UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

~~21522~~ 118328

HUMAN RESOURCES DIVISION

B-207017

APRIL 19, 1982

RELEASED

The Honorable Matthew J. Rinaldo
House of Representatives

Dear Mr. Rinaldo:

Subject: Inquiry About Alleged Discriminatory Medicare Part B Reimbursement in New Jersey (HRD-82-58)

This is in response to your request for a study of allegations of discriminatory rate reimbursement to New Jersey senior citizens under the Supplemental Medical Insurance program (Medicare part B). The allegations were contained in a July 1981 report entitled "What's Wrong With Medicare Part B in New Jersey?" by the Medicare Task Force of the New Jersey Federation of Senior Citizens.

We found that, although beneficiaries in New Jersey are paying a substantial portion of their medical costs for services which are covered by part B, they are on the average no worse off than beneficiaries elsewhere in the Nation. The level of reimbursement for benefits within the State is affected by reimbursement localities; that is, the different areas within the State for which maximum payment levels are set. While current charge data suggest that changes might be warranted in the locality designations, such changes would likely result in some beneficiaries being helped and others hurt financially.

SCOPE AND METHODOLOGY

We visited the Millville, New Jersey, office of The Prudential Insurance Company of America, the carrier which, under contract with the Department of Health and Human Services' Health Care Financing Administration (HCFA), is responsible for administering Medicare part B in New Jersey. We discussed the equity of reimbursement in various parts of the State with Prudential officials. We also analyzed copies of available studies and data related to this issue. According to Prudential officials, the most detailed study available was completed in January 1982. An explanation of the data and our analysis is provided in enclosure III.

(106222)

We also spoke with HCFA staff from both the headquarters in Baltimore and the regional office in New York. In Baltimore, we obtained information about general program requirements and collected overall statistical data. Our discussions with the New York HCFA staff primarily involved the justification for past and potential changes in reimbursement localities. Our work was conducted in accordance with the Comptroller General's current standards for audit of government organizations, activities, programs, and functions.

As requested by your office, we did not obtain comments on this report from HCFA or Prudential.

BACKGROUND

Part B of Medicare is available to (1) all citizens, and resident aliens living in the United States for at least 5 years, who are 65 years of age or older, (2) disabled persons who have been entitled to Social Security disability benefits for at least 24 consecutive months, and (3) persons suffering from end stage renal disease who are fully or currently insured under Social Security or are dependents of someone who is. Eligible individuals obtain part B coverage by enrolling in the program and paying a monthly premium, currently $11.00. 1/

After the beneficiary meets a $75 deductible, part B pays 80 percent of reasonable charges for health services provided by practitioners (physicians, chiropractors, etc.) and suppliers (laboratories, durable medical equipment providers, etc.). 2/ The amount on which part B determines what it will pay for a particular service is called the reasonable charge for that service. Medicare law limits the reasonable charge to the lowest of (1) the provider's actual charge, (2) the provider's customary charge (that is, the most frequent charge by the provider for that service), or (3) the prevailing charge for the service in the area where it was provided. The law further defines the prevailing charge as the amount necessary to cover 75 percent of the customary charges for

---

1/The Government contributes through appropriations enough money to pay part B expenses above the income from such premiums. In 1982, the Government is expected to pay about 76 percent of total part B costs for aged beneficiaries.

2/Part B also pays 100 percent of the covered costs of home health care, and no deductible amount applies to these services. Part B home health services are not paid by the same contractors who pay for other part B services; the discussion in this report does not pertain to home health services.

the most recent calendar year preceding the start of the current fee screen year. The prevailing charge, however, cannot be higher than 75 percent of the customary charges from calendar year 1971, as increased by an appropriate economic index. (See below.) The index that the Department of Health and Human Services uses for this purpose is designed to measure changes in physician operating expenses and general earnings levels.

New Jersey's carrier (Prudential Insurance Company) is responsible for (1) determining whether the services provided are covered by part B, (2) determining the reasonable charges for the services, and (3) paying for the services. Claims can be submitted to carriers in one of two ways. First, the provider can accept assignment of the claim, which means the provider agrees to accept Medicare's determination of reasonable charges as payment in full and the beneficiary is liable only for any unmet deductible and the 20-percent coinsurance based on the reasonable charge. Second, if the provider does not accept assignment, the beneficiary can bill Medicare directly. In this case, the beneficiary is liable for any unmet deductible, the 20-percent coinsurance, and any amount the provider's charges were reduced by the reasonable charge determination process. Currently, nationwide about half of the part B claims are for services for which the provider does not accept assignment. Overall, reasonable charge reductions average about 25 percent of billed charges.

THE ECONOMIC INDEX

Although the legislation did not require a specific type of index, the general form of the index follows the recommendations of the Senate Committee on Finance. The two categories in the index, physicians' operating expenses and general earnings levels, have been given weights of 40 percent and 60 percent, respectively, designed to reflect the average division of physician gross revenues between practice expenses and net income. The physician practice costs portion is currently composed of six components, each of which is assigned a specific weight. The six components are (1) salaries and wages, (2) office space, (3) drugs and supplies, (4) automobile expense, (5) malpractice insurance premiums, and (6) other expenses. The weights of these components, which have changed over the years, are based on special studies done at HCFA's request and studies by others.

The economic index values used for payment purposes have been as follows:

Fee screen year	Economic index value
1976	1.179
1977	1.276
1978	1.357
1979	1.426
1980	1.533
1981	1.658
1982	1.790

The base period to which this value is applied is fee screen year 1973--July 1972 through June 1973. The actual provider charges used to compute the prevailing charges for fee screen year 1973 were those collected in calendar year 1971. Thus, for services provided today, Medicare cannot pay more than 179 percent of what was charged 75 percent of the time in 1971 for the same service in the same area.

REASONABLE CHARGE
REDUCTIONS IN NEW JERSEY

The practical effect of the index is significant. For example, in locality 1 in New Jersey in 1980, the prevailing charges for 16 of 30 common procedures performed by general practioners were lower because of the application of the economic index than they would have been if based on the 75th percentile of current charges. For specialists, the economic index limited the prevailing charges for 49 of 75 common procedures. For 1982, the numbers increased to 18 and 54, respectively, for general practitioners and specialists.

The New Jersey Federation of Senior Citizens report said that the index was "outdated." As noted, the index is updated annually based on various studies.

The Federation also stated that:

> "The economic index used in computing the rising medical costs is inaccurate and when it is applied annually to adjust payments to beneficiaries, it falls extremely short of what doctors are actually charging senior patients for medical services."

In other words, submitted charges are being substantially reduced by Medicare's reasonable charge determination process.

To determine how large reasonable charge reductions were and whether senior citizens and physicians were suffering larger reductions in New Jersey than in other areas of the Nation, we looked at HCFA statistics on reasonable charge reductions. These statistics reflect not only the impact of the economic index, but also any reductions from actual charges made in accordance with program policy. We compared New Jersey data to nationwide data and also data on the neighboring States of New York and Pennsylvania. We also compared New Jersey data to data from Georgia (where Prudential is also the carrier), because the Federation had cited inequitable reimbursement rates between the two States. The comparisons follow:

Comparison of Reasonable Charge Reductions

	Average amount of reduction as a percent of covered charges				
	Nationwide	New Jersey	New York (note a)	Pennsylvania	Georgia
July - Sept. 1980	21.1	20.5	25.1	20.8	20.5
Oct. - Dec. 1980	21.7	21.8	25.4	21.9	21.6
Jan. - Mar. 1981	23.1	23.5	27.4	22.7	23.7
Apr. - June 1981	24.9	25.1	29.7	23.7	25.0
	Average amount of reasonable charge reductions per claim				
July - Sept. 1980	$20.67	$18.63	$25.35	$21.27	$19.33
Oct. - Dec. 1980	21.70	21.49	26.79	22.71	20.62
Jan. - Mar. 1981	23.75	24.74	33.13	24.43	23.11
Apr. - June 1981	26.21	24.89	34.77	26.61	25.22

a/The data shown here are for Blue Cross and Blue Shield of Greater New York, the largest of the three carriers in the State. About 75 percent of the Medicare part B covered charges are handled by this carrier.

The above data show on an overall basis that, while reasonable charge reductions are considerable, New Jersey senior citizens and providers are being affected about the same as those located elsewhere in the United States.

Although the Federation did not cite any instances in which Prudential has erred in computing the adjusted prevailing charges based on the economic index, we performed a limited analysis to check for such a possibility. We found no errors for the 42 reasonable charge levels we checked.

In summary, the impact of the economic index on New Jersey beneficiaries does not appear to be much different than it is in other States and the Nation.

LOCALITY DESIGNATION

The legislation states that prevailing charge levels will be determined by reimbursement localities, but does not specify how such localities should be established. Both the regulations (42 C.F.R. 405.505) and the Medicare Carrier Manual (5020.1) give similar, rather general guidance. The Manual provides that:

> "For the purpose of making reasonable charge determinations, a locality is the geographic area for which the carrier is to derive the prevailing charges for services. Usually a locality will be a political or economic subdivision of a State, and it should include a cross-section of the population with respect to economic and other characteristics. Where people tend to gravitate toward certain population centers to obtain medical care or service, localities may be recognized on a basis constituting medical service areas (interstate or otherwise), comparable in concept to 'trade areas.'
>
> "Carriers should delineate localities on the basis of their knowledge of local conditions. The localities may differ in population density, economic level, and other major factors affecting charges for services. However, distinctions between localities should not be so finely made that a locality includes only a very limited geographic area whose population has distinctly similar income characteristics (e.g., a very rich or very poor neighborhood within a city)."

Any changes in locality designation must receive HCFA's written approval.

In implementing these regulations, carriers have established localities that vary widely among the States. Fifteen States have only one statewide locality. One locality, including Washington, D.C., and the neighboring counties in Maryland and Virginia, crosses State boundaries. Texas has 32 localities, but most States have fewer than 5.

New Jersey had eight localities (see enc. I) until July 1974, when the number was reduced to three (see enc. II). Prudential, at the time of our review, did not have the statistical data supporting the locality change, but gave several reasons for the

reduction in the number of localities. One factor was that several of the eight localities were so small that only a few specialists o certain types practiced there. Because of their small number, thes specialties could largely control their own prevailing charges. Other reasons for the reduction included increased urbanization and population shifts in the State.

The Federation said that the reduction from eight to three localities was an "illegal locality change." It also said that "New Jersey is the only State in the Country to have its reimbursement localities reduced in number." However, the reduction in the numbe of localities does not appear contrary to the legislation, regulations, or Medicare Manual. Also, other States have had a reduction in the number of reimbursement localities. In fact, according to HCFA, of the 15 States mentioned above having one statewide locality, 6 formerly had more than one locality.

Since the locality change in 1974, Prudential and HCFA have done several studies relating to locality designation. In November 1980, at the request of the Federation and others, Prudential completed an analysis of charge data comparing 1971 to 1979 for the former locality 3 (eastern Bergen County) with the present locality 1 (northern New Jersey, including Bergen County). The analysis showed that, if the localities had remained unchanged, the beneficiaries and providers in former locality 3 would not be receiving consistently higher reimbursements. Nine procedures would be reimbursed at a higher level, three would be lower, and eight would remain unchanged.

In March 1981, the HCFA New York Regional Office gave the Federation information involving 1971 and 1979 charge data from the three New Jersey localities, one Georgia locality, both North Carolina localities, six of the eight New York localities, and all four Pennsylvania localities. The data indicated that some reimbursement levels in New Jersey were equal to or higher than those in other States and some were lower. When compared to the median charge for the other States, all three New Jersey localities had equal or higher reimbursement rates in 64 percent of the cases. At least two of the three New Jersey localities had equal or higher reimbursement rates than the median of the others in 86 percent of the cases.

From the beneficiary's point of view, it would seem more appropriate to compare reasonable charge reductions rather than actual reimbursement rates; that is, comparisons of the maximum amounts the beneficiary could be liable to pay. As shown on page 5, reasonable charge reductions are about the same in New Jersey as in other States.

The most extensive study of the New Jersey localities, according to Prudential officials, was begun in September 1981 at the request of HCFA's New York Regional Office. The regional office selected 16 different procedures and 7 physician specialty types (internist, urologist, etc.) for the study. The office also specified the study approach and the form in which the data were to be summarized. Prudential submitted the data to HCFA in January 1982.

We reviewed these data, which show that some counties within current localities have significantly larger proportions of charges exceeding current statewide average charges than do other counties within the same locality. This indicates that beneficiaries in the high charge counties might benefit by a change in localities. 1/ (See enc. III for a discussion of these data.)

However, while changing localities would probably benefit some beneficiaries by increasing reimbursement rates, it would probably also reduce reimbursements to others. This would occur because, when higher charge areas are removed from a locality, the reasonable charge level in the locality gaining the high charge area increases, but at the same time the reasonable charge level in the locality losing the high charge area decreases. Thus, any change in locality designations results in some beneficiaries being helped and others hurt financially. Of course, a change in locality designation would have minimal impact on beneficiaries whose physicians accept assignment, only changing the coinsurance amount, unless the locality change would have enough impact on reimbursement rates to reduce the number of physicians that accept assignment.

The HCFA New York Regional Office is analyzing the data from the latest locality study. A HCFA representative said that in general the agency does not oppose changing a locality designation if its analysis of the data indicates that a change is warranted.

1/While such a change would benefit the beneficiaries when the prevailing charge is based on 75 percent of current customary charges, it might not necessarily benefit them when the economic index limits the prevailing charge to 75 percent of the 1971 customary charges. For those prevailing charges limited by the economic index, if charging patterns have shifted within the State over the years, changing localities might not benefit beneficiaries. That is, if counties that currently have relatively high charge levels did not in 1971, a change in locality designation might not result in reimbursement increases.

CONCLUSIONS

Although New Jersey Medicare beneficiaries incur substantial part B reasonable charge reductions and those whose claims are not accepted for assignment by the provider are incurring significant liabilities to pay above the level Medicare allows, New Jersey beneficiaries on the average are no worse off than beneficiaries elsewhere in the Nation. Data on current provider charges indicate that changes in New Jersey's locality designations might be warranted. However, any such changes would probably result in some beneficiaries being better off and others being worse off financially. For all beneficiaries to receive increased reimbursements, reasonable charge levels would probably have to be increased everywhere; this of course would increase the costs of the Medicare part B program.

We trust that this information is responsive to your request.

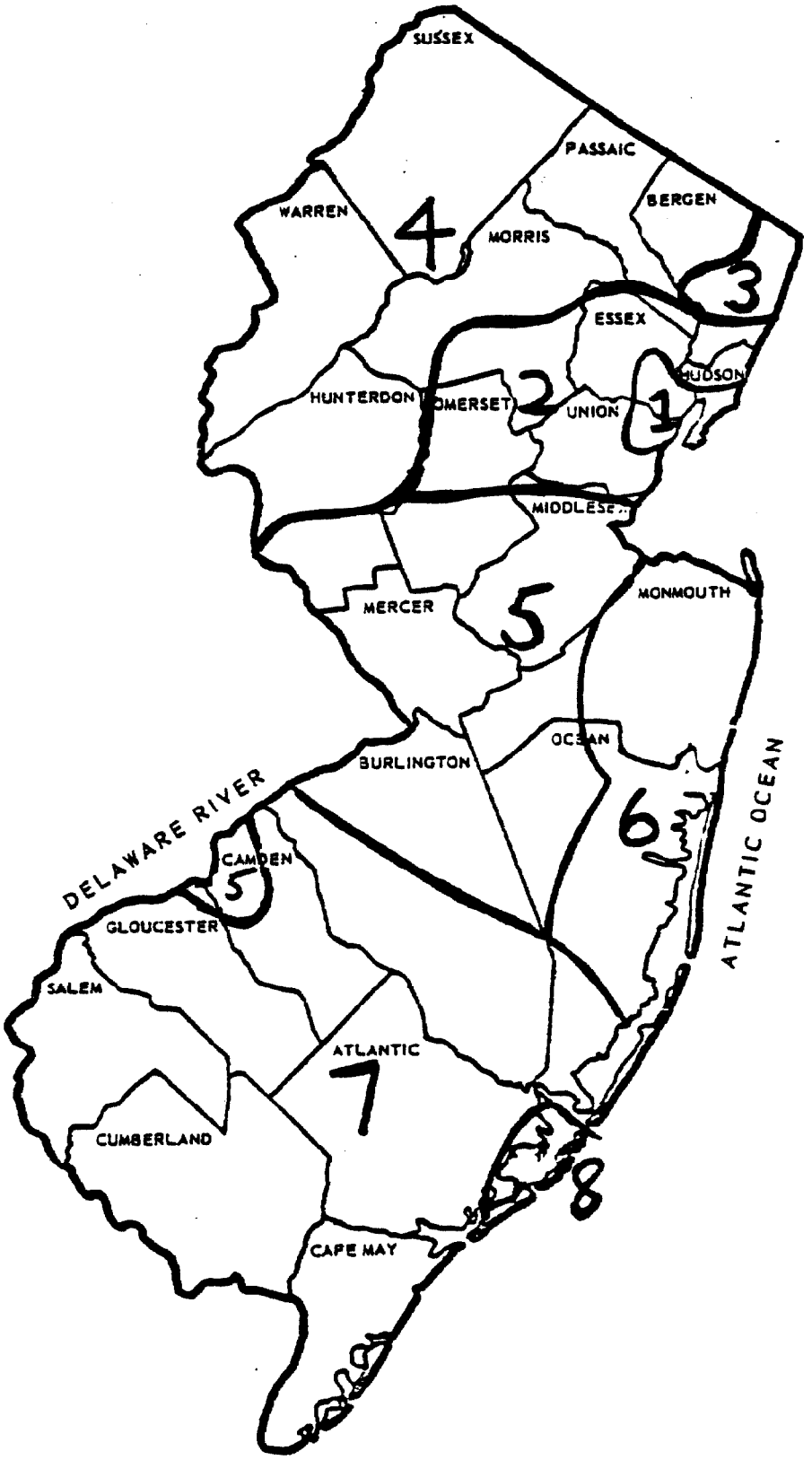
Sincerely yours,

Gregory J. Ahart
Director

Enclosures - 3

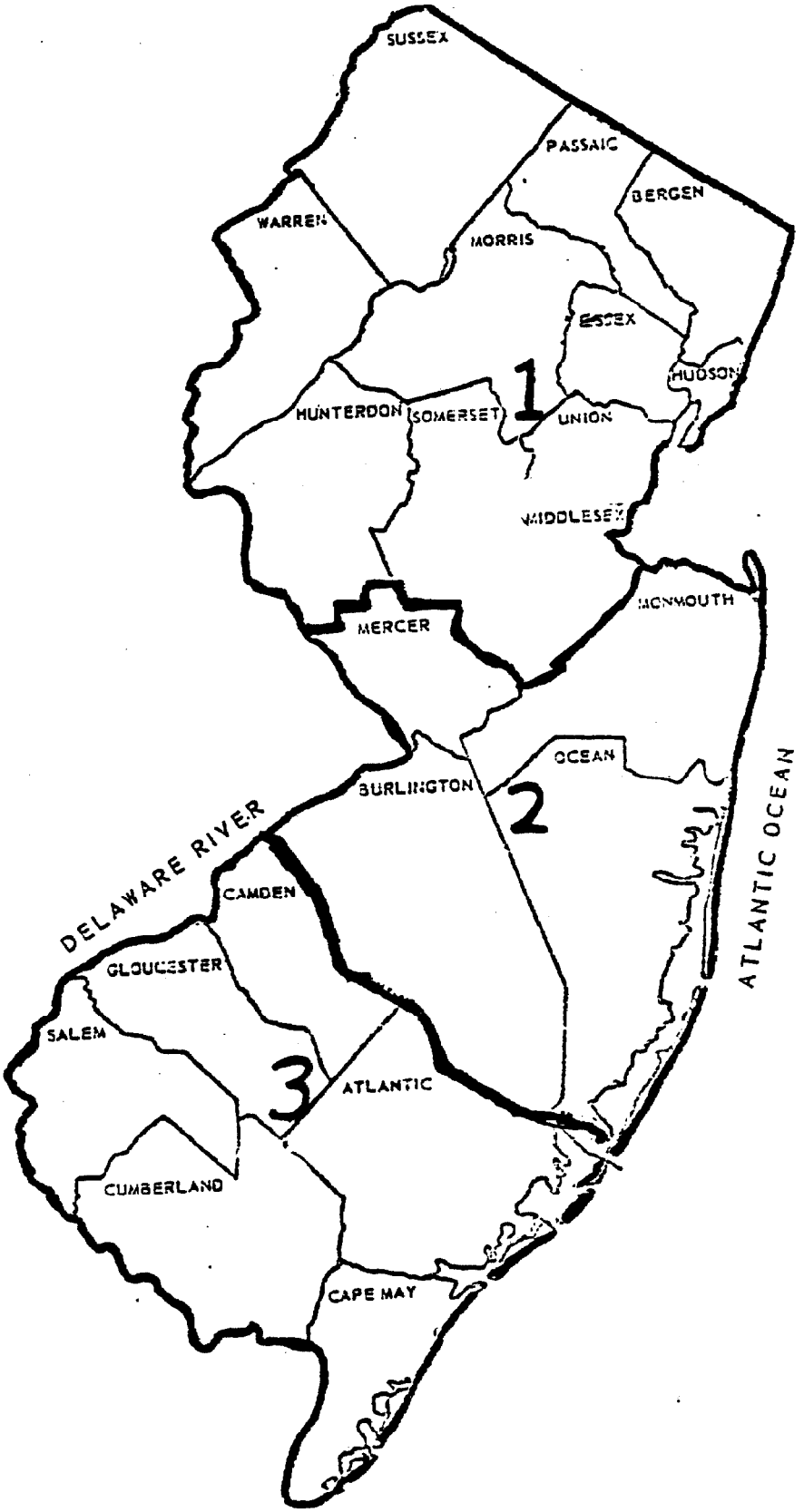
ENCLOSURE I

LOCALITIES BEFORE 1974



ENCLOSURE II

CURRENT LOCALITIES



DESCRIPTION OF ANALYSIS OF LOCALITY STUDY

Prudential's latest locality study was based on a methodology specified by HCFA. This methodology involved computing the statewide average customary charge for each procedure and specialty selected by HCFA for study. The customary charges for each physician in each county in the State were then compared to this average charge.

In this comparison, seven ranges were calculated around each statewide average customary charge. Roughly, the ranges were based on intervals of 20 percent--for example, the average range was the statewide average customary charge plus or minus 10 percent, and the +1 range was 110 to 130 percent of the statewide average customary charge. 1/

1/Since most charges studied fell into the "$10.01-$250.00" range, the 20-percent interval concept described above is a good approximation. However, the actual computations were more complex. The "Simplified Computations for Determining the Ranges" according to the HCFA instructions are as follows.

Where the average customary charge is:	Compute the ranges as follows:
$00.01-$10.00	Subtract $7 from the average customary charge to find the bottom of the -3 range; then add $2 to the bottom of the -3 range; repeat this six times. Example: If the average customary charge is $9.50; $9.50 - 7 = $2.50. ($2.50 + $2 = $4.50 + $2 = $6.50 + $2 = $8.50 + $2 = $10.50 + $2 = $12.50 + $2 = $14.50 + $2 = $16.50). The ranges are: $4.50 or less, $4.51 - $6.50, $6.51 - $8.50, $8.51 - $10.50, $10.51 - $12.50, $12.51 - $14.50, and $14.51 and above.
$10.01-$250.00	Multiply the average customary charge by 30% to find the bottom of the -3 range; then add 20% of the average customary charge to the bottom of the -3 range; repeat this six times. Example: If the average customary charge is $100; 30% of $100 = $30; 20% of $100 = $20. ($30 + $20 = $50 + $20 = $70 + $20 = $90 + $20 = $110 + $20 = $130 + $20 = $150 + $20 = $170). The ranges are: $50 or less, $50.01 - $70, $70.01 - $90, $90.01 - $110, $110.01 - $130, $130.01 - $150, and $150.01 and above.
$250.01-n	Subtract $175 from the average customary charge to find the bottom of the -3 range; then add $50 to the bottom of the -3 range; repeat this six times. Example: If the average customary charge is $300; $300 - $175 = $125. ($125 + $50 = $175 + $50 = $225 + $50 = $275 + $50 = $325 + $50 = $375 + $50 = $425 + $50 = $475). The ranges are: $175 or less, $175.01 - $225, $225.01 - $275, $275.01 - $325, $325.01 - $375, $375.01 - $425, and $425.01 and above.

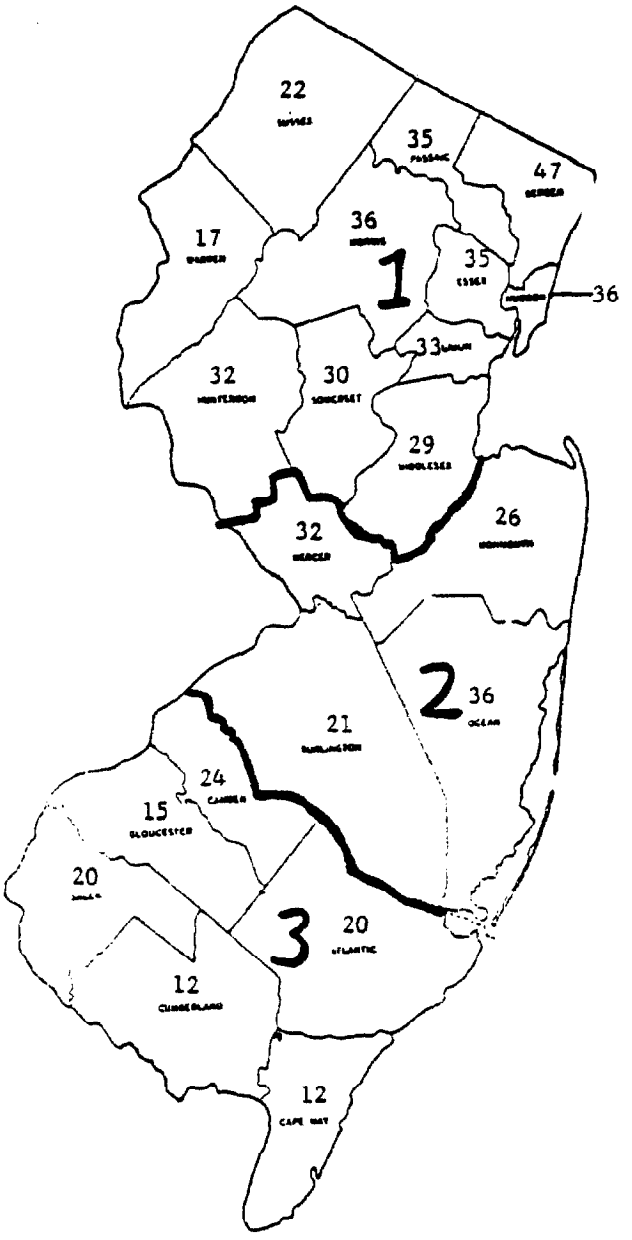
For each of the 21 counties in New Jersey, we totaled the number of customary charges in each range for each specialty. We calculated the percentage of the customary charges that appeared in each range for each county. To identify the counties in which the highest customary charges existed, we added the percentage falling in the +1, +2, and +3 ranges. This total roughly reflects the percentage of customary charges in each county that exceeds the statewide average by more than 10 percent. The map on the next page shows these percentages for each county in New Jersey.

One limitation of using the data from this study to determine locality designations is that only the current charge patterns are considered. To the extent that the economic index limits the reasonable charge for certain procedures, the 1971 charge patterns become relevant. We thought that a locality designation decision based on an analysis of reasonable charge reductions by county might be more equitable to beneficiaries in New Jersey.

We asked about the feasibility of computing reasonable charge reductions by county based on the existing locality designation as well as one or more alternative locality designations. A Prudential official said that such an analysis would be quite expensive, and a HCFA representative said that, because of budget constraints, doing such an analysis would be very difficult.

ENCLOSURE III

Percent of Charges in Ranges +1, +2, and +3



= Current Locality Boundaries

Three Localities Currently Existing:

1 - Bergen, Essex, Hudson, Hunterdon, Middlesex, Morris, Passaic, Somerset, Sussex, Union, and Warren Counties.

2 - Burlington, Mercer, Monmouth, and Ocean Counties.

3 - Atlantic, Camden, Cape May, Cumberland, Glouster, and Salem Counties.