REPORT OF THE COMPTROLLER GENERAL OF THE UNITED STATES

Reasonable Charge Reductions And Related Matters Under Part B Of Medicare

Social Security Administration
Department of Health, Education, and Welfare

Blue Cross-Blue Shield of Greater New York reduced about two-thirds of the Medicare claims it processed during fiscal year 1974. The reductions were made because charges exceeded reasonable charges which under program regulations are based on charge data 6- to 30-months old. Incorrect coding of claims contributed to the reasonable charge reductions. Relatively few claims were involved in the appeals process; however, a large portion of claims involved in the appeals process were reversed in favor of the claimants.

MWD-76-92

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

B-164031(4)

The Honorable Elizabeth Holtzman
House of Representatives

Dear Ms. Holtzman:

Pursuant to your request of August 26, 1974, and subsequent discussions with your office, we have reviewed reasonable charge reductions and related matters under Part B of Medicare as administered by Blue Cross-Blue Shield of Greater New York.

On August 1, 1975, we furnished you with a preliminary report on the results of some of our work. This is our final report.

As you requested, we did not afford Blue Cross-Blue Shield of Greater New York or Bureau of Health Insurance, Social Security Administration, officials an opportunity to formally review and comment on this report. However, we have discussed our findings with representatives of both these organizations and their comments have been incorporated where appropriate.

Sincerely yours,

Comptroller General
of the United States

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ABBREVIATIONS

BHI	Bureau of Health Insurance
EDSF	Electronic Data Services Federal Corporation
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
SSA	Social Security Administration

COMPTROLLER GENERAL'S REPORT TO THE HONORABLE ELIZABETH HOLTZMAN HOUSE OF REPRESENTATIVES

REASONABLE CHARGE REDUCTIONS AND RELATED MATTERS UNDER PART B OF MEDICARE

Social Security Administration
Department of Health, Education, and Welfare

D I G E S T

BASIC FACTS

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

The reasonable charge is generally the lowest of (1) the amount billed for the service, (2) the physician's customary charge for the service, and (3) the prevailing charge for the service in the locality.

The beneficiary is responsible for the first $60 of the reasonable charges for covered services in each year. Eighty percent of reasonable charges exceeding the $60 deductible may be paid either to a physician or supplier or to the beneficiary.

The Social Security Administration requires that carriers grant physicians, suppliers, and beneficiaries an opportunity for a review (reconsideration) and a fair hearing if they (1) are dissatisfied with the carrier's determination denying a request for payment or with the amount of payment or (2) believe that a request for payment is not being acted on with reasonable promptness.

FINDINGS AND CONCLUSIONS

Reasonable charge methods

New York Blue Cross-Blue Shield develops customary and prevailing charges (profiles) as the basis for determining reasonable charges for most services. For certain supplies and services, such as blood and drugs, price

lists are used to establish maximum charges. (See p. 8.)

For procedures for which charge data is not available, reasonable charges are developed based on relative value scales. (See p. 9.)

Most profiles for fiscal year 1975 were updated effective July 1, 1974, as required by the Social Security Administration. However, for certain procedures which were not updated by July 1, claims were paid using the previous fiscal year profiles. (See pp. 11 and 12.)

Increases in physicians' fees after the calendar year used to establish profiles result in reasonable charge reductions. The effect of such increases is indicated by the fact that the Consumer Price Index for physicians' fees nationally increased 23.4 percent from the calendar year 1973 average to April 1975. (See p. 11.)

Incorrect coding of claim line items resulted in reasonable charge reductions of at least $608,000 on claims paid during the first quarter of fiscal year 1975. (See pp. 12 and 13.)

The Bureau of Health Insurance is responsible for reviewing, evaluating, and determining the adequacy of carriers' performance. The Bureau reported in March 1974 that New York Blue Cross-Blue Shield scored next to worst of all carriers on regional office evaluations of carriers' reasonable charge methods for fiscal year 1974. (See p. 13.)

Reduction of claims

Medicare claims submitted by Kings County beneficiaries from July 1, 1973, through April 30, 1974, indicate that New York Blue Cross-Blue Shield reduced 66.5 percent of the claims paid by 16.8 percent.

Of the total Kings County reductions, 57.5 percent were attributable in whole or in part to identified customary charges. The causes of the remaining 42.5 percent of reductions could not be determined. (See pp. 16 and 17.)

Analysis of reconsiderations and fair hearings

Of the 155,852 reconsiderations and 767 fair hearings resolved by New York Blue Cross-Blue Shield during fiscal year 1974, 47 percent of the reconsiderations and 68 percent of the fair hearings resulted in additional payments to the claimants.

GAO's sample analysis of reconsiderations and fair hearings indicated that reversals were made in reconsideration cases primarily because of incorrect coding of procedures and additional information supplied by the claimant; additional information was also the principal reason for reversal of fair hearing cases. (See pp. 20 and 21.)

Complementary health insurance

Insurance coverage is offered by several insurance companies to complement Part B of Medicare. Generally, the insurance does not cover Medicare reasonable charge reductions. (See p. 22.)

CHAPTER 1

INTRODUCTION

Pursuant to a request dated August 26, 1974, from Congresswoman Elizabeth Holtzman, we reviewed reasonable charge reductions and related matters under Part B of Medicare, as administered by Blue Cross-Blue Shield of Greater New York (New York Blue Cross-Blue shield). Although New York Blue Cross-Blue Shield is the Medicare carrier for 16 counties in southeastern New York State, we gave special attention in this review to Kings County. We issued a preliminary report to the Congresswoman on August 1, 1976 (MWD-76-12), which discussed some of the matters included in the request.

SCOPE OF REVIEW

As a result of the Congresswoman's request and subsequent discussions with her office, we

--examined the methods used by New York Blue Cross-Blue Shield to develop and adjust customary and prevailing charges for surgical and medical procedures for fiscal years 1974 and 1975;

--ascertained the dollar amounts and percents by which claims were reduced during calendar years 1971 to 1974 by New York Blue Cross-Blue Shield and by all carriers;

--analyzed claims submitted to New York Blue Cross-Blue Shield by Kings County beneficiaries from July 1, 1973, to April 30, 1974, and determined the percentage of, and causes for, reasonable charge reductions;

--analyzed the extent to which claim reductions were appealed and, as a result of reconsideration and fair hearing procedures, amended;

--obtained information on selected insurance plans available to complement Medicare Part B insurance in the New York City area;

--ascertained the measures taken by New York Blue Cross-Blue Shield and the Bureau of Health Insurance (BHI) to assure that payments for services under Part B of Medicare do not exceed payments for similar services to non-Medicare patients;

--reviewed the policies and procedures used by New York Blue Cross-Blue Shield for coding claims;

--reviewed the procedures used to exclude token (unusually low) and extreme (unusually high) charges from the development of reasonable charges; and

--assessed the impact of reasonable charge reductions on the standards of living of Kings County beneficiaries.

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

We made our review at Social Security Administration (SSA) headquarters, Baltimore, Maryland; the New York Regional Office of the Bureau of Health Insurance (BHI) of SSA; New York Blue Cross-Blue Shield, New York, N.Y.; and at its subcontractor, Electronic Data Services Federal Corporation (EDSF), New York, N.Y., and Camp Hill, Pennsylvania.

CHAPTER 2

DESCRIPTION OF PERTINENT FEATURES OF MEDICARE

Title XVIII of the Social Security Act (42 U.S.C. 1395), enacted on July 30, 1965, established the Medicare program, effective July 1, 1966, to provide eligible persons over age 65 with protection against the costs of health care. The Social Security Amendments of 1972 (86 Stat. 1329), extended Medicare protection (effective July 1, 1973) to persons under 65 who have received social security or railroad retirement disability benefits for at least 24 consecutive months and to certain individuals with kidney disease.

Part B, Supplementary Medical Insurance Benefits for the Aged and Disabled, is a voluntary plan which covers physicians' services, outpatient hospital services, certain home health care services, diagnostic tests performed by independent laboratories, and several other medical and health benefits.

Part B is financed by premiums collected from, or on behalf of, each enrolled individual and by amounts appropriated from the general revenues of the Federal Government. The amount payable to a beneficiary for covered physician and medical services furnished in a calendar year is reduced by a $60 deductible and generally by coinsurance of 20 percent of reasonable charges.

PAYMENTS FOR SERVICES ON THE BASIS OF REASONABLE CHARGES

Sections 1842(a) and (b) of the Social Security Act authorized the Secretary of HEW to enter into contracts with carriers to (1) determine the rates and amounts of payments on a reasonable charge basis and (2) receive, disburse, and account for funds spent in paying the charges. In conformance with these sections, SSA instructed carriers that the reasonable charge allowed for a service should generally not exceed the lowest of (1) the customary charge for a similar service generally made by the physician or supplier, (2) the prevailing charge in the locality for a similar service, and (3) the actual charge for the service. The act also provides that the reasonable charge for a service may not exceed the charge applicable for a comparable service and under comparable circumstances to the policy-holders or subscribers of the carrier.

Customary charges

SSA instructed carriers to develop customary charges for each fiscal year based on charges by physicians and suppliers during the preceding calendar year. When the customary charge is calculated for a service, each physician's or supplier's charge for the service is arrayed in ascending order. The lowest actual charge which is high enough to include the median of the arrayed charge data is then selected as the physician's or the supplier's customary charge for the service. When a carrier does not have adequate statistics on charges for a service for all of a calendar year, the fees charged or the price lists in effect as of June 30 of that year may be used.

Once a carrier has established the customary charge screens for a fiscal year, further increases (other than to correct errors) are to be permitted only in individually identified and highly unusual situations where equity clearly indicates that the increases are warranted. In determining whether a revision in a customary charge is warranted, consideration is to be given to factors such as (1) the elapsed time since the last change in the customary charge (2) the size of the requested increase and the relationship of the new and old charges to the charges made by others for the service, (3) increases in the physician's or other person's operating expenses which are used to justify an increase in charges, and (4) whether a physician has achieved "board certification."

Prevailing charges

Section 1842(b) of the Social Security Act states that the prevailing charge covers 75 percent of the customary charges made for similar services in the same locality during the calendar year preceding the start of the fiscal year in which the bill is submitted. SSA instructed carriers to calculate the prevailing charge for a procedure by arraying in ascending order customary charges for the service. The lowest customary charge which is high enough to include 75 percent of the cumulative services related to the charges is then selected as the prevailing charge.

Charges for rare or unusual surgical procedures

Where there is not sufficient information for determining the customary or prevailing charge for a service in a locality, the carrier may use appropriate relative value scales developed by a State medical society together with dollar conversion factors that take into consideration known

customary and/or prevailing charges for other services for developing the customary or prevailing charge.

Relative value scales provide a measure of the complexity, skill requirements, and other characteristics of a procedure. A relative value scale which is used by the carrier should accurately reflect charge patterns in the area serviced by the carrier.

A carrier may also exercise judgment based on information on the customary and prevailing charges for services in other localities and on the advice of its medical staff and the local medical society.

Requirement of Economic Stabilization Program

The Cost of Living Council ruled that increases in Medicare allowable charges would be restricted to 2.5 percent for each of the fiscal years 1973 and 1974 with a 5.06 percent increase over the 2-year period. Reasonable charges would have been increased approximately 9.5 percent over the 2-year period without the Economic Stabilization Program. To implement the Cost of Living Council's ruling, only 55 percent of the increase that would ordinarily have been allowed was recognized in calculating Medicare allowable charges for fiscal year 1974.

DENIALS AND REDUCTIONS OF AMOUNTS CLAIMED

Claims may be denied in full or in part (a claim may include numerous services) for reasons such as duplicate claims being submitted, services not covered, claimant not eligible, and services not medically necessary. During fiscal year 1974, about 10.5 million of the 62.9 million claims processed by all carriers were denied in part or in full. The amounts denied totaled $542,564,813, or 11.6 percent of amounts claimed during the year.

Amounts claimed and not denied are called covered charges. Covered charges are subject to reductions based on reasonable charge determinations by carriers. During fiscal year 1974, reasonable charge reductions were made on 38,235,908 claims by all carriers. These reductions totaled $545,789,409, or 13.2 percent of the covered charges on claims processed during the year.

METHODS OF PAYING FOR MEDICAL SERVICES

Eighty percent of reasonable charges exceeding the $60 deductible is paid by the carrier to a physician or supplier (assigned claim) or to the beneficiary (unassigned claim).

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

SSA obtains information showing the percentage of all claims that were assigned and the percentage of claims assigned exclusive of hospital claims for hospital-based physician services and claims from some prepaid group practice plans (net assignments). Net assignment rates for the last 4 years for which data was available for New York Blue Cross-Blue Shield and all carriers are shown below.

	Calendar year			
	1971	1972	1973	1974
All carriers	58.5	55.1	52.7	51.9
New York Blue Cross-Blue Shield	43.6	44.1	44.7	48.0

Physicians and suppliers ordinarily have no option but to accept assignment of Medicare claims for services provided to duel beneficiaries (Medicare-Medicaid recipients). Although we were unable to determine the number of claims for dual beneficiaries, we believe assignment rates would be considerably lower if claims from dual beneficiaries were excluded.

BHI REVIEW OF THE CARRIER DETERMINATION OF REASONABLE CHARGES

Section 1875(b) of the Social Security Act provides that the Secretary of HEW shall make a continuing study of the operation and administration of the Part B program.

BHI has the primary responsibility for reviewing, evaluating and determining the adequacy of carriers' performance. Regional offices prepare performance evaluation reports annually on each carrier. In preparing the report, BHI reviews major segments of the Medicare operation, including reasonable charge methods.

APPEALS PROCESS

SSA requires that carriers establish and maintain procedures for granting physicians or suppliers and individuals enrolled under Part B an opportunity for a review (reconsideration) and a fair hearing if they (1) are dissatisfied with the

carrier's denying a request for payment or with the amount of the payment or (2) believe that a request for payment is not acted upon with reasonable promptness. A review is a prerequisite for a fair hearing. To be eligible for a fair hearing, the amount in controversy must be $100 or more. On assigned claims, both the beneficiary and the assignee may request a reconsideration and a fair hearing.

COST TO ADMINISTER PART B OF MEDICARE

The cost to administer Part B of Medicare from program inception through fiscal year 1974 is shown below.

Fiscal year	New York Blue Cross-Blue Shield	Other contractors	State agencies	SSA	Total
	(thousands)				
1967	$ 4,267	$ 63,410	$ 2,777	$ 28,497	$ 98,951
1968	7,569	104,729	1,927	41,386	155,611
1969	8,932	128,191	1,369	47,634	186,126
1970	10,490	150,032	1,719	55,138	217,379
1971	14,028	175,695	2,472	63,686	255,881
1972	14,883	179,807	1,470	62,929	259,089
1973	15,795	207,223	1,602	83,709	308,329
1974	17,189	239,708	1,805	100,591	359,293

The administrative costs for 1974 were about 12 percent of Part B benefits of $2,900,833 paid during 1974.

CHAPTER 3

METHODS USED BY NEW YORK BLUE CROSS-BLUE SHIELD TO ESTABLISH REASONABLE CHARGES

Medicare carriers are to develop customary and prevailing charges (profiles) to determine reasonable charges. Under the Social Security Act, profiles are to be updated at the beginning of each fiscal year, using available statistics on charges which physicians and suppliers made for services during the preceding calendar year. Consequently, reasonable charges are based on data which is 6- to 18-months old at the beginning of the fiscal year and 18- to 30-months old at the end of the fiscal year. Profiles for some services were not updated by Blue Cross-Blue Shield at the beginning of fiscal years 1974 and 1975. Also, incorrect charge data was used to update profiles which could adversely affect the reasonable charge computations.

METHODS USED TO ESTABLISH CUSTOMARY AND PREVAILING CHARGES

New York Blue Cross-Blue Shield's annual updating of customary and prevailing profiles for most services was generally based on Medicare charge data. For those procedures where insufficient charge data existed to develop either a customary or prevailing charge, approximations of reasonable charges were calculated using "relative value units." For blood, biologicals, and drugs, price lists rather than customary and prevailing charges were used as maximum charges.

EDSF, under contract with New York Blue-Cross Shield for data processing and related services, was responsible for recording claims data and determining amounts of payments. In carrying out these functions, it maintained historical charge data from which it developed customary and prevailing charges and made reasonable charge determinations.

Establishment of customary charges

EDSF, generally developed the customary charges of physicians and suppliers in accordance with SSA regulations. However, charge data from New York Blue Cross-Blue Shield's non-Medicare insurance business was not included in calculating customary charges. Requests from BHI to include charge data from its non-Medicare business have resulted in New York Blue Cross-Blue Shield plans to consider such charges in determining customary charges for fiscal year 1977.

Establishment of prevailing charges

EDSF developed by locality prevailing charges for general practitioners and for specialists. It arrayed the customary charges in ascending order and calculated the lowest customary charge which was high enough to include the 75th percentile of the charges.

SSA regulations state that, to develop prevailing charges, a locality should be, economically and otherwise, a cross section of the population and an area where people tend to seek medical care services. For most services, Blue Cross-Blue Shield has divided its 16-county area of coverage into four localities. One of these localities includes the Bronx, Brooklyn (Kings County), Staten Island, and Westchester.

The locality structure is based on (1) a study made in 1965 in which responses to questionnaires were received from 12,000 physicians, indicating the fees they charged for medical and surgical services in 1964 and (2) considerations of similarities in socioeconomic conditions. In March 1974 BHI asked New York Blue Cross-Blue Shield to reevaluate its locality structure, but as of January 1976 the evaluation had not been completed. Blue Cross-Blue Shield officials told us that they expected the evaluation to be completed about February 1976.

Use of other data to establish reasonable charges

For some precedures charge data was insufficient to provide a basis for calculating reasonable charges. In such cases New York Blue Cross-Blue Shield approximated the customary or prevailing charge by computing a "fill-gap" charge.

A fill-gap charge is arrived at by using

--relative value units adopted by the Medical Society of New York which measure numerically the characteristics of a procedure in terms of complexity, skill required, risk, performance time, and charge history and

--a dollar conversion factor, which represents the average customary or prevailing charge for one relative value unit.

A customary fill-gap charge for a procedure is computed by multiplying the provider's dollar conversion factor by the number of relative value units assigned to the procedure. A prevailing fill-gap charge for a procedure is computed in the same manner, using the locality's dollar conversion factor.

DETERMINATION OF REASONABLE CHARGES

For those procedures for which EDSF used charge data or fill-gap procedures to develop profiles, reasonable charges were calculated by comparing the submitted, customary, and prevailing charges for the procedures. The lowest of the three charges is the reasonable charge.

For procedures whose profiles were based on price lists, reasonable charges were determined by selecting the lower of the profile amount or the submitted charge.

TOKEN AND EXTREME CHARGES

Section 405.503 of Regulation No. 5, Federal Health Insurance for the Aged, provides that customary charges represent the amount which the physician or other person charges in the majority of cases for a medical procedure or service and that token (unusually low) and extreme (unusually high) charges are to be excluded in developing a customary charge because they may distort the profile.

Blue Cross-Blue Shield defined token and extreme charges for fiscal year 1975 as those charges which were less than one third or greater than three times the physician's customary charge and excluded them for profile generation. The range established by the carrier for token and extreme exclusion does not eliminate some charges that, in our opinion, should be considered token or extreme. For example, charges by a physician of as little as $30 and as much as $270 for a procedure for which the customary charge is $90 would not be considered, using this range, as token or extreme charges and excluded from profile development. If a physician's customary charge has not been established for a procedure, the carrier's method does not eliminate token or extreme charges.

Failure to exclude token and extreme charges from profile development could distort profiles and result in overpayments and underpayments.

A Blue Cross-Blue Shield official told us that the carrier planned to evaluate alternative methods, including a method we developed based on statistical measures of standard deviations from actual charges, for eliminating token and extreme charges. BHI officials concurred with Blue Cross-Blue Shield's plan to evaluate alternatives methods to eliminate token and extreme charges from profile development.

COMPARABILITY OF ALLOWED CHARGES UNDER MEDICARE AND CARRIER'S INSURANCE POLICIES

Section 405.508 of Regulation No. 5, Health Insurance for the Aged, provides that a carrier may not allow a charge under Medicare that is higher than the charge on which it would base payment to its own policyholders for a comparable service under comparable circumstances.

SSA has taken the position that under the comparable circumstances provision, reasonable charges under Medicare should not be limited to amounts paid under the most widely held Blue Shield plans, because they are not comparable to the Medicare program.

Blue Cross-Blue Shield officials said that in 1970 they began comparing on a continuing test basis prevailing Medicare charges with allowed charges established at the 90th percentile of charges under one of its business plans (the UC-90 plan), but they did not document the results of the comparisons. Blue Cross-Blue Shield informed BHI that the comparison showed that Medicare reasonable charges were not higher than UC-90 charges.

EFFECT OF USING PRIOR-YEAR CHARGE DATA FOR PROFILE DEVELOPMENT

Increases in physicians' charges after the calendar year used to establish the profiles will result in reasonable charge reductions. While we could not determine how much physicians' charges had risen in Kings County or in the Blue Cross-Blue Shield area, the Consumer Price Index for physicians' fees nationally increased 23.4 percent from the calendar year 1973 average to that of April 1975. Also, compared to an increase of 20.4 percent for all urban areas, the Consumer Price Index for medical care increased 22.8 percent in the greater New York-Northeastern New Jersey area from the calendar year 1973 average to April 1975.

Thus, using prior-year data required by the Social Security Act could result in considerable reasonable charge reductions.

FREQUENCY IN UPDATING PROFILES

All profiles were updated effective July 1, 1974, except for the following services:

--Ambulance and purchased and rented durable medical equipment and supplies were updated on August 16, 1974, using charge information.

--Profiles of two laboratories were updated August 16, 1974, using price list information.

--Pathology and diagnostic testing were updated on August 23, 1974, using charge information.

Until profiles for the above services were updated to indicate calendar year 1973 charge data, claims for the services were paid on the basis of fiscal year 1974 profiles, which were derived from calendar year 1972 charge data.

Adjustments of customary charges were made throughout the year to correct errors. From July 1, 1974, through October 11, 1974, about 450 adjustments were made. However, adjustments were not made to the corresponding prevailing charges. Blue Cross-Blue Shield officials said they would institute procedures to make adjustments in prevailing charges when warranted by changes in customary charges. They stated, however, that the impact of such adjustments would be minimal.

Adjustments of customary charges were also made as a result of equity changes requested by physicians. Carrier officials stated that the peak period of equity adjustments is immediately after the annual update of profiles in July. They said that 43 equity adjustments were granted from July 1, 1974, through October 11, 1974.

REASONABLE CHARGE REDUCTIONS RESULTING FROM CODING ERRORS

To ascertain the accuracy of Blue Cross-Blue Shield's reasonable charge determinations and the validity of data that was to be used to generate fiscal year 1976 profiles, we statistically selected a sample of 300 surgical claim line items from 123,500 surgical line items on claims paid during the first quarter of fiscal year 1975. The charges on the 123,500 items totaled $26.1 million, of which $19.4 million was allowed--reasonable charge reductions were $6.7 million.

At our request, internal auditors of Blue Cross-Blue Shield reviewed the 300 claim line items. They determined that 51 line items were incorrectly coded. On the basis of the analysis of the line items included in the sample, we believe that at least 16,000 or 13.0 percent, of the 123,500 line items, were incorrectly coded and resulted in erroneous reasonable charge reductions of at least $608,000. The incorrect coding included such cases as a biopsy of stomach

with laparotomy having a reasonable charge of $750 being coded as an exploratory celiotomy having a reasonable charge of $696, which resulted in an erroneous reasonable charge reduction of $54.

The BHI official stated that the figures presented on reasonable charge reductions resulting from coding errors may be misleading if corrections made through the appeals process have not been taken into account. He stated, however, that when incorrectly coded items have been identified, the incorrect data should not be used for calculating reasonable charge screens.

BHI REVIEW OF THE CARRIER S REASONABLE CHARGE ACTIVITIES

BHI reported in March 1974 that New York Blue Cross-Blue Shield scored next to worst (82 points of a possible 100) of all carriers on regional office evaluations of carriers' reasonable charge methods for fiscal year 1974. The carrier lost 16 points because it had not promptly established satisfactory reasonable charges for certain nonphysician services, such as durable medical equipment and laboratory services.

BHI had not reviewed the computer programs used by Blue Cross-Blue Shield to generate reasonable charges. However, BHI did review the carrier's detailed printout of profiles for fiscal year 1975. Also, BHI reviewed the results of a test of the carrier's Medicare claims processing procedures which EDSF performed at BHI's request.

CONCLUSIONS

The statutory requirement that reasonable charge determinations be based on data from 6- to 30-month old tends to increase the amount of reasonable charge reductions in periods of rising charges for medical services. Delay in updating customary and prevailing charge profiles, as in fiscal year 1975, also tends to increase the amounts of such reductions.

Also, erroneous reasonable charge reductions were made by Blue Cross-Blue Shield because of incorrect coding of line items. Additionally, its method of excluding token and extreme charge information in developing the bases for reductions may have affected reasonable charge reductions.

CHAPTER 4

INFORMATION ON REDUCED FISCAL YEAR 1974 CLAIMS

In fiscal year 1974 Blue Cross-Blue Shield made reasonable charge reductions which exceeded the national average in both numbers of claims and dollar amounts reduced. The percentage of Kings County beneficiaries' reduced claims was about the same as the New York Blue Cross-Blue Shield average, but the dollar amounts of reductions were lower for the Kings County beneficiaries.

The Cost of Living Council's Phase III Economic Stabilization Program limited increases in fiscal year 1974 Medicare profiles over 1973 profiles to 2.5 percent. Because of this limitation, BHI instructed all carriers to alter their method of calculating profiles. This change in method prevented us from identifying the causes (customary charge, prevailing charge, or economic stabilization controls) for all reasonable charges reductions.

COMPARISON OF REASONABLE CHARGE REDUCTIONS BY NEW YORK BLUE CROSS-BLUE SHIELD AND BY ALL CARRIERS

During fiscal year 1974 New York Blue Cross-Blue Shield processed about 8 percent of the claims processed by all carriers and reduced about 9 percent of the claims reduced by all carriers. The amount of the reductions by New York Blue Cross-Blue Shield was almost 15 percent of the reductions made by all carriers. The amount of the average claim processed by New York Blue Cross-Blue Shield exceeded the national average for all carriers by 13 percent, and the amount of the average reduction by New York Blue Cross-Blue Shield exceeded the national average by 82 percent per claim processed and 62 percent per claim reduced.

The following table compares certain aspects of New York Blue Cross-Blue Shield's claim processing operations, including reasonable charge reductions, with all carriers during fiscal year 1974. A similar comparison for calendar years 1971 through 1974 is included as appendix I.

	New York Blue Cross-Blue Shield	All carriers
Total processed (in millions):		
Total covered claims	5.1	62.9
Covered charges	$379.3	$4,139.8
Total reduced (in millions):		
Total claims	3.5	38.2
Total reductions	$ 80.6	$ 545.8
Averages:		
Covered charges per claim processed	$ 74.37	$ 65.82
Reduction per claim processed	$ 15.80	$ 8.67
Reduction per claim reduced	$ 23.03	$ 14.29
Percent:		
Claims reduced	68.6	60.7
Covered charges reduced	21.2	13.2

CONCLUSIONS

New York Blue Cross-Blue Shield's percentage of claims reduced exceeded by 7.9 percent the percentage of claims reduced by all carriers. Also, New York Blue Cross-Blue Shield's percentage of reasonable charge reductions exceeded by 8.0 percent the percentage of reasonable charge reductions by all carriers.

We were unable to identify the specific factors that account for the high rate of reductions by New York Blue Cross-Blue Shield. BHI officials told us that they believed there had been a more rapid rise in New York City physicians' fees than those in other areas. This may have contributed to the higher rate of reductions by New York Blue Cross-Blue Shield than by other carriers.

METHODS USED TO DETERMINE REASONABLE CHARGES

New York Blue Cross-Blue Shield officials said that under their modified method of calculating reasonable charges to conform with Phase III of the Economic Stabilization Program, actual charges were used to determine reasonable charges when available. In those cases the reasonable charge established for each procedure for fiscal year 1974 was the lowest of

--the lower of the customary and prevailing charge for calendar year 1972;

--the lower of the customary and prevailing charge for calendar year 1970, plus 55 percent of the difference between this amount and the lower of the customary and prevailing charge for calendar year 1972; or

--the submitted charge.

This method was in accordance with BHI instructions.

The officials also said that for certain procedures, profiles were established by using price lists, and reasonable charges were determined by selecting the lower of the price list amount or the submitted charge.

REASONABLE CHARGE REDUCTIONS OF KINGS COUNTY BENEFICIARIES' CLAIMS

Our analysis of claims submitted by Kings County beneficiaries during the period July 1, 1973, through April 30, 1974, showed that New York Blue Cross-Blue Shield reduced 66.5 percent of the claims paid by 16.8 percent of the charges on those claims. During the same period, for its entire carrier area, Blue Cross-Blue Shield reduced 65.7 percent of the covered claims processed by 20.1 percent.

We analyzed all available claims (about 122,000) submitted by or on behalf of about 90,000 Kings County beneficiaries during the period July 1, 1973, to April 30, 1974. These claims totaled $8.6 million in covered charges, and the following tables show the distribution of reductions by percent and by amount.

Percent of reduction	Number of claims (note a)		
	Assigned	Unassigned	Total
Less than 5.01	6,403	10,855	17,258
5.01 to 10.0	15,961	23,972	39,933
10.01 to 20.0	34,302	55,194	89,496
20.01 to 30.0	21,281	30,601	51,882
30.01 to 40.0	16,575	23,582	40,157
40.01 to 50.0	7,111	9,054	16,165
More than 50.0	7,634	8,113	15,747
Total claims	109,267	161,371	270,638

Amount of reduction	Number of claims (note a) Assigned	Unassigned	Total
$ .01 to $ 1.00	34,847	46,679	81,526
1.01 to 3.00	30,329	59,253	89,582
3.01 to 5.00	20,305	29,218	49,523
5.01 to 10.00	12,842	16,857	29,699
10.01 to 50.00	9,380	8,500	17,880
50.01 to 100.00	749	470	1,219
100.01 to 500.00	750	361	1,111
More than $500.00	65	33	98
Total claims	109,267	161,371	270,638

a/For purposes of this analysis, each unit of medical service on the 122,000 claims is counted as a claim.

We determined that at least 57.5 percent of the reductions were based on customary charges. We could not determine whether the remaining 42.5 percent of reductions were based on customary charges, prevailing charges, or economic stabilization controls.

The causes for the reductions are shown below.

Amount of reduction	Identifiable customary charges As-signed	Un-assigned	Total (note a)	Other than identifiable customary charges As-signed	Un-assigned	Total (note a)
$ .01 to $ 1.00	13,777	36,631	50,408	27,335	18,475	45,810
1.01 to 3.00	21,639	51,395	73,034	18,539	18,856	37,395
3.01 to 5.00	8,676	14,983	23,659	11,400	18,007	29,407
5.01 to 10.00	2,351	4,352	6,703	9,577	10,007	19,584
10.01 to 50.00	866	804	1,670	7,987	6,302	14,289
50.01 to 100.00	87	47	134	685	415	1,100
100.01 to 500.00	59	23	82	687	329	1,016
More than $500.00	1	0	1	59	32	91
Total claims	47,456	108,235	155,691	76,269	72,423	148,692

a/Totals shown exceed the total number of claims reduced (see p. 16) because in many cases claim reductions were attributable to both categories.

IMPACT OF CHARGE REDUCTIONS ON STANDARDS OF LIVING

We analyzed all unassigned claims submitted by Kings County beneficiaries during the period July 1, 1973, to April 30, 1974, to assess the impact that reasonable charge

reductions had on individuals' standards of living. Our analysis revealed that about 42,500 beneficiaries submitted one or more claims that were reduced. The average reduction for 94.1 percent of the beneficiaries was about $10; about 2.1 percent had reductions of $100 or more.

The number of beneficiaries are shown below according to dollar ranges of reasonable charge reductions.

Range of reasonable charge reductions	Number of beneficiaries	Percent
$ .01 to $ 49.99	40,006	94.1
50.00 to 99.99	1,588	3.8
100.00 to 199.99	599	1.4
200.00 to 299.99	167	.4
300.00 to 399.99	57	.1
400.00 or more	82	.2
	42,499	100.0

To assess the impact that large reasonable charge reductions had on standards of living, we sent questionnaires to all Kings County beneficiaries who, according to Blue Cross-Blue Shield records, experienced $400 or more in reasonable charge reductions. Of the 82 beneficiaries, 37 or 45.1 percent responded. Reasonable charge reductions for the 37 beneficiaries amounted to $22,207, or an average of $600.

The 37 beneficiaries reported that expenses for doctors and medical services not paid by Medicare had the following effects on their savings and standards of living.

Reported income	Savings: Decreased	Savings: Remained the same	Medical bills paid by other than beneficiary	No response and other	Total
Not shown	-	1	-	-	1
Less than $2,500	6	1	3	3	13
$2,500 to $4,999	10	2	-	1	13
$5,000 to $10,000	3	1	1	2	7
Above $10,000	3	-	-	-	3
	22	5	4	6	37

Reported income	Effect on Standards of Living: Cutback of purchase of Food	Clothing	Furniture	Forced to move	No effect	Total (note a)
Not shown	1	-	-	-	-	1
Less than $2,500	7	8	3	1	1	20
$2,500 to $4,999	9	7	2	-	4	22
$5,000 to $10,000	1	2	1	-	3	7
Above $10,000	-	1	-	-	1	2
	18	18	6	1	9	52

a/Total figures do not agree with total number of respondents because individuals were allowed to give multiple answers. One respondent reported moderate effect on standard of living but it is not included in table.

Our analysis showed that a large number of beneficiaries experienced small amounts of reasonable charge reductions which, in our opinion, would have little impact on their standards of living. The results of the questionnaire showed that larger reasonable charge reductions had a significant impact on individuals' savings and standards of living.

CONCLUSIONS

New York Blue Cross-Blue Shield reduced 66.5 percent of the Kings County beneficiaries' claims by an average of 16.8 percent of covered charges. The reduction for a medical service was $5 or less for 220,631 of the 270,638 medical services--85,481 being on assigned claims where the beneficiaries were not liable for the reductions.

CHAPTER 5

ANALYSIS OF RECONSIDERATIONS AND FAIR HEARINGS

During fiscal year 1974 New York Blue Cross-Blue Shield reported that 155,852 reviews (reconsiderations) were resolved, of which 73,770, or 47 percent, resulted in additional payments to claimants. During the same period 767 fair hearings were resolved, of which 523, or 68 percent, resulted in additional payments to claimants.

The percentage of reconsidered cases reversed by New York Blue Cross-Blue Shield was lower than the 61 percent reversed by all other carriers. However, the percentage of fair hearing cases reversed was higher than the 27 percent reversed by all other carriers.

RECONSIDERATIONS

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

The determination notice after a reconsideration must be in writing and mailed to the claimant. The notice states the basis for the reconsideration determination and advises the claimant of his right to request a fair hearing if not satisfied with the determination.

FAIR HEARINGS

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

A requirement was added by the Social Security Amendments of 1972 that $100 or more must be in controversy before a claimant is entitled to a fair hearing. The amount in controversy may comprise disputed amounts of a single claim or a series of claims. The hearing officer must be an individual who has not been previously involved with the determination in question and has neither advised nor given

consultation on the claimant's request for payment which is the basis for the hearing.

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

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

ANALYSIS OF REVERSALS

We analyzed 73 fair hearing cases processed from January 1973 through April 1974 and 97 cases reconsidered during August 1974 by New York Blue Cross-Blue Shield. Thirty-two of the fair hearing cases and 51 of the reconsidered cases were reversed in favor of the claimant. Reversals were made in the reconsiderations primarily because of errors that had been made in coding procedures (21 cases) and additional information supplied by the claimant incident to the request for a reconsideration (12 cases).

In the fair hearing cases, the most frequent reason for reversals was additional information in the form of testimony given at the fair hearings (21 cases). The other fair hearing cases were reversed due to improper interpretation or application of relative value units (3 cases), original determination based on insufficient evidence (2 cases), overruling of decision that procedure was not medically necessary (2 cases), original determination improperly classified procedure (2 cases), wrong charge data had been used to establish reasonable charge (1 case), and the submitted charge had been reduced below the reasonable charge (1 case).

CHAPTER 6

AVAILABILITY OF COMPLEMENTARY HEALTH INSURANCE

We obtained information on three organizations--New York Blue Cross-Blue Shield, Metropolitan Life Insurance Company, and the American Association of Retired Persons (under contract with the Colonial Penn Franklin Insurance Company)--that offer insurance in New York City covering some of the health care cost not paid by Medicare. An official of the New York State Insurance Department assisted us in identifying these organizations. The official said there were other organizations which offer such insurance. Generally, the complementary insurance does not cover Medicare reasonable charge reductions. This could be important when claims are not assigned.

NEW YORK BLUE CROSS-BLUE SHIELD

New York Blue Cross-Blue Shield offers several types of complementary insurance to individuals and groups. For individual coverage, a person must convert from a Blue Cross-Blue Shield health insurance plan to a complementary plan. The individual and group plans generally cover the Medicare 20 percent coinsurance for surgery, anesthesia, and certain hospital expenses, including the Medicare deductible for hospital charges.

The quarterly premiums for individuals are $7.17 or $13.56, depending on the coverage provided. The monthly premiums for groups range from $2.23 to $4.04 per member, depending on the coverage provided.

METROPOLITAN LIFE INSURANCE COMPANY

Metropolitan Life Insurance Company offers complementary health insurance to small groups of 10 to 49 persons and to other groups of 50 or more persons. Coverage for small groups must be purchased with a major medical plan.

The insurance for small groups covers surgery and radiotherapy. The insurance for other groups is tailored to fit the groups' needs. The insurance pays 100 percent of reasonable charges for covered services less Medicare payments. The reasonable charges are determined by the company and may be different than Medicare reasonable charges.

The monthly premium for insurance for small groups is $4.60 for each member. The premiums for insurance for other groups depend on the coverage provided. For physicians' and other services included in Part B, premiums generally range from $.40 to $8.04 a month for each member.

AMERICAN ASSOCIATION OF RETIRED PERSONS

The American Association of Retired Persons offers several complementary health insurance plans to its members. To be a member of the Association, a person must be 55 or older and must pay an annual membership fee of $2.

One plan which is available to all members covers out-of-hospital expenses. With certain limitations, this plan pays 80 percent of out-of-hospital expenses, including blood not covered by Medicare and up to $240 a year for prescription drugs. The monthly premium for this plan is $10.45.

The Association offers to all members two other plans which cover in-hospital care and surgery. The plans pay for surgery even when it is covered by Medicare. The monthly premium is $8.50 or $11.50, depending on the extent of in-hospital coverage provided.

Another plan which is available to members 65 or older pays the Medicare 20 percent coinsurance for in-hospital physicians' services, including surgery, and for hospital room and board in certain cases. The monthly premium for this plan is $4.50.

COMPARISON OF REASONABLE CHARGE REDUCTIONS BY NEW YORK BLUE CROSS-BLUE SHIELD WITH THOSE OF ALL CARRIERS FOR CALENDAR YEARS 1971 to 1974

	1971	1972	1973	1974
Total claims processed (in millions):				
Total claims:				
Blue Cross-Blue Shield	3.9	4.2	4.7	5.5
All carriers	48.1	52.5	57.9	69.2
Total dollar amount:				
Blue Cross-Blue Shield	$285.8	$310.4	$343.5	$419.3
All carriers	$3,011.0	$3,332.9	$3,746.2	$4,713.0
Total claims reduced (in millions):				
Total claims:				
Blue Cross-Blue Shield	2.3	2.5	3.1	3.7
All carriers	22.1	25.7	32.6	44.1
Total reductions:				
Blue Cross-Blue Shield	$50.9	$58.3	$71.4	$90.2
All carriers	$343.9	$374.9	$456.8	$676.6
Percent of processed claims reduced:				
Blue Cross-Blue Shield	58%	60%	66%	68%
All carriers	46%	49%	56%	64%
Average reduction per reduced claim:				
Blue Cross-Blue Shield	$23	$23	$23	$24
All carriers	$16	$15	$14	$15
Reductions as percent of dollar amount processed:				
Blue Cross-Blue Shield	18%	19%	21%	22%
All carriers	11%	11%	12%	14%