiaries as it is for physicians. At least they still have the 800 number. My office frequently gets put on hold and then gets the same kinds of information.

Senator COHEN. Do you think we should reinstitute that 800 number for physicians as well?

Dr. DICKEY. Absolutely.

The third recommendation talks about the charge limits on the EOMB and as you've already stated, we would like to see the physicians get a copy of that as well, and think that would speed the opportunity to reimburse patients where there would have been an overcharge.

Clearly the dissemination of information to both beneficiaries and physicians is terribly important. It is confusing, it's not easy to get the information out there, but lack of information can contributes to the problem.

As you already pointed out, the physicians don't get that handbook or any comparable physician handbook. Clearly, it would be useful if there were some relatively succinct summary of the rules that went to physician offices and other billing entities.

The enforcement of balanced billing and the legal responsibility of the Medicare program, I don't think we have any problem with that. Obviously, the AMA and other organizations attempt very much to get the information to our beneficiaries. We try to recommend policy that will be protective of beneficiaries, for example, the lack of balanced billing for patients under 200 percent of poverty.

I think clearly though that adequately funded HCFA efforts can go a great distance to try and make sure that information gets out.

Senator COHEN. How about bundling? Do you have a problem with that?

Dr. DICKEY. Bundling of charges?

Senator COHEN. Yes?

Dr. DICKEY. Or do you mean the bundling to add up my services, getting up to $300?

Senator COHEN. What takes place is that instead of being able to bill separately, HCFA may bundle the charges so you come up with the lower number.

Dr. DICKEY. Yes, there clearly are times that I would disagree with that. I think that's one of those times that it would be useful if they send me the limiting charge information where it may not have been an intentional overcharge on my office's part, but rather that HCFA bundled differently or my Medicare carrier bundled differently than my interpretation of the rules.

The rightness or wrongness of bundling is less an issue for my beneficiaries, for my patients, than it is whether you accuse me of being intentionally overcharging. So I think here, it's not an issue of whether I approve of the way they bundle, it's an issue of if you

communicate it to me, I have the opportunity to defend my interpretation or to simply reimburse the difference to my patient.

If that information comes to me as much as 6 to 8 months after the service was provided, then you put me in an adversarial position with my patient. Medicare is interpreting and sending information to my patient. I don't have access to that information and suddenly, as you have implied several times today, what should be an extremely important relationship becomes an adversarial relationship.

Senator COHEN. As a matter of fact, I was going to pick up on what Mr. Guildroy from AARP related in that example of a woman who, while receiving marvelous treatment, took occasion to write her doctor a letter saying that he may have overcharged and she got a phone call which said take it up with his lawyer.

In view of the complexity of the law, in view of the inability of many of the older citizens to be able to come up with that money to pay for it, shouldn't there be greater sensitivity on the part of all physicians when they are dealing with this issue rather than say, if you've got a problem, go see a lawyer?

Dr. DICKEY. I think there is no language to appropriately address that physician's behavior and it cannot be justified. I disagree in terms of whether the carrier should cover all of these interactions. My patient's well-being is certainly the most important issue. However, if our relationship is so tenuous that my patient doesn't share with me his or her economic straits or their concerns, then our relationship is not what it should be and patients and I routinely have discussions not only about what bills in my office are or have been, but I routinely have discussions with them when I'm going to refer them to another physician.

I think that patients ought to be encouraged to have those discussions. If indeed they find a physician who refuses to include their economic well-being in his or her concerns, then perhaps they ought to look around and see if they can't find an equally competent, more compassionate physician.

Are there any other areas you want to disagree with? If you do, you can submit them for the record.

Dr. DICKEY. No.

Mr. BLEHART. Just to add in response to your question about getting information out to physicians, as recently as March 16th of this year, there was a detailed story about this that appeared in the AM News which is a weekly newspaper that the American Medical Association puts out. It goes to all member physicians and gets fairly wide distribution even beyond that.

I fully suspect that based on this hearing and other activities in the near future, there will be more such information put forth in AM News and other sources.

Senator COHEN. I want to thank both of you for agreeing to appear today. I think it's been very helpful to start to ventilate some of these issues because they are of tremendous importance to all of us.

I'd like to thank Bonnie Hogue of Senator Pryor's staff for her work on this hearing and also in drafting the legislation Senator Pryor and I intend to introduce very shortly, I would also like to

thank Mary Gerwin and Priscilla Hanley of my staff who have worked diligently on this problem.

Thank you all for coming.

The Committee will stand adjourned.

[Whereupon, at 11:47 a.m., the committee adjourned, to reconvene at the call of the Chair.]

APPENDIX

Item 1

April 3, 1992

The Honorable David Pryor
Chairman
Special Committee on Aging
United States Senate
Washington, DC 20510

Dear Senator Pryor:

Enclosed please find three copies of the Physician Payment Review Commission's testimony on implementation and enforcement of the OBRA89 charge limits that was prepared at the request of your committee. As time considerations have now precluded the Commission from testifying before the Aging Committee next week, I trust that our views will be entered into the record.

Sincerely,

Philip R. Lee /AS

Philip R. Lee, M.D.
Chairman

ENFORCEMENT OF OBRA89 CHARGE LIMITS

Paul B. Ginsburg, Ph.D.
Executive Director
Physician Payment Review Commission
2120 L Street, NW
Suite 510
Washington, DC 20037

Mr. Chairman, I appreciate the opportunity to testify this morning on behalf of the Physician Payment Review Commission concerning the enforcement of the limiting charge provisions of the Omnibus Budget Reconciliation Act of 1989 (OBRA89). Since the Commission's first meeting in 1986, it has devoted considerable thought to ensuring that physician payment policies are designed and implemented to safeguard access to care and to protect beneficiaries from significant financial hardship. Our most recent annual report, which was transmitted to Congress last week, makes several recommendations to ensure that limits on balance billing provide the type of protection that was expected from the legislation. My testimony this morning will highlight these recommendations and the Commission's rationale in making them. A complete list of our recommendations is attached.

THE IMPORTANCE OF CHARGE LIMITS

The payment reforms recommended by the Commission and enacted by the Congress in 1989 included three distinct but integral parts -- the Medicare Fee Schedule, Volume Performance Standards, and charge limits. Together, these three mechanisms form the basis of a payment system intended to achieve the goals of improving equity among physicians, slowing growth in expenditures, and protecting beneficiaries. While in the months since the Medicare Fee Schedule became the basis for payment, much attention has been focused on the impact of changes in fees on physicians, it is the Commission's view that implementation of charge limits is equally significant. Charge limits are an important mechanism to protect beneficiaries from additional costsharing burdens and to maintain access to care.

The Commission's most recent simulations indicate that charge limits will dramatically reduce total liabilities for balance bills. If physicians do not change their assignment status and submitted charges, balance bills will be reduced by 74 percent. In addition, fewer beneficiaries will have large expenditures for balance bills than previously. In 1988 about 2 percent of beneficiaries had total balance bills in excess of $500. Under the fee schedule, almost no beneficiaries are likely to have total balance bills of this magnitude.

Although it has been more than a year since the new limiting charge provisions were implemented, it is difficult to say whether this policy has been effective. Few, if any, cases of repeated patterns of charge violations have been reported by the regional offices of the Health Care Financing Administration (HCFA) to the Office of the Inspector General (OIG). This could be considered as evidence that physicians have been attentive to the new limits and have been billing appropriately. On the other hand, problems for beneficiaries have been reported, some serious enough to warrant legal action. The fact that few potential violations have been investigated raises the possibility that physicians and beneficiaries are not aware of the limits or that they have not been adequately enforced.

In either case, the Commission has concerns about whether the law, either as written or as it has been implemented, can effectively limit the liability of beneficiaries. To ensure that the promise of payment reform is realized, it is the Commission's view that changes are needed in the law, in the dissemination of information about the charge limits, and in enforcement.

STATUTORY CHANGES

Although the Congress clearly expected charge limits to constrain beneficiary liability, current law does not appear to shield Medicare patients from liability for charges in excess of the limit or to ensure a refund to beneficiaries who pay their physicians at the time of service and only later learn that the charge exceeded the legal limit. As written, the law subjects physicians who charge in excess of limits to civil sanctions and money penalties. But it does not include language stating that beneficiaries are not liable for those excess amounts, and there is no authority for HCFA to seek refunds from physicians on beneficiaries' behalf.

The Commission has learned that the law, as written and as it has been interpreted by HCFA, is not only confusing to Medicare beneficiaries but is also creating confusion for Medigap insurers. Many of these payers have interpreted OBRA89 to mean that their liability for balance bills of subscribers is constrained by the limiting charge. But the National Association of Insurance Commissioners has instructed its members that this interpretation is incorrect. OBRA89 does not relieve beneficiaries of the liability for balance bills exceeding the charge limit. Therefore, unless the Medigap policy specifically limits coverage of balance bills to the amounts specified in OBRA89, Medigap insurers must pay up to the limits stated in the policy, even if these exceed the charge limit.

Thus, to ensure that beneficiaries are not held liable for excess balance bills, Congress must clarify the law. First, the statute should be changed to make it explicit that beneficiaries are not liable for amounts billed above the limiting charge. Moreover, additional language should be added that requires physicians to refund to beneficiaries any amount above the legal limit.

Recently, HCFA changed its interpretation of the statute and has now instructed its carriers to inform beneficiaries that they are not liable for charges above the OBRA89 limits. This is a positive step. On the other hand, because the rationale for this change in interpretation is unclear, it is the Commission's view that a change in statute is preferable and will be more likely to ensure protection in the future. Moreover, HCFA continues to state that it does not have authority to seek refunds. Thus, despite this recent turn of events, the Commission stands by its recommendations that changes in the statute are necessary to protect beneficiaries.

These statutory changes are the most important steps necessary to ensure that Medicare beneficiaries are protected from significant financial hardships. But other administrative actions are also required to complement the statutory protection. These include strengthening the dissemination of information about limits, improving systems for monitoring compliance, and assigning responsibility for enforcement.

UNDERSTANDING CHARGE LIMITS

More must be done to inform beneficiaries and physicians of the limiting charge policy. HCFA has recently instructed its carriers to remove misleading statements from the Explanation of Medicare Benefits (EOMB) form. The Commission applauds this action and enthusiastically supports HCFA's plan to include the charge limit on the Explanation of Medicare Benefits (EOMB) form in 1993, an action critical to the successful implementation of the charge limits. Inclusion of the limit on the EOMB will give beneficiaries ready access to evidence that the physician billed appropriately or in excess of the charge limit and can direct carriers to initiate intensive monitoring or other enforcement actions.

Additional educational efforts are also needed. For example, program changes, including the limiting charge, were explained in the *1991 Medicare Handbook*, but this publication is sent only to new beneficiaries. Since those already enrolled in the program also need to know about these changes, HCFA should either distribute this handbook to all beneficiaries or develop a newsletter describing program changes that can be sent to beneficiaries at the beginning of the year. The Congress should instruct HCFA and its carriers to disseminate information about the limiting charge policy more widely to beneficiaries and physicians, and provide adequate funding to support development and dissemination of such materials.

Similarly, greater efforts should be made to ensure that nonparticipating physicians are notified about the charge limits by furnishing examples for commonly provided services and providing an easy mechanism for physicians to make inquiries. Organizations representing physicians and Medicare beneficiaries should also take steps to educate their members about Medicare policies.

MONITORING COMPLIANCE WITH CHARGE LIMITS

To back up these educational efforts, improved systems of monitoring are needed to ensure detection of potential violations. HCFA has recently instructed its carriers of new monitoring requirements including education of staff to handle beneficiary complaints, designation of a limiting charge coordinator, and regional office monitoring of carrier performance. While these steps should prove helpful, it is somewhat disheartening that they are only being taken now, a full 15 months after implementation of the law. Additional steps are needed. Carriers should be directed and funded to screen all unassigned claims to determine if charges exceed the limits. Changes in computer systems required for implementation of other payment policies would make the addition of this screen relatively simple for carriers to undertake. While prepayment screening is relatively inexpensive, additional carrier funding may be necessary to follow-up on any problems identified. Congress should ensure that the carriers have sufficient funds to undertake these activities.

The program should also notify physicians each time the charge limit is exceeded using a standardized document similar to the EOMB received by beneficiaries. Confusion about the limiting charge will likely diminish as physicians become more familiar with the new fees, limits, and standardized payment policies under the fee schedule. Even so, honest mistakes (either on the part of the physician or the carrier) should provide an opportunity for learning. Physicians need to know when they may have violated the law both so they can make an appropriate restitution to their patient and so they can avoid the mistake in the future.

Notifying physicians each time the charge limit is exceeded may both improve voluntary compliance and facilitate identification of physicians who "knowingly and willfully" violate charge limits. Such a document should be carefully designed and worded to be an educational, rather than a punitive, tool.

TAKING ACTION WHEN APPROPRIATE

The effectiveness of the limiting charge policy also depends on the Medicare program's ability to respond appropriately when charge limits have been exceeded, including the imposition of sanctions when necessary. Currently, there appears to be some uncertainty about which agency within the Department of Health and Human Services (HHS) is responsible for enforcing the charge limits. Although the Inspector General was responsible for enforcement of the system of Maximum Allowable Actual Charges, many believe that HCFA and its carriers could manage enforcement of charge limits more efficiently and effectively. In any case, the authority for enforcement should be clearly delegated by the Secretary.

CONCLUSION

The Congress took a major step for Medicare beneficiaries in OBRA89 by enacting charge limits, a policy that has been projected to reduce beneficiaries' out-of-pocket liability significantly. But additional action must be taken to ensure that the limits achieve this goal. The statutory and administrative changes described here could substantially improve financial protection of the nation's elderly and disabled citizens.

PHYSICIAN PAYMENT REVIEW COMMISSION

1992 ANNUAL REPORT TO CONGRESS

RECOMMENDATIONS ON ENSURING FINANCIAL PROTECTION FOR BENEFICIARIES

- Congress should amend the Medicare statute to clarify that beneficiaries should not be held liable for charges on unassigned claims that exceed the limiting charge.

- Congress should amend the Medicare statute to require physicians to make refunds to beneficiaries for charges on unassigned claims that exceed the limiting charge.

- The Commission enthusiastically supports the plan of the Health Care Financing Administration to include the charge limit on the Explanation of Medicare Benefits form in 1993 as an important step to empower beneficiaries and enhance their understanding of the policy.

- HCFA and the carriers should be instructed to disseminate information about the limiting charge policy to beneficiaries and physicians through a variety of channels. In particular, the limiting charge should be clearly explained in the *Medicare Handbook*; this publication or comparable information on program changes should be distributed to all Medicare beneficiaries. Congress should provide adequate funding to support this educational effort.

- While enforcement of balance billing limits is clearly the legal responsibility of the Medicare program, organizations representing physicians and beneficiaries should also take steps, working in close cooperation with HCFA and its carriers, to educate their members about Medicare rules and regulations.

- Effective monitoring of charges on unassigned claims is critical to ensuring financial protection of beneficiaries. Carriers should be required to monitor compliance by conducting prepayment screening of all unassigned claims to identify potential violations of the limiting charge.

- HCFA should be directed to explore the feasibility of notifying physicians of all potential violations of the limiting charge with a document similar to the Explanation of Medicare Benefits form received by beneficiaries. Improved communication between carriers and physicians could lead to fewer honest mistakes and assist in establishing the case for sanctioning those who violate the limit on a repeated basis.

- Distinct delineation of authority within the Department of Health and Human Services for enforcing the limiting charge is essential to protecting beneficiaries. This authority should be clearly delegated by the Secretary to the appropriate agency.

Item 2

STATEMENT OF
MARTHA McSTEEN
PRESIDENT
THE NATIONAL COMMITTEE TO PRESERVE
SOCIAL SECURITY AND MEDICARE

SUBMITTED TO

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

REGARDING
MEDICARE BALANCE BILLING

Mr. Chairman, members of the Committee, I am Martha McSteen, President of the National Committee to Preserve Social Security and Medicare. Our five million members and supporters are mostly Medicare beneficiaries who are keenly interested in understanding exactly what their medical costs are and liability is.

The National Committee has a long history of advocating for eliminating balance billing so that beneficiaries only have to pay 20 percent of what Medicare approves. The 1991 National Committee membership issues poll showed that 73 percent of members placed "limiting doctor charges to no more than Medicare allows" as a high priority--up from 68 percent in the 1990 issue poll. If we eliminated balance billing, there would be little need to monitor compliance, to have special language on Medicare notices, to answer numerous questions of the carriers about the limiting charge, to notify physicians of charges above the limit, to set up a system to retrieve overpayments or to sanction violators. It would save beneficiaries out-of-pocket costs, it would save Medicare administrative costs, and it would save a lot of time and aggravation for both beneficiaries and Medicare.

Barring the elimination of balance billing, a system must be put in place to protect beneficiaries against paying more than the law specifies. The law allows the physician to charge up to 120 percent of what Medicare approves in 1992, and 115 percent of what Medicare approves in 1993. PPRC estimates that Medicare balance billing will be reduced 74 percent when balance billing is limited to 115 percent of what Medicare approves. Based on

a 1989 CBO estimate that balance billing costs Medicare beneficiaries $2.2 billion, Medicare beneficiaries have at stake up to $1.6 billion annually in the effective enforcement of the limiting charge.

Inform beneficiaries on the EOMB

The first thing that should take place is to inform beneficiaries directly on the new simplified Explanation of Medicare Benefits (EOMB) when the limiting charge has been exceeded. The National Committee has testified before the Physician Payment Review Commission (PPRC), the first time in December 1990, requesting that this be done. We are pleased to say that the PPRC has been a champion on this issue. We are also pleased that HCFA has developed a new, standardized EOMB form which is much easier to understand than many of the old forms. However, the form for unassigned cases is still missing the vital information in the Summary Box stating: "Your total responsibility is... (the lesser of the limiting charge or the actual charge)." Medicare carriers' computers should easily be able to calculate this figure and print it on the EOMB.

Additionally, in cases where the limiting charge has been violated, there should be a statement in the body of the EOMB that says that "you are not responsible for any amount above the limiting charge which is.... If you paid more than this amount you are entitled to a refund. Call us if you need assistance."

The most recent EOMB for unassigned claims leaves out the line that tells beneficiaries what their payment responsibility is. This could lead beneficiaries to think that they are responsible for the entire difference between what the doctor charges and what Medicare reimburses. This is unfortunate and should be corrected. Some of the old forms used until very recently carried the erroneous information that the beneficiary *was* responsible for this difference. Not only has this statement been erroneous since the new limiting charge went into effect January 1991, it was wrong for several years before that. Since 1987, the Maximum Allowable Charge (MAAC) placed a limit on non-participating physicians' charges--however, to beneficiaries this limit was generally not known.

Inform beneficiaries in general about their rights under the law

In addition to informing beneficiaries on the EOMB when overcharges occurred, beneficiaries should be informed about the limiting charge law and how to go about recovering payments already made to physicians. This could be done in several ways. Information could be included with Social Security checks; the Medicare Handbook could clearly state that beneficiaries are not responsible for any amount above the 120 percent of the Medicare approved amount (115 percent after 1992), and that beneficiaries are entitled to a refund if they paid more than the allowable; carriers could be in a position to inform beneficiaries by telephone of the limiting charge and what to do about overcharges. In this regard, HCFA should be recognized for their efforts of notifying the Regional offices with instructions to the carriers about how to promptly handle inquiries about limiting charges.

Improved monitoring of limiting charge violations

All non-assigned claims should be screened for limiting charge compliance. Currently, carriers are only required to screen the ten top procedures and five randomly selected procedures within each specialty. Carrier computers should be set to flag every unassigned claim that indicates charges above the limiting charge. A letter should go out to the health care provider reminding them of that fact and stating that they may owe the beneficiary money if they have already received payment.

Conclusion

As a consumer organization, we take our responsibility to inform and to educate seriously. We encourage our members to appeal any decision they feel is unfair, we recommend ways to keep track of medical bills and reimbursements, and we write articles in our newspaper about how to make sense out of a very complex medical system. Many times seniors are quite capable of pursuing their rights, but it should not be assumed that beneficiaries are always in such a position. Beneficiaries frequently are overwhelmed by their illness, their large medical bills and the complex Medicare and Medigap claims process. Beneficiaries must be afforded adequate protection through a system in which all parties involved accept their responsibility for this complicated process.

Thank you again for the opportunity to express the views of the National Committee.

Item 3

W. HOWARD JOHNSON
CERTIFIED PUBLIC ACCOUNTANT (Retired)
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TELEPHONE (301) 929-1850

April 1, 1992

Senator David Pryor, Chairman
U. S. Senate Special Committee on Ageing
SD - G 31
Washington, DC 20510

Attention: Miss Bonnie Hogue

Dear Senator Pryor:

I spoke with Miss Hogue of your office today about Medicare patients being overcharged by doctors.

My wife's illness resulted in an overcharge that angers us.

It seems that:

(1) doctors are unaware of limits imposed on their charges to medicare patients,
(2) the Health Care Financing Administration is confused about what Medicare instructs Medicare patients to pay providers, and
(3) Insurance companies are reimbursing insureds for amounts in excess of legal charges.

Lack of information caused or is causing embarrassment for doctors because they did not know of limits on allowable charges; and, insurance companies are paying those unallowable charges which result in additional premiums being collected to pay illegal charges.

Because I cannot attend the hearing to be held April 7, 1992, we respectfully request that our plaint as contained in the attached chronology be made part of the record.

Thank you.

Sincerely,

W. Howard Johnson

3/21/92

RE: "OVERCHARGE"

1 of 4

DATE	
1991	
10-4	DOCTOR RECOMMENDS OPERATION
10-8	"MEDICARE LETTER" SIGNED AND RETURNED TO DOCTOR. LETTER SAYS ESTIMATED TOTAL CHARGE TO BE $3949.80 AND MEDICARE ESTIMATED PAYMENT TO BE $800 OR $1000 -- MY ESTIMATED PAYMENT WOULD THEREFORE BE $3,149.80 OR $2,949.80
10-17	OPERATION PERFORMED
11-5	DOCTORS STATEMENT RECEIVED FOR $4550
1992	
1-17	EXPLANATION OF MEDICARE BENEFITS RECEIVED:

	SERVICE DATE	BILLED AMOUNT	MEDICARE APPROVED	MEDICARE PAID
PROCEDURE	10-17-91	$3800.00	$1375.40	$1100.32
PROCEDURE	10-17-91	750.00	-0-	-0-

(MEDICARE SAYS NO PAYMENT FOR SECOND ITEM BECAUSE IT IS INCLUDED IN THE MAJOR SURGICAL FEE). CHECK FOR THE $1100.32 ACCOMPANIED.

MEDICARE ADVISES WE ARE RESPONSIBLE TO PHYSICIAN FOR THE REMAINED OF BILL THEY DID NOT PAY OF $3449.68

1-17	MEDICARE'S EOMB MAILED TO AARP - PRUDENTIAL

National 45-606 Eye-Ease 45-706 20/20 Buff Made in USA

RE: "OVERCHARGE" 3/21/92

DATE 1992	
2-1	AARP-PRUDENTIAL CHECK FOR $3,699.68 RECEIVED. AARP-PRU SAYS SINCE THE $750 AMOUNT WAS NOT APPROVED BY MEDICARE, BENEFITS ARE NOT PAYABLE.
EARLY FEBRUARY 1992	AARP-BULLETIN REC'D. FRONT PAGE STORY IS ABOUT "OVERCHARGE". ONE CASE IS AMAZINGLY SIMILAR TO OURS.
2-6	MISS FINLEY AT MEDICARE 1-800-233-1124 HEARD MY STORY, SAID SHE WAS AWARE OF THIS MATTER. SHE PUT ME ON "HOLD" -- THEN RETURNED TO SAY I HAD TO PAY ONLY $674.13 OF THE $750 CHARGE. AND, IF I NEEDED MORE INFORMATION, I COULD WRITE TO MEDICARE POST PAY REVIEW, P.O. BOX 890108, CAMP HILL, PA 17089-0108.
2-6	LORETTA LEE AT AARP-PRUDENTIAL 1-800-523-5880 ~~WAS~~ SAYS SHE WILL OBTAIN COPY OF AARP BULLETIN AND SHE OR HER SUPERVISOR WILL CALL ME BACK WITH AN EXPLANATION.
2-7	I CALLED WASHINGTON OFFICE OF HEALTH CARE FINANCING ADMINISTRATION FOR CAROL WALTON. WAS TOLD MISS WALTON IS IN BALTIMORE OFFICE AND I WAS GIVEN HER BALTO PHONE (410-966-5876) AND WASHINGTON TRANSFERRED ME. MISS WALTON NOT IN: SOMEONE WILL CALL ME BACK. NO ONE DID.

National 45-606 Eye-Ease 45-706 20-20 Buff Made in USA

RE: "OVERCHARGE" 3/21/92

3 of 4

DATE 1992	
2-11	3PM I SPOKE WITH DOCTOR'S OFFICE ([redacted]) ABOUT BILL AND STRANGE NUMBERS. [redacted] SAYS NUMBERS ARE M.A.A.C (MAAC) MAXIMUM AMOUNT ALLOWABLE CHARGE. NO HELP OTHERWISE. I DID NOT TELL HER ABOUT MY "OVERCHARGE" ACTIVITY.
2-13	2PM - I CALLED CAROL WALTON IN BALTIMORE. NOT IN TODAY - SNOW. HER SECRETARY NOT IN EITHER.
2-13	3:10 PM - DELILAH SCHMITT OF HCFA RETURNS CALL. SHE'LL LOOK INTO MATTER AND CALL ME NEXT WEEK.
2-14	4:30 PM - NANCY O'CONNOR IN HCFA AT PHILADELPHIA CALLED. SHE HAD JUST GOTTEN OFF PHONE WITH BALTIMORE. SHE ASKED FOR CLAIM NUMBER AND SAID HOPEFULLY SOMEONE FROM MEDICARE WOULD CALL ME BACK THAT AFTERNOON OR ON TUESDAY (MONDAY WAS HOLIDAY).
2-18	(TUESDAY) TAMI MOHNEY OF PENNSYLVANIA BLUE SHIELD (MEDICARE ADMINISTRATOR) CALLED. SHE REQUESTED (3) COPIES OF (1) MEDICARE'S EOMB (2) STATEMENT FROM PROVIDER, AND (3) "MEDICARE LETTER" SIGNED BY PATIENT.
	ABOVE SENT TO HER SAME DAY.
	SHE GAVE ME HER DIRECT PHONE LINE. SHE SAID "LIMITING CHARGE" WAS $2,553.75.

National 45-406 Eye-Ease 45-706 20/20 Buff Made in USA

RE: "OVERCHARGE" 5/12/92

4 of 4

DATE 1992	
2-25	KIRSTEN SLOAN OF AARP - FEDERAL OFFICE 202-434-3770 CALLED
2-28	K. SLOAN CALLS TO ASK IF I WAS WILLING TO SPEAK WITH ROBERT PARE OF NY TIMES - YES.
2-29	WASHINGTON POST HAS STORY ABOUT OVERCHARGE
3-4	STATEMENT FROM DOCTOR SHOWS CREDIT ADJUSTMENT - MEDICARE WRITE-OFF - OF THE $750 CHARGE.
3-20	SARAH SCHULTE OF AARP CALLS,
3-21	SCHULTE AND CAMERA MAN ARRIVE TO TAPE AN INTERVIEW

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