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REPORT BY THE

Comptroller General

OF THE UNITED STATES

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

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

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

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

HRD-79-111
SEPTEMBER 6, 1979

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

B-164031(3)

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

Dear Mr. Chairman:

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

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

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

Sincerely yours,

Comptroller General
of the United States

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

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

D I G E S T

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

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

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

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

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

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

charges used by the private businesses in only 11 percent of 787 comparisons. (See p. 13.)

--The four commerical carriers made reasonable charge reductions in 0 to 7 percent of the private claims GAO reviewed. One Blue Shield carrier made reductions in 27 percent of its private claims, the other Blue Shield carrier in 56 percent. In handling Medicare claims, however, all six carriers reduced from 64 to 83 percent of the sampled claims. (See p. 15.)

COMPARABILITY PROVISION SHOULD BE CHANGED

GAO assessed the Department of Health, Education, and Welfare's (HEW's) use of a Medicare provision which, in effect, requires that charges allowed as reasonable under Medicare not be higher than those allowed under Medicare carriers' private business for comparable services under comparable circumstances. This provision was apparently meant to limit program costs.

GAO found that HEW was not using this provision of the law to limit or reduce program costs. (See p. 16.) Also, neither the law nor HEW regulations defined what constituted comparability. Health Care Financing Administration headquarters and regional officials have stated that they do not know the intent of this provision. Consequently, regional offices, which have been made responsible for comparability determinations, have received little guidance from the Health Care Financing Administration headquarters. As a result, determinations of reasonable charges are inconsistent.

HEW could not provide GAO with any statistics on the extent, if any, that Medicare claims are reduced due to comparability determinations.

MATTERS FOR CONSIDERATION BY THE SUBCOMMITTEE

The Subcommittee should consider either

--deleting the comparability language in the law or

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

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

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

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Contents

ABBREVIATIONS

GAO	General Accounting Office
HCFA	Health Care Financing Administration
HEW	Department of Health, Education, and Welfare
HIAA	Health Insurance Association of America
R&C	reasonable and customary
UCR	usual and customary

CHAPTER 1

INTRODUCTION

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

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

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

The Subcommittee asked that we:

--Determine what data the carriers have provided to the Department of Health, Education, and Welfare (HEW) on comparability and what HEW has done with the data when verifying or analyzing comparability.

--Compare physicians' charges paid or allowed as reasonable by the carriers under their private plans to the Medicare amounts for like procedures by the same practitioners.

--Compare carriers' "customary" charge allowances under their private business with Medicare's "prevailing" charges for like procedures and physician specialties in the same geographic area.

--Compare the reasonable charge reductions made by the carrier under Medicare with the reductions made by

the carrier under its private lines of business for "assigned" and "unassigned" claims.

The Subcommittee also requested information on how much Medicare beneficiaries are not required to pay the reasonable charge reductions or the deductible and coinsurance amounts provided for in the law. In order to fulfill this portion of the request, we sent a questionnaire to Medicare beneficiaries nationwide. The results of our questionnaire analysis will be provided to the Subcommittee as soon as it is completed.

MEDICARE PROGRAM

The Social Security amendments of 1965 (42 U.S.C. 1395), established the Medicare program to protect eligible persons, principally those over age 65, against the costs of health care. In 1972 Medicare was extended to those under 65 who are disabled. Medicare provides two forms of protection:

--Medicare part A, hospital insurance benefits, covers inpatient hospital services and post-hospital care in extended-care facilities or in the patients' homes. Payment is financed by regular social security taxes collected from employees, employers, and the self-employed.

--Medicare part B, supplementary medical insurance benefits, is a voluntary program which reimburses part of a physician's services and a number of other medical and health benefits. Benefits under this part are financed by premiums paid by enrollees and funds appropriated from general U.S. Treasury revenue.

The responsibility for administering Medicare rests with the Secretary of HEW. Within HEW the responsibility has been delegated to the Medicare Bureau of the Health Care Financing Administration (HCFA). The Bureau contracts with public or private agencies to process Medicare claims and make payments on behalf of the Government.

Contractors that pay institutional providers (such as hospitals) are called intermediaries; contractors that pay physicians and suppliers are called carriers. The Subcommittee's request addresses reimbursement for physicians' services under part B of Medicare.

MEDICARE REIMBURSEMENT FOR PHYSICIAN SERVICES

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

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

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

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

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

The data from which customary and prevailing charges are established are collected during a calendar year. Customary and prevailing charges are revised annually on July 1, and are used as charges (or screens) for the next 12 months (a fee screen year) based on charge information collected during the preceding calendar year. For example, for fee screen year 1979 (July 1, 1978, to June 30, 1979) charge data was based on the actual charges physicians made from January 1, 1977, to December 31, 1977. Consequently, the data used to compute customary and prevailing charges can be from 6 to 30 months old when a beneficiary or physician submits a bill; most of the time, this results in the reasonable charge being lower than the actual charge.

The actual reimbursed amount depends on (1) whether or not the beneficiary has met the $60 deductible during the calendar year, (2) the amount of the 20-percent coinsurance for which the beneficiary is responsible, and (3) the amount the actual charge is reduced to reflect Medicare's determination of what is reasonable for the service.

ASSIGNED CLAIMS

Physicians and suppliers may choose to "accept assignment" of a beneficiary's claim. Under this Medicare provision, the beneficiary need not pay any difference between what the physician or supplier actually charges and what is determined to be the reasonable charge for his/her service. When the physician or supplier bills Medicare directly and agrees to accept assignment of the Medicare part B claim, he/she must then agree to accept Medicare's determination of the reasonable charge as his/her total charge. Medicare then pays the physician or supplier 80 percent of the reasonable charge. The physician or supplier may charge the beneficiary for only the remaining 20 percent of the reasonable charge.

On the other hand, if the physician or supplier does not accept assignment of the claim, he/she may charge the beneficiary for the 20-percent coinsurance plus the remainder of the bill.

About 71 percent of Medicare part B claims had reasonable-charge reductions in fiscal year 1978. This created an additional beneficiary burden (on top of the required 20-percent coinsurance) of about 19 percent of submitted charges whenever the beneficiaries' physicians elected not to "accept assignment" under Medicare.

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

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

PRIVATE PLANS' USE OF HEALTH INSURANCE ASSOCIATION OF AMERICA DATA

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

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

SCOPE OF REVIEW

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

--Pan American Life Insurance Company in Louisiana,

--Occidental Life Insurance Company of California in southern California,

--General American Life Insurance Company in Missouri, and

--Connecticut General Life Insurance Company in Connecticut.

Each of these insurance companies is a Medicare carrier. We only reviewed private plan data from claims submitted to these companies for areas where they act as Medicare carriers--this was to facilitate comparisons between each carrier's private and Medicare business.

Because of this limitation, the claims universe for the commercial carriers' private lines of business was necessarily restricted by three dominant factors:

--We limited the universe to a small geographic portion of each company's business (one State or area).

--We only compared 7 to 13 medical and surgical procedures out of thousands of procedures; however, the procedures selected were commonly used under Medicare.

--We limited our sample to about 100 physicians who performed these procedures for both private and Medicare patients at each carrier.

Consequently, our samples were drawn from an extremely limited universe of private business claims at each carrier which resulted, ultimately, in very small sample sizes.

As a result of discussions with officials of the Blue Cross and Blue Shield Associations, we agreed to review claims data prepared under an ongoing study that is being performed for HCFA, which included four Blue Shield carriers:

--Blue Cross and Blue Shield of Alabama.

--Colorado Medical Service, Inc.

--Blue Shield of Florida, Inc.

--Blue Shield of Massachusetts, Inc.

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

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

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

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

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

CHAPTER 2

SUMMARY OF COMPARISONS BETWEEN MEDICARE AND PRIVATE HEALTH INSURANCE PLANS

We compared the actual and allowed charges for a sample of physicians at four commercial and two Blue Shield Medicare carriers for their private and Medicare businesses. We also compared their private and Medicare reasonable charge screens and reductions. We found that:

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

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

--Private plan allowed charges usually exceeded Medicare allowed charges by more than 10 percent.

--At three of the six carriers, each physicians' customary (usual) charge for a service, rather than his/her actual charge, was the most common amount allowed for Medicare billings. At two carriers, the prevailing (most common) charge for each medical or surgical procedure for physicians in the area was the most common amount allowed. At the remaining carrier the effect of the customary and prevailing charge screens was about the same.

--Medicare reasonable charge screens for the doctors and the procedures covered in this report were higher than the reasonable charge screens used by private businesses in only 11 percent of 787 comparisons.

--The four commercial carriers surveyed made reasonable charge reductions in 0 to 7 percent of the private claims that we reviewed--the two Blue Shield carriers made reductions in 27 and 56 percent of their private claims. As Medicare carriers, however, all six carriers made reductions in 64 to 83 percent of the Medicare claims we sampled.

Our findings for each carrier are detailed in appendixes III through VIII of this report.

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

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

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

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

COMPARISON OF ACTUAL CHARGES

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

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

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

under Medicare. We attempted to determine each physician's most frequent Medicare charge by selecting the charge that most closely represented what the physician usually charged. For example, if a physician had five charges of $10, $10, $8, $10, and $11, we selected the $10 charge (mode charge) as that which he/she usually charged. However, if the most frequent charge was not apparent, we averaged the physician's charges. For example, if there were an equal number of charges at each of two or more different amounts, we averaged these amounts. If there were three or more charges that were all different, we averaged these amounts.

The following table compares all carriers:

Carrier	Number of services	Private actual charges		
		Lower than Medicare	Equal to Medicare	Higher than Medicare
		(Number (%))		
Pan American	561	52 (9)	448 (80)	61 (11)
Occidental	252	19 (8)	205 (81)	28 (11)
General American	271	21 (8)	184 (68)	66 (24)
Connecticut General	325	15 (5)	304 (94)	6 (2)
Blue Shield of Massachusetts	9,747	889 (9)	8,105 (83)	753 (8)
Blue Shield of Florida	2,675	185 (7)	1,898 (71)	592 (22)
Total	a/13,831 (100%)	1,181 (9%)	11,144 (81%)	1,506 (11%)

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

COMPARISON OF ALLOWED CHARGES

The allowed charges in the private plans were lower than those allowed under Medicare in only 7 percent of the cases we reviewed.

To compare the allowed charges of both businesses, each allowed charge for each physician in the private health care plans was compared to the physician's most frequently allowed charge for the same procedure under Medicare. The following table summarizes all carriers' charges:

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

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

HOW MUCH HIGHER ARE PRIVATE ALLOWANCES THAN MEDICARE ALLOWANCES?

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

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

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

than under Medicare. This charge would be counted as one of the 600 charges on the following table and would represent one of the charges included in the 26-50 percent column. For a specific example of the method we used to determine the percentages, see appendix III, page 38 of this report.

Carriers	Number of charges	Extent that physicians' private charges exceeded their Medicare charges				
		1-10%	11-25%	26-50%	51-75%	76% and over
Pan American	156	16	60	55	10	15
Occidental	69	14	30	19	5	1
General American	114	11	49	32	13	9
Connecticut General	97	35	32	26	4	-
Blue Shield of Massachusetts	47	12	19	16	-	-
Blue Shield of Florida	117	22	48	36	10	1
Total	600	110	238	184	42	26
	(100%)	(18%)	(40%)	(31%)	(7%)	(4%)

SCREENS FOR DETERMINING MEDICARE ALLOWED CHARGES

At three of the six carriers reviewed (General American, Blue Shield of Massachusetts, and Blue Shield of Florida), the customary charge screen was the most common amount allowed for Medicare billings. At two carriers (Occidental and Connecticut General) the prevailing charge screen was the most common amount allowed. At Pan American the effect of the customary and prevailing charge screens was about the same.

Each Medicare allowed charge in our sample was evaluated to determine whether the actual, customary, or prevailing charge resulted in the amount allowed. The allowed charge for a service under Medicare is the lowest of these three amounts in most instances. Since two or possibly all three of these figures could be the same, the following table also shows the number of instances where these charges were the same and represented the lowest amount and, therefore, were used as the basis for determining the amount that was allowed

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

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

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

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

COMPARISON OF MEDICARE REASONABLE CHARGE SCREENS TO PRIVATE PLAN SCREENS

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

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

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

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

The commercial carriers reviewed do not produce physician profiles for their private business because they generally do not have enough data on a physician to create meaningful profiles. Consequently, no private business customary charge screens are used and no comparisons can be made to Medicare.

The two Blue Shield carriers reviewed utilized customary screens under their private businesses. Following is a comparison of Medicare and private customary screens for the physicians reviewed:

Carrier	Number of screen amounts compared	Medicare customary screen higher than private screen	
		Number	Percent
Blue Shield of Massachusetts	118	22	19
Blue Shield of Florida	75	-	-
Total	193	22	11

Of the 787 comparisons, 88 (11 percent) show Medicare screens that are higher than the corresponding private plan screens. It should be emphasized, however, that a comparison of screens only reveals what could hypothetically happen if the screen amount represents the lowest or "reasonable" charge. For example, although Connecticut General is the carrier with the highest percentage of cases (34 percent) where its Medicare prevailing charge screens exceed its private prevailing screens, it has a policy of allowing its claims examiners to apply tolerances to its screens in order to allow a greater number of actual charges in full under its private business. As shown on page 70, Connecticut General actually allowed less under its private business than under Medicare in only 1 percent of the cases reviewed.

REASONABLE CHARGE REDUCTIONS

As a part of the analysis of Medicare and private insurance claims, we determined the range of reasonable charge reductions for each procedure for each carrier in our sample. The following table shows the total number of charges in our sample for each carrier and the number of charges reduced.

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

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

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

b/No breakdown by assigned or unassigned was available.

CHAPTER 3

STATUTORY REQUIREMENT ON COMPARABILITY BETWEEN MEDICARE AND PRIVATE PLANS SHOULD BE DELETED OR CLARIFIED

The Subcommittee asked that we assess HEW's use of the comparability provision contained in section 1842(b)(3)(B) of the Medicare law. This provision says, in effect, that Medicare charges allowed as reasonable under Medicare should not be higher than charges allowed under the Medicare carriers' private lines of business under comparable circumstances. The apparent intent of this provision was to limit or reduce program costs. However, our sample of claims data at six Medicare carriers showed that HEW's use of this provision is resulting in no limitation or reduction of program costs. In addition, neither the law nor HEW's regulations define comparability. Therefore, we believe the Subcommittee should introduce legislation to delete the comparability language from section 1842(b)(3)(B), or it should clarify the language to assure appropriate and consistent application.

We found that this provision was not used for lowering Medicare program costs, and no statistics were available from Medicare to show that any Medicare claims were reduced due to comparability determinations.

Yet, according to HEW, each year HCFA regional office personnel compare the payment screens used by about 24 carriers for their private and Medicare businesses. These comparisons are made to determine if Medicare payment screens are higher than private plan payment screens in order to comply with the comparability provision. Since we found no reduced program costs to the Medicare program, we believe that deleting this provision would have little, if any, economic effect on Medicare; rather, deletion would remove the need to perform numerous annual comparisons now made by HCFA regional offices.

Current HEW regulations are not clear about whether all of the regulation's criteria are necessary for showing comparability, and whether meeting all these criteria always constitutes comparability. Medicare headquarters officials stated that this issue has never been settled, and that minimal guidance is provided to the regional offices, which are responsible for administering the provision because the headquarters policy staff does not know the provision's intent.

Consequently, this provision is inconsistently administered by HCFA.

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

STATUTORY REQUIREMENT

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

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

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

CONFUSION IN INTERPRETING COMPARABILITY

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

Committee staff reported on "Medicare and Medicaid, Problems, Issues, and Alternatives" in February 1970. On comparability, the report states:

> "The plain meaning of that provision is that a Blue Shield Plan, serving as a medicare carrier, would not allow more as a medicare charge than it ordinarily allowed under its regular basic surgical-medical contract for its own subscribers. The limitation could have been applied on the benefits allowed under the plan's most widely-held contract or even the average payments actually made under all of the plan's different types of basic contracts. Additionally, allowances could have been calculated using a relative value scale for those services covered by medicare but not by the particular Blue Shield carrier.
>
> "Such limitations upon 'reasonable charges,' were, we believe, intended by the Congress as a sensible control which could have been determined with reasonable objectivity."

In response to statements in the Committee staff report, HEW provided a statement included in congressional hearings also held during February 1970:

> "We disagree with the idea that present law can be interpreted as the Staff suggests it could. We do not believe that it was the intent of Congress that a reimbursement policy be developed that would require Medicare patients typically to pay their physicians substantial amounts in excess of the deductible and coinsurance * * *. We believe it is clear from the law and from the legislative history that reasonable charges under Medicare were not to be limited to amounts paid by private insurers under their own plans when such payments were unrelated to the total liability of the patient and, on the contrary, were only in partial indemnity for what the patient would have to pay. Such plans are not comparable to the Medicare program, which was, generally speaking, designed, except for deductibles and coinsurance, to relieve patients of what they would otherwise have had to pay the physician." (Our underscoring.)

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

> "§405.508 Determination of comparable circumstances; limitation.
>
> "(a) Application of limitation. The carrier may not in any case make a determination of reasonable charge which would be higher than the charge upon which it would base payment to its own policyholders for a comparable service in comparable circumstances. The charge upon which it would base payment, however, does not necessarily mean the amount the carrier would be obligated to pay. Under certain circumstances some carriers pay amounts on behalf of individuals who are their policyholders, which are below the customary charges of physicians or other persons to other individuals. Payment under the supplementary medical insurance program would not be limited to these lower amounts.
>
> "(b) When comparability exists. 'Comparable circumstances,' as used in the Act and this subpart, refers to the circumstances under which services are rendered to individuals and the nature of the carrier's health insurance programs and the method it uses to determine the amounts of payments under these programs. Generally, comparability would exist where:
>
> "(1) The carrier bases payment under its program on the customary charges, as presently constituted, of physicians or other persons and on current prevailing charges in a locality, and
>
> "(2) The determination does not preclude recognition of factors such as speciality status and unusual circumstances which affect the amount charged for a service.

"(c) Responsibility for determining comparability. Responsibility for determining whether or not a carrier's program has comparability will in the first instance fall upon the carrier in reporting pertinent information about its programs to the Health Care Financing Administration. When the pertinent information has been reported, the Health Care Financing Administration will advise the carrier whether any of its programs have comparability."

The Medicare Bureau has delegated the responsibility for determining comparability to its regional offices.

THE REGIONAL OFFICE INTERPRETATION OF THE COMPARABILITY PROVISION

According to a Medicare headquarters official, as of April 1979 there were 46 Medicare carriers operating in 61 service areas. 1/ Medicare regional office personnel make annual comparisons between the private and Medicare businesses for at least some medical procedures for 24 Medicare carriers in 25 service areas, in order to comply with the comparability provision. The Medicare Bureau does not know how many of these carriers have private plans that are comparable to Medicare.

The five regional offices we visited believe that commercial carriers' private plans reviewed by us are not comparable to Medicare. Their reasons were that these carriers (1) do not establish physician profiles, and consequently do not base payment on both the customary and prevailing charges of physicians or suppliers and/or (2) do not recognize physician specialities in their determinations of reasonable charge. One Medicare regional official stated that, if a carrier asserts that it has no comparable plans and no comparable service procedures to Medicare, then it is not comparable. This makes the decision on comparability subject to the interests and incentives of the private businesses--not to the Medicare program.

The two Blue Shield companies reviewed do establish physician profiles, and consequently they do base their

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1/Seven States have more than one Medicare carrier. A service area is the geographic jurisdiction of each carrier in a State.

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

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

Blue Shield of Florida's private plans are comparable to Medicare even though:	Blue Shield of Massachusetts' private plans are not comparable to Medicare because:
--It uses no indexes to limit prevailing charge increases, while Medicare does apply indexes.	--It uses indexes to limit prevailing charge increases; but they are different from Medicare indexes. It also applies these indexes to its customary charge increases, while Medicare does not.
--It uses more recent physician profile data than Medicare uses, and updates these data in a different month from Medicare.	--It does not regularly update its physician profiles, while Medicare does.
--Its private plan prevailing charge screens are set at the 90th percentile, whereas Medicare uses the 75th percentile.	--Its private plan prevailing charge screens are set at the 90th percentile, whereas Medicare uses the 75th percentile.
	--It breaks the State into two geographic areas having separate sets of screens for Medicare, but it has only one set of screens for its private business.

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

The decisions made by HCFA regional offices that the five carriers in our review were not comparable seemed to contradict HEW comments in the Senate Finance Committee Staff report published in 1970, and in HCFA guidelines issued in June 1977. The decisions of no comparability were made primarily because the private plans do not consider physicians' customary charges in their reasonable charge determinations. However, HEW's 1970 comments on the Senate Finance Committee Staff report stated:

> "Contrary to what the Staff Report indicates, we have required the carriers to use the charges they recognize as a basis of what they pay in their own business as a limitation on what they can pay under Medicare when circumstances are comparable. For example, most of the commercial companies in their own business set up a prevailing rate which results in the reduction of reimbursement of physicians' fees that exceed these prevailing levels. They are instructed to make sure that the prevailing levels in Medicare do not exceed the prevailing levels which they have established for their own business."

Blue Shield of Massachusetts was judged not comparable for the reasons stated on page 86. At least one of these reasons (the period for updating profiles) seems to contradict HCFA part B intermediary letter number 77-26 1/ dated June 1977, which states:

> "The Part B payment mechanism, which incorporates the reasonable charge criteria and the comparability provision, seeks to achieve parity between the Medicare program's payments for covered medical and other health services and those made by private insurers under their own health plans for similar services provided to their policyholders and subscribers. Thus, where a Medicare carrier has a comparable private health plan, which seeks to achieve full payment (exclusive of any deductible or coinsurance) of charges for covered services received by policyholders, as opposed to only partial indemnity payment, the payment levels under that plan, if lower

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1/An intermediary letter contains statements of program policy, which are binding on all Medicare carriers.

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

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

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

ALTERNATIVES TO PRESENT ADMINISTRATION OF THE COMPARABILITY PROVISION

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

bases its screens on the same historical claim data as Medicare, but at the 90th percentile of physician charges instead of at the 75th as Medicare does. Consequently, the carriers' private and Medicare screens were not compared, and no reductions were required.

We believe the Subcommittee should consider one of the following alternatives to alleviate the problems associated with comparability:

--Delete the comparability language from section 1842 (b)(3)(B) of the Medicare law.

--Define comparability in the law so that any private health insurance plan which intends to reimburse physicians, suppliers, and/or beneficiaries on the basis of a current "reasonable charge" is considered comparable to Medicare.

The apparent advantage of the first alternative would be that it would eliminate an inconsistently applied administrative step and the costs associated with it; this alternative would also have a limited effect on program payments. The only situations that would add to program costs would occur when carriers are required to make Medicare screen reductions because their reasonable charge screens are higher than their private plan screens (assuming these lower Medicare screens reduced the actual amounts allowed by Medicare). No cases in our sample have been affected by eliminating the comparability section. As mentioned previously, five of the six carriers were considered by HEW as not comparable to Medicare; the sixth, although comparable, was not required to make any reductions to its Medicare screens in order to comply with the law.

Medicare headquarters officials do not know how many, if any, reductions are taking place at all the carriers as a result of the law's comparability provision.

If the comparability provision is retained in the law, comparability should be clarified so that it may be consistently and effectively applied. If it is defined as we have suggested above, it will apply to a greater number of private plans and would theoretically increase the number of comparisons between private business screens and Medicare screens. These comparisons would reduce some Medicare screens and might achieve some program savings due to decreased reimbursements.

However, there are several problems with this alternative:

--There would be increased administrative costs to Medicare because HCFA regional office personnel would conduct comparative analyses of payment screens at more carriers. Although five of the six carriers reviewed did not have private plans considered comparable to Medicare, all six carriers based at least some of their private plans on current reasonable charges. Most Medicare carriers use this basis for at least some of their private plans.

--Many carriers use different claim coding and nomenclature systems for their private and Medicare businesses. Consequently, the comparison of payment screens on a procedure-by-procedure basis is difficult, if not impossible in some instances.

--New problems may occur in defining a current reasonable charge.

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

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

We believe that, given the two alternatives, deletion of the language would be preferable. Removing the comparability wording from the law, in our opinion, would have little, if any, economic effect on Medicare, and it would alleviate ineffective program requirements on the regional offices.

CONCLUSIONS

There is considerable confusion within HEW about the administration of the comparability provision of the Medicare law. Our sample showed no program savings resulting from the present methods of implementing this provision. Consequently, we believe that the comparability language in the law needs to be changed.

MATTER FOR CONSIDERATION BY THE SUBCOMMITTEE

The Subcommittee should consider either

--deleting from section 1842(b)(3)(B) of the Medicare law the language requiring that a comparison be made--specifically the words--

> "and not higher than the charge applicable for a comparable service under comparable circumstances, to the policyholders and subscribers of the carrier * * *"--

so that the section, as amended, will provide that each carrier--

> "(B) will take such action as may be necessary to assure that, where payment under this part for a service is on a charge basis, such charge will be reasonable, and such payment will (except as otherwise provided in section 1870(f)) be made * * *," or

--defining comparability in the law so that any private health insurance plan that intends to base reimbursements to physicians, suppliers, and/or beneficiaries on a current reasonable charge is comparable to Medicare.

We believe that the first alternative is preferable because it would have little, if any, financial effect on Medicare and would alleviate an ineffective program requirement and the administrative costs associated with it; it would also remove inconsistencies in program administration.

APPENDIX I

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

WASHINGTON, D.C. 20515

SUBCOMMITTEE ON HEALTH

June 29, 1978

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

Dear Mr. Staats:

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

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

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

the amount allowed by the most widely used Blue Shield fee schedule in that state.

We find this information very disturbing in view of the specific provision in section 1842(b)(3) of the medicare law which requires that under part B of the medicare program: "Each contract shall provide that the carrier -

* * *

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

According to HEW regulations, carriers are responsible for reporting information about their programs to the Health Care Financing Administration for determination as to whether any of their programs have comparability.

We would like your office to select at least eight Blue Shield and commercial carriers who pay for physicians' services under their private lines of business on the basis of usual, customary and reasonable charges and/or pay on the basis of fee schedules (where such fee schedules are intended to represent payment for the full charge) to test the actual implementation of section 1842(b)(3). Specifically, we would like to have information on the following points:

(1) Over the past three years, what information have such carriers provided to HEW with respect to comparability and what has HEW done with it in terms of verification or analysis in determining comparability.

(2) Comparisons of charges actually paid or allowed as reasonable by the carrier for specific procedures to specific practitioners under their private plans with the amounts considered reasonable by medicare for like procedures and the same practitioners.

(3) Comparisons of the carriers' "customary" charge allowances under their private business with the "prevailing" charges determined under medicare for like procedures and physician specialties for the same geographic area.

APPENDIX I

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

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

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

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

Sincerely yours,

Dan Rostenkowski
Chairman

John J. Duncan
Ranking Minority Member

APPENDIX II

GLOSSARY

Appendectomy	Surgical removal of the appendix.
Bronchoscopy	An internal examination of the air passages within the lungs.
Cholecystectomy	Surgical removal of the gallbladder.
Cystoscopy	An internal examination of the urinary tract with an examining tube.
Electrocardiogram (EKG)	A graphic tracing of the electric current produced by the contraction of the heart muscle.
Extraction of lens	Surgical removal of the lens of an eye which has a cataract on it.
Hernia repair	Correction of a hernia.
Hemorrhoidectomy	Surgical removal of hemorrhoids.
Hysterectomy	Surgical removal of the uterus, fallopian tubes, and ovaries through the abdominal wall.
Intermediate hospital visit	A visit in a hospital for a complete examination of one or more organ systems but not a comprehensive examination of the patient.
Mastectomy	Surgical removal of breast(s).
Proctosigmoidoscopy	Internal examination of the rectum and part of the colon by means of an examining tube.

APPENDIX II

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

PAN AMERICAN LIFE INSURANCE COMPANY

Pan American, based in New Orleans, Louisiana, is licensed to operate in 31 States, the District of Columbia, 10 Central and South American countries, many of the Caribbean Islands, and Spain. In addition to life insurance and pension programs, it offers about 1,300 group health plans in the United States plus individual private policies. Under these health plans, about 93,000 claims were paid in calendar year 1977. In Louisiana, about 35,000 claims for hospital and physician services were paid during this period, representing payments of almost $10 million.

Pan American basically markets three types of group private health care plans. These plans are (1) the basic plan, (2) the basic plan plus major medical benefits, and (3) a comprehensive plan.

DETERMINATION OF REASONABLE PHYSICIAN CHARGES AND BENEFIT PAYMENTS UNDER THE PRIVATE BUSINESS

According to a Pan American official, there are very few group health plans which use the basic plan. Under the basic plan, a fee schedule is used to determine what payments will be made. If the actual charge for a procedure is higher than the dollar figure found on the fee schedule, only the amount on the fee schedule is allowed.

The basic plan with major medical benefits requires a two-step process for determining payments:

1. The plan determines what the reasonable charge is for a particular service. To determine whether a charge is reasonable, the actual charges are compared to the prevailing charges published by HIAA. The lower of these two charges is considered to be the reasonable charge.

2. The reasonable charge is broken into two parts. The fee schedule amount is paid in full; that portion of the charge which exceeds the fee schedule is entered as a major medical expense. After an annual cash deductible has been satisfied, major medical expenses up to the reasonable charge are reimbursed at a set percentage which is in the contract. The beneficiary is responsible for charges above the reasonable charge.

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

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

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

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

Actual charge	$800	Prevailing charge	$600
Reasonable (allowed) charge	$600		

1. Amount allowed	$600
Less deductible (if not already met)	-100
Amount eligible for reimbursement	$500
Reimbursement percentage	80%
2. Amount paid to beneficiary	$400

All Pan American group plans (except one comprehensive plan) reviewed had the basic plan with major medical benefits.

MEDICARE BUSINESS

Pan American has been the part B Medicare carrier for Louisiana since the program began in 1966. It serves a State beneficiary population of about 400,000 and more than 4,000 physicians and suppliers. During the study period (April 1, 1977, to March 31, 1978) Pan American processed about 1.1 million part B claims totaling nearly $99 million in covered charges.

Pan American uses a computer system for its Medicare operations, but processes its private business claims manually.

OUR SAMPLE

We attempted to identify 100 physicians that performed one or more of 12 medical and surgical procedures under Pan American's private and Medicare businesses. These procedures were selected after agreement between the carrier and us that these would be the highest volume procedures common to both businesses.

The only practical way to obtain the needed sample was to manually review claims that were readily available to us under the carrier's private business. To get a meaningful cross section of claims, the carrier helped us select nine of their largest group plans--we also selected seven of their smallest plans. We reviewed all of the claims for these plans that were paid between April 1, 1977, and March 31, 1978. From them we recorded information on those claims for the 12 preselected procedures.

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

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

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

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

COMPARISON OF ACTUAL CHARGES

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

Procedure	Number of services	Private actual charges: Lower than Medicare	Private actual charges: Equal to Medicare	Private actual charges: Higher than Medicare
Sigmoidoscopy	45	5	30	10
Hemorrhoidectomy	8	1	5	2
Cholecystectomy	7	2	3	2
Hernia repair	3	1	2	-
Cystoscopy, office	17	-	15	2
Cystoscopy, hospital	13	4	6	3
Transurethral resection of prostate	4	-	4	-
Total hysterectomy	12	5	5	2
Vaginal hysterectomy	5	3	2	-
Routine followup brief office visit	239	21	194	24
Routine followup brief hospital visit	159	7	139	13
EKG	49	3	43	3
Total	561	52	448	61
	(100%)	(9%)	(80%)	(11%)

COMPARISON OF ALLOWED CHARGES

The allowed charges under the private plans were lower than those allowed under Medicare in 2 percent of the cases reviewed:

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

HOW MUCH GREATER ARE PRIVATE PLAN ALLOWANCES THAN MEDICARE ALLOWANCES?

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

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

For example, there were 14 physicians in our sample who were allowed more for performing sigmoidoscopies under the private business than under Medicare. We compared their charge histories under both programs to find how much their allowed charges under Pan American's private plans exceeded their Medicare allowed charges:

Number of physicians	Most frequently allowed charge under private plans	Most frequently allowed charge under Medicare	How much privately allowed charge exceeds Medicare allowed charge
1	$35	$30.00	17%
2	30	25.00	20
2	25	20.30	23
2	25	20.00	25
1	32	25.00	28
1	40	30.00	33
2	35	25.00	40
1	30	20.30	48
1	25	15.00	67
1	50	25.00	100
14			

These percentages were then arrayed on the following table for each medical and surgical procedure. The number of charges compared in this table is lower than the number of charges compared in the preceding tables because the number of private plan charges for each physician identified was reduced to his/her most frequent charge.

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

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

SCREENS USED TO DETERMINE MEDICARE ALLOWED CHARGES

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

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

Procedure	Number of charges	Actual charge	Customary charge	Prevailing charge	Actual and customary the same	Customary and prevailing the same	Prevailing and actual the same	All three charges the same	Unknown (note a)
Sigmoidoscopy	81	3	14	30	16	8	-	9	1
Hemorrhoidectomy	9	-	3	5	1	-	-	-	-
Cholecystectomy	17	-	11	2	-	4	-	-	-
Hernia repair	11	1	8	-	2	-	-	-	-
Cystoscopy, office	31	-	26	-	5	-	-	-	-
Cystoscopy, hospital	54	5	10	26	-	12	-	-	1
Transurethral resection of prostate	19	2	2	12	-	3	-	-	-
Hysterectomy	12	3	3	3	-	3	-	-	-
Vaginal hysterectomy	4	-	-	2	1	-	-	-	1
Routine followup brief office visit	396	-	121	179	30	44	2	9	11
Routine followup brief hospital visit	163	4	55	50	18	15	6	12	3
EKG	109	11	34	11	31	7	-	15	-
Total	906	29	287	320	104	96	8	45	17
	(100%)	(3%)	(32%)	(35%)	(11%)	(11%)	(1%)	(5%)	(2%)

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

COMPARISON OF CARRIER'S SCREENS UNDER BOTH BUSINESSES

There are considerable differences between the operations of Pan American's private and Medicare businesses. These differences make comparisons of screens difficult. Due to the small number of claims processed in Louisiana under its private business, Pan American, unlike Medicare, does not establish physician profiles. A Pan American official stated that Pan American does not have enough activity for individual physicians for each procedure to produce meaningful profiles. Consequently, no customary charges are computed and no screen is applied. Therefore, no comparison could be made to the Medicare customary-charge screens. Claims are judged reasonable under the private business on the basis of the lower of the prevailing or actual charge.

To determine the prevailing charge for a locality, Pan American's private business relies on information developed by HIAA. Pan American selects its prevailing charges at the 75th percentile. If a prevailing charge cannot be developed, the relative value (as established by the 1964 Relative Value

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

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

REASONABLE CHARGE REDUCTIONS

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

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

Under the private health care plans, an assigned claim does not mean what it does under Medicare. Unlike the Medicare law, there are no provisions in the Louisiana laws that provide that beneficiaries do not have to pay the reasonable charge reduction of an assigned claim. Therefore, the physician can always charge a beneficiary for any portion of the charge that Pan American does not pay.

During the sample year (April 1977 to March 1978) Pan American paid about 36,000 claims under its private business in Louisiana amounting to over $10 million, with corresponding reasonable charge reductions of $76,000. The average reduction for all paid claims was about $2. Since Pan American's private business claims are like Medicare's unassigned claims, this $2 per claim compares to $21 per claim on all unassigned Medicare claims.

The following table shows by procedure the total number of private and Medicare charges in our sample, charges reduced, and whether the Medicare claims involved were assigned or unassigned. Overall, about 21 percent of the Medicare charges pertained to assigned claims.

Comparison Of Reasonable Charge Reductions
Under Private And Medicare Businesses

	Private business			Medicare business							
		Charges reduced		Number of charges		Number of assigned charges			Number of unassigned charges		
	Total number of charges	Number	Amount reduced (percent) (note a)	Total	Reduced	Total	Reduced	Amount reduced (percent) (note a)	Total	Reduced	Amount reduced (percent) (note a)
Sigmoidoscopy	45	-	-	81	54	11	8	27	70	46	24
Hemorrhoidectomy	8	-	-	9	8	3	3	14	6	5	19
Cholecystectomy	7	-	-	17	15	3	2	15	14	13	14
Hernia repair	3	-	-	11	8	1	1	16	10	7	17
Cystoscopy, office	17	-	-	31	25	5	5	26	26	20	28
Cystoscopy, hospital	13	-	-	54	49	13	11	21	41	38	25
Transurethral resection of prostate	4	1	14	19	17	2	1	19	17	16	21
Hysterectomy	12	1	11	12	9	5	4	15	7	5	25
Vaginal hysterectomy	5	-	-	4	4	1	1	13	3	3	16
Routine followup brief office visit	239	30	15	398	349	83	79	27	313	270	27
Routine followup brief hospital visit	159	7	12	163	120	42	29	32	121	91	26
EKG	49	-	-	109	47	23	8	21	86	39	23
Total	561	39	13%	906	705	192	152	21	714	553	22
	(100%)	(7%)		(100%)	(78%)	(100%)	(79%)		(100%)	(77%)	

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

COMPARABILITY

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

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

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

2. The data base is compiled from different periods of time. The private data are more up-to-date than the Medicare data.

3. The localities, although similar, are not exactly the same.

4. The economic index limit used by Medicare on its prevailing charges is not used under the private health care plans.

5. The private health care plans do not create physician profiles and, consequently, they develop no customary charge for comparisons.

However, contrary to its position of no comparability, the carrier reported in 1978 that a few medical and surgical procedures are comparable to Medicare, and a HCFA official stated that Medicare screens would be revised to reflect this situation. For example, if the carrier indicated that the privately allowed charge for an office visit was lower than the Medicare screen, the Medicare screen would be reduced to the privately allowed charge. No analysis of comparability is planned by the regional office.

OCCIDENTAL LIFE INSURANCE COMPANY OF CALIFORNIA

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

PRIVATE BUSINESS

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

Group	Policy	Outline of Benefits (note a)
A	Single policy	80 percent of covered expenses up to $5,000 during a calendar year, 100 percent during remainder of the calendar year. Maximum $250,000; cash deductible $100 for insured person, $300 for family per calendar year.
B	1	80 percent of covered expenses up to $2,000 during a calendar year, 100 percent during remainder of the calendar year. Maximum $100,000; cash deductible $125 for insured person, $250 for family per calendar year (no deductible for hospital and surgical expenses).
B	2	80 percent of covered expenses up to $2,000 during a calendar year, 100 percent during remainder of the calendar year. Maximum $250,000; cash deductible $125 for insured person, $250 for family per calendar year.
B	3	80 percent of covered expenses up to $3,000 during a calendar year, 100 percent during remainder of the calendar year. Maximum $100,000; cash deductible $100 for insured person, $250 for family per calendar year.
C	Single policy	80 percent of covered expenses up to lifetime maximum of $10,000 after payment of $100 ($200 family maximum) is paid.
D	Single policy	80 percent of covered expenses up to $2,000 during a calendar year, 100 percent during the remainder of the calendar year. Also, 100 percent of covered expenses if covered person incurs hospital room and board expenses while (a) confined as a registered bed patient or (b) confined not as a registered bed patient for emergency treatment within 24 hours after an accident, for treatment of an emergency illness, or for a surgical procedure (excluding all charges for professional, medical, and surgical services other than anesthesia and ambulance service).
E	Single policy	Same as group A.
F	Single policy	Basic medical benefits: as scheduled in the policy. Major medical benefits: 90 percent of covered expenses to a maximum of $50,000.
G	1	Basic medical benefits: as scheduled in the policy. Major Medical Benefits: 80 percent of covered expenses, after $100 deductible to a maximum of $100,000.
	2	Basic medical benefits: as scheduled in the policy. Major medical benefits: 80 percent of covered expenses, after $100 deductible, of first $5,000 of expenses in a calendar year; 100 percent of expenses over $5,000 to a maximum of $250,000.

a/Excludes psychometric testing, psychotherapy, mental illness, and nervous disorders.

MEDICARE BUSINESS

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

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

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

OUR SAMPLE

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

COMPARISON OF ACTUAL CHARGES

In 8 percent of the cases reviewed, physicians charged their private plan patients less than they charged their Medicare patients. The following table shows this comparison:

Procedure	Number of services	Private actual charges: Lower than Medicare	Private actual charges: Equal to Medicare	Private actual charges: Higher than Medicare
Appendectomy	1	-	1	-
Proctosigmoidoscopy	9	1	8	-
Cholecystectomy	2	-	2	-
Hernia repair	4	3	1	-
Transurethral resection of prostate	4	1	3	-
Hysterectomy	1	-	1	-
Extraction of lens	4	2	2	-
Routine follow-up brief office visit	186	12	147	27
Routine follow-up brief hospital visit	21	-	21	-
Intermediate hospital visit	20	-	19	1
Total	252	19	205	28
	(100%)	(8%)	(81%)	(11%)

COMPARISON OF ALLOWED CHARGES

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

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

HOW MUCH GREATER ARE PRIVATE ALLOWANCES THAN MEDICARE ALLOWANCES?

The following table shows that physicians were allowed over 10 percent more by private plans than they were by Medicare in about 80 percent of the cases included in this analysis.

Procedure	Number of charges	Extent to which physicians' private allowed charges exceeded their Medicare allowed charges				
		1-10%	11-25%	26-50%	51-75%	76% and over
Appendectomy	1	-	1	-	-	-
Proctosigmoidoscopy	6	-	4	2	-	-
Cholecystectomy	1	-	1	-	-	-
Hernia repair	3	-	1	2	-	-
Transurethral resection of prostate	3	-	3	-	-	-
Hysterectomy	1	-	-	1	-	-
Extraction of lens	3	1	2	-	-	-
Routine follow-up brief office visit	45	13	14	13	4	1
Routine follow-up brief hospital visit	2	-	1	1	-	-
Intermediate hospital visit	4	-	3	-	1	-
Total	69	14	30	19	5	1
	a/(100%)	(20%)	(43%)	(28%)	(7%)	(1%)

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

SCREENS USED TO DETERMINE MEDICARE ALLOWED CHARGES

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

COMPARISONS OF PRIVATE CUSTOMARY ALLOWANCES TO MEDICARE PREVAILING ALLOWANCES

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

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

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

TABLE SHOWING THE NUMBER OF TIMES THAT

THE ACTUAL, CUSTOMARY, AND/OR PREVAILING CHARGE RESULTED

IN THE MEDICARE ALLOWED CHARGE

Procedure	Number of charges	Actual charge	Customary charge	Prevailing charge	Actual and customary the same	Customary and prevailing the same	Prevailing and actual the same	All three charges the same	Unknown (note a)
Appendectomy	1	-	-	1	-	-	-	-	-
Protosigmoidoscopy	517	1	147	316	48	1	-	4	-
Cholecystectomy	1	-	-	1	-	-	-	-	-
Hernia repair	15	-	3	6	3	-	-	-	3
Transurethral resection of prostate	28	-	2	10	-	-	-	-	16
Hysterectomy	1	-	-	1	-	-	-	-	-
Extraction of lens	41	3	15	8	-	-	-	-	15
Routine followup brief office visit	17,601	443	478	11,612	2,578	1,811	-	319	360
Routine followup brief hospital visit	691	-	36	186	469	-	-	-	-
Intermediate hospital visit	171	1	11	41	31	87	-	-	-
Total	19,067	448	692	12,182	3,129	1,899	-	323	394
	(100%)	(2%)	(4%)	(64%)	(16%)	(10%)		(2%)	(2%)

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

APPENDIX IV

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

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

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

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

APPENDIX IV

COMPARISON OF REASONABLE CHARGE REDUCTIONS

UNDER PRIVATE AND MEDICARE BUSINESSES

Procedure	Private business			Medicare business		
		Charges reduced			Charges reduced	
	Total number of charges	Number	Amount reduced (percent) (note a)	Total number of charges	Number	Amount reduced (percent) (note a)
Appendectomy	1			1	1	18
Proctosigmoidoscopy	9			517	464	19
Cholecystectomy	2			1	1	13
Hernia repair	4			15	12	22
Transurethral resection of prostate	4	No reductions		28	28	17
Hysterectomy	1			1	1	21
Extraction of lens	4			41	38	16
Routine follow-up brief office visit	186			17,601	14,261	17
Routine follow-up brief hospital visit	21			691	222	10
Intermediate hospital visit	20			171	139	20
Total	252			19,067	15,167	
				(100%)	(80%)	

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

COMPARABILITY

A Medicare San Francisco regional official stated that the Bureau has always interpreted quite strictly the requirement for comparability as cited in 42 C.F.R. 405.508. For example, if a carrier does not allow for physician specialties when arriving at allowable charges under its private business, the carrier's private plans are not comparable to Medicare. Further, if the carrier does not consider each physician's customary charge when arriving at a reasonable charge for a given procedure, the carrier's plans are not comparable.

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

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

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

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

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

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

GENERAL AMERICAN LIFE INSURANCE COMPANY

The General American Life Insurance Company (General American) is a mutual company that was chartered in 1933. Through its 27 group sales offices and 16 regional claim offices, General American provides life and health insurance, annuities, and pensions on an individual policy and group insurance basis. It is licensed to operate in 49 States. The St. Louis office, which handles all of General American's Missouri claims, is the largest office, representing about half of General American's claims business nationwide.

PRIVATE BUSINESS

From July 1, 1977, to September 30, 1978, General American received 442,347 private plan claims and paid about $81 million for health and dental care and weekly indemnity benefits. As of September 1978, General American provided health care insurance for about 598,000 beneficiaries in the St. Louis office service area through about 300 customer group plans.

Approximately 82 percent of the St. Louis office private business is represented by five plans for five major firms. The remainder of their private health insurance business involves approximately 300 additional plans. Primarily, General American's health insurance policies are a combination of basic benefit and supplemental major medical coverage governed by preestablished reasonable and customary rates for specific medical and surgical services. Deductibles and coinsurance are generally specified, depending on the type of policy the customer prefers.

Approximately 55 percent of the St. Louis office's private business is with one major company. These claims are processed through an online computerized system. The remainder of their private business claims are processed manually.

MEDICARE BUSINESS

General American administers part B of the Medicare program in 84 counties in eastern and southern Missouri. The northwest quadrant of Missouri, including Kansas City, is not within General American's jurisdiction for servicing Medicare claims.

General American processes Medicare claims for about 6,000 physicians and suppliers in its service area in Missouri. From July 1, 1977, to September 30, 1978, General American processed and made payments for approximately 1.8

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

OUR SAMPLE

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

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

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

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

COMPARISON OF ACTUAL CHARGES

In 8 percent of the cases we reviewed, physicians charged their private plan patients less than they charged their Medicare patients:

Procedure	Number of services	Private actual charges: Lower than Medicare	Private actual charges: Equal to Medicare	Private actual charges: Higher than Medicare
Mastectomy	4	1	3	-
Bronchoscopy	1	1	-	-
Proctosigmoidoscopy	19	-	14	5
Hemorrhoidectomy	5	2	1	2
Cholecystectomy	19	3	11	5
Appendectomy	7	6	1	-
Transurethral resection of prostate	4	-	2	2
Hysterectomy	4	-	3	1
Extraction of lens	5	-	3	2
Hernia repair	26	3	10	13
Routine follow-up brief office visit	45	3	21	21
Routine follow-up brief hospital visit	110	-	98	12
EKG	22	2	17	3
Total	271	21	184	66
	(100%)	(8%)	(68%)	(24%)

COMPARISON OF ALLOWED CHARGES

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

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

HOW MUCH HIGHER ARE PRIVATE PLAN ALLOWANCES THAN MEDICARE ALLOWANCES?

The following table shows that physicians were allowed over 10 percent more by private plans than they were by Medicare in 89 percent of the cases included in this analysis:

Procedure	Number of charges	How much physicians' private allowed charges exceeded their Medicare allowed charges				
		1-10%	11-25%	26-50%	51-75%	76% and over
Mastectomy	3	-	2	-	-	1
Proctosigmoidoscopy	14	1	3	5	2	3
Hemorrhoidectomy	4	-	3	-	1	-
Cholecystectomy	13	2	6	5	-	-
Appendectomy	6	-	2	2	2	-
Transurethral resection of prostate	3	1	1	-	1	-
Hysterectomy	4	-	2	1	1	-
Extraction of lens	5	3	1	-	1	-
Hernia repair	21	3	7	6	2	3
Routine follow-up brief office visit	17	1	8	6	1	1
Routine followup brief hospital visit	11	-	3	6	1	1
EKG	13	-	11	1	1	-
Total	114	11	49	32	13	9
	(100%)	(10%)	(43%)	(28%)	(11%)	(8%)

SCREENS USED TO DETERMINE MEDICARE ALLOWED CHARGES

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

COMPARISONS OF PRIVATE PLAN SCREENS TO MEDICARE SCREENS

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

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

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

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

Procedure	Number of charges	Actual charge	Customary charge	Prevailing charge	Actual and customary the same	Prevailing and customary the same	Actual and prevailing the same	All three charges the same
Mastectomy	9	-	2	7	-	-	-	-
Bronchoscopy	126	41	-	85	-	-	-	-
Appendectomy	8	-	8	-	-	-	-	-
Proctosigmoidoscopy	626	165	257	43	129	4	-	28
Hemorrhoidectomy	23	2	1	20	-	-	-	-
Cholecystectomy	58	5	6	15	-	23	-	9
Hernia repair	128	2	56	57	10	3	-	-
Transurethral resection of prostate	71	22	27	-	-	17	-	5
Hysterectomy	5	-	-	-	-	5	-	-
Extraction of lens	368	2	288	-	78	-	-	-
Routine follow-up brief office visit	3,589	282	588	1,484	282	618	19	316
Routine follow-up brief hospital visit	9,122	49	5,091	536	3,242	204	-	-
EKG	2,113	5	631	6	571	346	1	553
Total	16,246	575	6,955	2,253	4,312	1,220	20	911
	a/(100%)	(4%)	(43%)	(14%)	(27%)	(8%)		(6%)

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

APPENDIX V

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

REASONABLE CHARGE REDUCTIONS

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

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

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

COMPARISON OF REASONABLE CHARGE REDUCTIONS UNDER PRIVATE AND MEDICARE BUSINESSES

	Private business			Medicare business							
		Amount reduced				Assigned charges			Unassigned charges		
				Charges							
Procedure	Total number of charges	Number	Amount reduced (percent) (note a)	Total	Reduced	Total	Reduced	Amount reduced (percent) (note a)	Total	Reduced	Amount reduced (percent) (note a)
Mastectomy	4	-	-	9	9	-	-	-	9	9	19
Bronchoscopy	1	-	-	126	85	126	85	20	-	-	-
Proctosig-moidoscopy	19	2	40	626	304	42	21	36	584	283	36
Hemorrhoi-dectomy	5	1	8	23	21	-	-	-	23	21	19
Cholecystectomy	19	-	-	58	44	17	14	19	41	30	24
Appendectomy	7	-	-	8	8	-	-	-	8	8	42
Transurethral resection of prostate	4	-	-	71	46	21	10	29	50	36	13
Hysterectomy	4	-	-	5	5	1	1	20	4	4	23
Extraction of lens	5	-	-	368	291	24	13	10	344	278	13
Hernia repair	26	-	-	128	112	29	26	14	99	86	18
Routine follow-up brief office visit	45	-	-	3,589	2,672	140	120	26	3,449	2,552	25
Routine followup brief hospital visit	110	2	40	9,122	5,832	4,093	2,506	28	5,029	3,326	20
EKG	22	-	-	2,113	1,039	77	26	16	2,036	1,013	18
Total	271	5		16,246	10,468	4,570	2,822	23	11,676	7,646	17
	(100%)	(2%)		(100%)	(64%)	(100%)	(62%)		(100%)	(65%)	

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

APPENDIX V

COMPARABILITY

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

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

CONNECTICUT GENERAL LIFE INSURANCE COMPANY

The Connecticut General Insurance Corporation, headquartered in Hartford, Connecticut, is the Nation's third largest stockholder-owned insurance corporation. It provides life and health insurance and annuities through its largest subsidiary, the Connecticut General Life Insurance Company (Connecticut General).

Connecticut General has field offices nationwide--including three in Connecticut, where it acts as a Medicare carrier:

--The Bristol claims office handles about 1,200 private group plans representing about 50 percent of Connecticut General's private business in Connecticut.

--The Windsor office handles claims for one corporation, Connecticut General's largest Connecticut customer, representing the other 50 percent of its private business in Connecticut.

--The Wallingford office handles all Medicare claims.

Bristol processes about 380,000 claims a year. We were told that Windsor handles about the same claims volume as Bristol, but we were unable to obtain specific data on Windsor's operation.

PRIVATE BUSINESS

Connecticut General markets three types of private health care plans. These plans are (1) the basic plus major medical, (2) a Blue Shield supplemental plan, and (3) comprehensive.

Under the basic plus major medical plan, the basic payment for a procedure is 100-percent reimbursement up to limits set by its policyholders--usually employers. These limits are somewhat arbitrary, since they depend on the premium employers are willing to pay for their employees' health care plan. They can specify one dollar limit for all procedures or choose a conversion factor which establishes a different limit for each procedure based on its relative value, or both. Under major medical, Connecticut General pays 80 percent of the difference between its basic payment and the reasonable charge.

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

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

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

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

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

MEDICARE BUSINESS

Connecticut General has been Connecticut's Medicare part B carrier since July 1966. The carrier's Medicare volume far exceeds its private plan volume, based on its estimates of 35,000 to 40,000 Medicare claims a week and its monthly reports showing over 1.8 million claims processed in fiscal year 1978.

OUR SAMPLE

Connecticut General proposed an approach for our sample under which its personnel would supply raw data on incoming physician claims to the Bristol office for 1 month. To expedite the collection of claims data, we agreed to this approach.

Benefit analysts set aside all claims which they received during October 1978 for 10 preselected procedures. These procedures were selected in an agreement between the carrier and us that they would be the highest claims volume procedures with activity under both its private Medicare businesses. We monitored how Connecticut General personnel took the sample and recorded sample data on a random basis.

Although we attempted to acquire data for 100 different physicians, this methodology resulted in matching Medicare and private plan data on only 89 physicians for 7 of our 10 selected procedures:

Procedure	Number of physicians performing procedure	Number of services identified	
		Private	Medicare
Routine followup brief office visit	59	119	1,717
Routine followup brief hospital visit	15	124	779
EKG	38	48	495
Sigmoidoscopy	19	25	184
Hernia repair	2	3	3
Cholecystectomy	3	3	8
Transurethral of resection of prostate	3	3	21
Total	a/139	325	3,207

a/This total is higher than the 89 physicians mentioned above because some physicians performed more than one procedure in our sample.

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

COMPARISON OF ACTUAL CHARGES

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

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

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

COMPARISON OF ALLOWED CHARGES

The allowed charges under the private plans were lower than those allowed under Medicare in 1 percent of the cases we reviewed:

Procedure	Number of services	Private allowed charges: Lower than Medicare	Equal to Medicare	Higher than Medicare
Routine followup brief office visit	119	1	5	113
Routine followup brief hospital visit	124	-	15	109
EKG	48	-	31	17
Sigmoidoscoy	25	-	14	11
Hernia repair	3	-	1	2
Cholecystectomy	3	-	1	2
Transurethral resection of prostate	3	1	-	2
Total	325	2	67	256
	a/(100%)	(1%)	(21%)	(79%)

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

HOW MUCH HIGHER ARE PRIVATE PLAN ALLOWANCES THAN MEDICARE ALLOWANCES?

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

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

SCREENS USED TO DETERMINE MEDICARE ALLOWED CHARGES

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

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

Procedure	Number of charges	Actual charge	Customary charge	Prevailing charge	Actual and customary the same	Customary and prevailing the same	Prevailing and actual the same	All three charges the same	Unknown (note a)
Routine followup brief office visit	1,717	36	379	1,211	79	-	-	-	12
Routine follow-up brief hospital visit	779	-	19	721	39	-	-	-	-
EKG	495	16	-	94	28	96	8	252	1
Sigmoidoscopy	184	6	58	4	66	10	-	40	-
Hernia repair	3	-	1	-	-	-	-	1	1
Cholecystectomy	8	2	3	3	-	-	-	-	-
Transurethral resection of prostate	21	-	-	20	-	-	-	-	1
Total	3,207	60	460	2,053	212	106	8	293	15
	a/(100%)	(2%)	(14%)	(64%)	(7%)	(3%)	(0%)	(9%)	

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

APPENDIX VI

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

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

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

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

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

Specialty Groups

Specialty 01	Specialty 02	Specialty 03
General practice	General surgery	Cardiovascular diseases
Osteopath	Allergy	Gastroenterology
Chiropractor	Othology	Neurology
Podiatrist	Laryngology	Neurological surgery
Audiologist	Rhinology	Pulmonary diseases
Independent physical therapist	Anesthesiology	Neprology
	Dermatology	Oncology
	Family practice	Hematology
	Internal medicine	Rheumatology
	Obstetrics and gynecology	
	Ophthalmology	
	Oral surgery	
	Orthopedic surgery	
	Pathology	
	Plastic surgery	
	Physical medicine and rehabilitation	
	Psychiatry	
	Proctology	
	Radiology	
	Thoractic surgery	
	Urology	
	Nuclear medicine	
	Pediatrics	
	Geriatrics	
	Vascular diseases	
	Hand surgery	

As discussed above, Medicare prevailing rates are determined differently from Connecticut General's private plan R&C allowances. R&C determinations involve individual judgment, while Medicare prevailing rates are computed mathematically. Moreover, the Multi Guide amounts, which form the basis for the company's R&C determinations, are computed differently from Medicare prevailing rates:

--Charges from March 1977 to February 1978 were used to compute the current Multi Guide allowances and, therefore, they are slightly more recent than the calendar year 1977 charges used to compute the current Medicare prevailing rates.

--Multi Guide allowances are updated every 6 months, compared to once a year for Medicare prevailings.

--The company divides Connecticut into four areas for both Medicare and private plan business, but the areas are somewhat different.

--Only Medicare charges are considered in computing Medicare prevailings, and only a sample of HIAA charges are used for Multi Guide allowances.

--Connecticut General selects the 80th percentile charge and adds 10 percent to determine Multi Guide allowances, but it uses the 75th percentile charge for determining Medicare prevailings, subject to the index.

--Unlike Medicare, the company does not recognize physician customary charges or specialties before selecting the appropriate percentile charge.

--Medicare prevailing rates, unlike Multi Guide allowances, are limited by an economic index.

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

REASONABLE CHARGE REDUCTIONS

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

(55 percent) of claims were unassigned, representing $79 million in covered charges. About 74 percent of these claims were reduced. Overall, the beneficiaries were responsible for paying about $13 per claim on all unassigned claims.

All 325 private plan charges used in our comparisons were allowed in full. In contrast, Connecticut General reduced 2,641 (82 percent) of 3,207 Medicare charges we analyzed. The following table, which presents data on 2,721 Medicare charges for which we were able to determine an assignment status, shows that assigned charges were reduced more frequently than unassigned charges, but by a slightly lower percentage. About 27 percent of the charges pertained to assigned claims.

	Medicare charges		
	Assigned charges	Unassigned charges	Total
Number of charges submitted	744	1,977	2,721
Data on reduced charges:			
Number reduced	662	1,598	2,260
Percent reduced	89%	81%	83%
Amount of charges on reduced claims	$15,764	$44,708	$60,472
Amount reduced	$ 2,802	$8,545	$11,347
Percent reduced	18%	19%	19%

COMPARABILITY

Although the carrier and the Medicare Bureau's Boston Region had discussed comparability before October 1974, it was not until then that Connecticut General advised the region that it had no health plans that were comparable to Medicare. This was because the carrier did not use individual physician's customary charges as a basis for paying its private claims. Connecticut General provided verification from two claims managers who shared responsibility for its private Connecticut business.

Since Medicare officials doubted the adequacy of Connecticut General's documentation, they forwarded the verification to Bureau headquarters in Baltimore for a decision. Bureau headquarters advised the region in March 1975 that it agreed with Connecticut General's position, but neither the region nor Bureau headquarters personnel verified the carriers' justification.

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

BLUE SHIELD OF MASSACHUSETTS, INC.

In calendar year 1976 Blue Shield of Massachusetts, Inc. (Massachusetts Blue Shield) had a claims volume of 3.3 million private plan claims totaling nearly $148 million. It services over 13,000 physicians in Massachusetts. It services about 23,000 groups and holds 1.3 million individual and family group contracts. About 96 percent of Massachusetts Blue Shield's group policies are "usual and customary" (UCR) reimbursement-type contracts.

PRIVATE BUSINESS

For the most part Massachusetts Blue Shield utilizes a 5-percent coinsurance for its private UCR policies. It uses the same data base for determining each physician's usual and customary charges that it uses for determining the Medicare customary and prevailing charges. However, it does not update its UCR charges regularly, and limits the rates of increase for both types of charges when it updates. In addition, rate increase restrictions have been imposed by the Massachusetts insurance commissioner; these restrictions have caused the company to restrict increases in physician reimbursements even more.

As a result, Massachusetts Blue Shield is currently reimbursing about 75 percent of the physicians' actual charges for most of its private policy holders. A carrier official stated that the average policy involves varying deductibles besides the 5-percent coinsurance. Depending on the price customers are willing to pay, the amount of the deductible varies from zero up. Generally, there are no deductibles for inpatient services and certain outpatient services (such as X-rays, laboratory work, surgery, etc.). Other outpatient services are subject to a deductible.

Massachusetts Blue Shield's private business claims are processed on a fully computerized system.

MEDICARE BUSINESS

Massachusetts Blue Shield is the carrier for Medicare in Massachusetts, which is the same operating area as its private business. 1/ In calendar year 1976 the carrier experienced

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1/In December 1977 Massachsetts Blue Shield began processing Medicare claims in Maine after winning the experimental fixed-price contract.

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

OUR SAMPLE

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

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

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

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

COMPARISON OF ACTUAL CHARGES

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

Procedure	Number of services	Private actual charges: Lower than Medicare	Private actual charges: Equal to Medicare	Private actual charges: Higher than Medicare
Bronchoscopy	19	-	19	-
Appendectomy	16	2	8	6
Sigmoidoscopy	62	4	57	1
Cholecystectomy	27	7	15	5
Transurethral resection of prostate	3	-	2	1
Hysterectomy	19	2	4	13
Routine followup brief office visit	1	-	1	-
Routine followup brief hospital visit	7,304	715	5,882	707
EKG	2,296	159	2,117	20
Total	9,747	889	8,105	753
	(100%)	(9%)	(83%)	(8%)

Most of the 889 charges which were lower than the predominate Medicare charge were attributed to three physicians who accounted for 68 percent (607) of these charges. Two of the three physicians made charges under the Routine Followup Brief Hospital Visit procedure. Both routinely charged Medicare patients $12, while charging private health care plan patients $10. The third physician charged Medicare patients $25 for EKGs, while charging $20 to provide health care plan patients.

COMPARISON OF ALLOWED CHARGES

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

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

HOW MUCH GREATER ARE PRIVATE PLAN ALLOWANCES THAN MEDICARE ALLOWANCES?

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

Procedure	Number of charges	How much physicians' private allowed charges exceeded their Medicare allowed charges: 1 to 10%	11 to 25%	26 to 50%	51 to 75%	76% and over
Appendectomy	1	-	-	1	-	-
Sigmoidoscopy	7	-	1	6	-	-
Cholecystectomy	2	1	1	-	-	-
Hysterectomy	3	-	3	-	-	-
Routine followup brief office visit	1	1	-	-	-	-
Routine followup brief hospital visit	23	6	10	7	-	-
EKG	10	4	4	2	-	-
Total	47	12	19	16	-	-
	(100%)	(26%)	(40%)	(34%)		

SCREENS USED TO DETERMINE MEDICARE ALLOWED CHARGES

The schedule on the following page shows that the customary charge screen is usually the amount allowed for Medicare billings. It was applied alone in about 41 percent of the charges, and applied in another 39 percent of the time, when it was the same as another screen.

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

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

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

APPENDIX VII

COMPARISON OF CARRIER'S SCREENS UNDER BOTH BUSINESSES

According to carrier officials, private business screens are based on the same customary 1/ and prevailing charge experience data as Medicare screens. Updates are always based on the same age data, although the private business has chosen not to update in some years (for example, our sample year of 1976) to save costs. Medicare requires yearly updates.

Private screens are established statewide. Medicare has changed since 1975 to two screen areas--urban and suburban. Both businesses recognize physician specialties in their screens. Massachusetts Blue Shield has reduced its benefit costs by limiting its screen increases in some recent years according to the cost of living index, in addition to allowing no update of screens in other years. We compared the private prevailing screens to the Medicare screens.

Information supplied by the carrier regarding the private and Medicare screens in effect for calendar year 1976 resulted in 80 prevailing screen comparisons and 118 customary screen comparisons for the medical and surgical procedures and specialties we selected. Out of the 80 prevailing screen comparisons, 5 (6 percent) reflected higher Medicare prevailing screens. Of the 118 customary screen comparisons for the physicians in our sample, 22 (19 percent) reflected higher Medicare customary screens.

REASONABLE CHARGE REDUCTIONS

During calendar year 1976 Massachusetts Blue Shield processed about 3.1 million Medicare claims which were paid or applied to the beneficiary's deductible; this represents about $200 million in covered charges. About 74 percent of these claims were reduced. The reductions totaled nearly $41 million--20 percent of the total covered charges. From the beneficiaries' viewpoint, about 702,000 (23 percent) of claims were unassigned, representing over $43 million in covered charges. About $9 million of these claims were reduced. Overall, the beneficiaries were responsible for paying an average reduction of about $13 per claim on all unassigned claims.

1/It should be noted that private customary charge screens are established by a minimum of two charges, whereas Medicare requires a minimum of three charges.

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

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

COMPARISON OF REASONABLE CHARGE REDUCTIONS

UNDER PRIVATE AND MEDICARE BUSINESSES

Procedure	Private business			Medicare business							
		Charges reduced (all assigned)				Assigned charges			Unassigned charges		
	Total number of charges	Number	Amount reduced (percent) (note a)	Charges Total	Reduced	Total	Reduced	Amount reduced (percent) (note a)	Total	Reduced	Amount reduced (percent) (note a)
Bronchoscopy	19	-	-	32	-	32	-	-	-	-	-
Appendectomy	16	16	12	5	4	5	4	28	-	-	-
Sigmoidoscopy	62	43	28	179	121	132	95	27	47	26	28
Cholecystectomy	27	27	11	16	13	12	9	17	4	4	6
Transurethral resection of prostate	3	3	25	19	18	18	18	9	1	-	-
Hysterectomy	19	11	20	11	8	9	6	19	2	2	13
Routine followup brief office visit	1	-	-	226	226	221	22.	10	5	5	31
Routine followup brief hospital visit	7,304	4,159	24	45,927	31,980	38,524	25,455	24	7,403	6,525	21
EKG	2,296	1,170	20	2,645	1,659	1,059	756	25	1,586	903	20
Total	9,747	5,429	23	49,060	34,029	40,012	26,564	24	9,048	7,465	21
	(100%)	(56%)		(100%)	(69%)	(100%)	(66%)		(100%)	(83%)	

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

APPENDIX VII

COMPARABILITY

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

--Medicare updates its profiles on a regular schedule, whereas Blue Shield updates its profiles on an irregular basis whenever it is financially feasible for the company to do so.

--Blue Shield profiles do not meet the test of comparability because they are not based on customary charges "as currently constituted" or on "current prevailing charges" in a locality, due to the irregularity of their updates.

--Blue Shield uses an economic index 1/ to limit its updates, but it is not the same one Medicare uses.

--The Blue Shield update limits apply to both customary and prevailing screens, whereas Medicare's limit only applies to prevailing.

--Medicare uses the 50th percentile of prevailing charges if a customary charge for a specific procedure cannot be computed because of insufficient services billed in the base year (for example, for new doctors). Blue Shield uses the 90th percentile of prevailing charges.

--The Blue Shield prevailing charge screens are currently set at the 90th percentile, as compared to the 75th percentile for Medicare.

--Medicare currently employs two areas of locality, while Blue Shield in 1975 reverted to a single locality.

--Medicare requires three claims to establish a customary profile if two claims use the same charge; they require four claims if two do not use the same charge. The private business uses two claims to establish a customary profile.

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

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

BLUE SHIELD OF FLORIDA, INC.

In calendar year 1976 Blue Shield of Florida, Inc., (Florida Blue Shield) paid 2.6 million claims under its private business totaling nearly $100 million. It services about 15,000 physicians throughout Florida. Private plan enrollment for 1976 was about 1.7 million people.

PRIVATE BUSINESS

A Florida Blue Shield official stated that reimbursement under all private plans is based on the usual and customary charge (UCR). There are, however, a number of differences in how UCR type plans are tailored to the needs and desires of different companies. For example, the reimbursement rate can be 80, 90, or 100 percent of the reasonable charge, depending on how much the purchaser wants to spend on premiums. In addition, the policy may only cover inpatient services, or it may extend to outpatient, or even doctors' office visits. Florida Blue Shield's private business claims are processed on a fully computerized system.

MEDICARE BUSINESS

Florida Blue Shield is the Medicare carrier for 65 of 67 counties in Florida. In calendar year 1976 the carrier experienced a Medicare claims volume of 4 million claims totaling over $378 million. It services about the same number of physicians under Medicare as it does under its private business. Medicare claims are processed on a computerized system.

OUR SAMPLE

The Blue Cross and Blue Shield Associations' computer tapes were sampled by a special program written for our purposes to identify 100 physicians at random that performed 1 or more of 10 preselected medical procedures. These procedures were selected in an agreement between the carrier and us that there would be numerous claims submitted for these procedures under both types of businesses (except for office visits, which the carrier does not routinely cover in its private business). We selected this procedure for comparison with the high volume of data we collected for office visits under the commercial carriers. The sample information covered claims submitted during calendar year 1976, the most recent period available. We obtained sample data for both businesses for this time period.

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

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

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

COMPARISON OF ACTUAL CHARGES

In only 7 percent of the cases reviewed, physicians charged their private plan patients less than they charged their Medicare patients:

Procedure	Number of services	Private actual charges: Lower than Medicare	Private actual charges: Equal to Medicare	Private actual charges: Higher than Medicare
Radical mastectomy	1	1	-	-
Appendectomy	3	1	1	1
Sigmoidoscopy	34	8	13	13
Hemorrhoidectomy	3	-	1	2
Cholecystectomy	5	3	1	1
Transurethral resection of prostate	7	3	1	3
Hysterectomy	43	3	31	9
Routine followup brief office visit	3	-	-	3
Routine followup brief hospital visit	2,275	143	1,603	529
EKG	301	23	247	31
Total	2,675	185	1,898	592
	(100%)	(7%)	(71%)	(22%)

COMPARISON OF ALLOWED CHARGES

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

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

HOW MUCH HIGHER ARE PRIVATE PLAN ALLOWANCES THAN MEDICARE ALLOWANCES?

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

Procedure	Number of charges	How much physicians' private allowed charges exceeded their Medicare allowed charges: 1 to 10%	11 to 25%	26 to 50%	51 to 75%	76% and over
Appendectomy	1	-	1	-	-	-
Sigmoidoscopy	9	-	5	4	-	-
Hemorrhoidectomy	3	1	2	-	-	-
Cholecystectomy	2	-	1	1	-	-
Transurethral resection of prostate	5	1	2	2	-	-
Hysterectomy	9	1	5	3	-	-
Routine followup brief office vist	1	-	-	1	-	-
Routine followup brief hospital visit	54	13	13	18	9	1
EKG	33	6	19	7	1	-
Total	117	22	48	36	10	1
	a/(100)	(19%)	(41%)	(31%)	(9%)	(1%)

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

SCREENS USED TO DETERMINE MEDICARE-ALLOWED CHARGES

The table on the following page shows that the customary charge screen is usually the amount allowed for Medicare billings. It was applied alone in about 44 percent of the charges, and applied another 18 percent of the time when it was the same as another screen.

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

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

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

APPENDIX VIII

COMPARISON OF CARRIER'S SCREENS UNDER BOTH BUSINESSES

According to Florida Blue Shield, both private and Medicare screens include all the experience they have as a carrier and insurer. The difference is that the private screens are now 1/ based on more recent data and use the 90th percentile for the prevailing charges, while Medicare uses the 75th percentile (with a consumer price index limitation). Private business screens are not updated in exactly the same month as the Medicare screens. The geographic screen areas covered by the private and Medicare business screens are identical; except for two counties at the southern tip of the State, which have a different Medicare carrier. Neither the private nor Medicare business recognizes physician specialties in establishing their screens.

We compared the customary and prevailing charge screens used for the physicians and procedures in our sample under the private health care plans to the customary and prevailing charge screens used for the same physicians and procedures under Medicare. This resulted in 23 prevailing screen comparisons and 75 customary screen comparisons. There was only one (4 percent) case where the Medicare prevailing screen was higher than the private prevailing screen. There was no case where the Medicare customary screen was higher than the private screen.

REASONABLE CHARGE REDUCTIONS

During calendar year 1976, Florida Blue Shield processed about 3.9 million Medicare claims which were paid or applied to the beneficiaries' deductible, representing $378 million in covered charges. About 72 percent of these claims were reduced. The reductions totaled over $78 million (21 percent) of the total covered charges. From the beneficiaries' viewpoint, about 2.9 million (73 percent) of claims were unassigned, representing $276 million in covered charges. About $58 million of these charges were reduced. Overall, the beneficiaries were responsible for paying an average reduction of about $20 per claim on all unassigned claims.

1/In 1976, the year we reviewed, the data on which screens were based were the same.

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

COMPARABILITY

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

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

COMPARISON OF REASONABLE CHARGE REDUCTIONS UNDER PRIVATE AND MEDICARE BUSINESSES

Procedure	Private business			Medicare Business							
		Charge reduced		Charges		Assigned charges			Unassigned charges		
	Total number of charges	Number	Amount reduced (percent) (note a)	Total	Reduced	Total	Reduced	Amount reduced (percent) (note a)	Total	Reduced	Amount reduced (percent) (note a)
Radical mastectomy	1	-	-	1	1	-	-	-	1	1	25
Appendectomy	3	-	-	3	3	1	1	7	2	2	12
Sigmoidoscopy	34	7	30	106	56	11	6	39	95	50	30
Hemorrhoidectomy	3	-	-	4	2	1	1	8	3	1	17
Cholecystectomy	5	-	-	8	7	4	4	15	4	3	13
Transurethral resection of prostate	7	2	10	92	86	37	33	13	55	53	13
Hysterectomy	43	11	12	22	20	10	9	14	12	11	13
Routine followup brief office visit	3	-	-	687	685	15	15	16	672	670	12
Routine followup brief hospital visit	2,275	655	16	26,926	20,562	8,537	5,828	23	18,389	14,734	24
EKG	301	57	21	2,979	2,691	325	280	19	2,654	2,411	15
Total	2,675	732	16	30,828	24,113	8,941	6,177	23	21,887	17,936	22
	(100%)	(27%)		(100%)	(78%)	(100%)	(69%)		(100%)	(82%)	

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

* U.S. GOVERNMENT PRINTING OFFICE: 1979 - 620-167/259

APPENDIX VIII