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

HUMAN RESOURCES
DIVISION

B-219002

The Honorable John Heinz
Chairman, Special Committee on Aging
United States Senate

Dear Mr. Chairman:

Subject: Medicare Part B Beneficiary Appeals Process (GAO/HRD-85-79)

This is in response to your request for information about claims processing and due process protections for beneficiaries under part B of Medicare, the supplementary medical insurance program under title XVIII of the Social Security Act. Specifically, you asked for information on (1) the adequacy of the beneficiary appeals process under the due process principle of the Constitution and (2) the extent to which the Department of Health and Human Services' (HHS') Health Care Financing Administration (HCFA), which administers Medicare, has implemented certain prior GAO recommendations directed at preventing underpayments to beneficiaries. You also asked for data on the extent and outcome of beneficiary appeals under part B.

Our review of court decisions related to the part B appeals process showed that courts have found HHS' appeals procedures did not satisfy the requirements of due process. HHS has taken some actions in response to these court decisions, and the courts are reviewing these actions to determine their sufficiency.

HHS said that it has not acted to implement our 1980 and 1981 recommendations to improve protection against underpayments to beneficiaries because to do so would increase administrative costs and program payments. While we recognize that costs would increase if our recommendations are implemented, taking the actions we recommended would help assure that beneficiaries receive the benefits they are entitled to by law.

The statistical information on beneficiary appeals that you requested is contained in HCFA's quarterly Carrier Appeals Report. A copy of the September 1984 report was provided to your office on October 11, 1984.

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FOOTNOTES

[1]Mathews v. Eldridge, 424 U.S. 319, 348-49 (1976).

[2]David v. Heckler, 591 F. Supp. 1033, 1041 (E.D.N.Y. 1984), citing the Mathews case; and Gray Panthers v. Schweiker, 652 F.2d 146, 148 n. 2, 156, 158 (D.C. Cir. 1981).

[3]42 U.S.C. 1395u (b)(3)(C).

[4]42 C.F.R. 405.801 et seq.

[5]Gray Panthers v. Califano, 466 F. Supp. 1317 (D.D.C. 1979).

[6]Gray Panthers v. Schweiker, 652 F.2d 146 (D.C. Cir. 1981).

[7]652 F.2d at 167, 168.

[8]652 F.2d at 150-152, 172, n.15.

[9]652 F.2d at 159.

[10]652 F.2d at 173.

[11]Gray Panthers v. Schweiker, No. 77-488 (D.D.C. Sept. 10, 1982).

[12]Gray Panthers v. Schweiker, 716 F.2d 23, 37 (D.C. Cir. 1983).

[13]716 F.2d at 35, 36.

[14]716 F.2d at 40.

[15]David v. Heckler, 591 F. Supp. 1033, 1042-43 (1984).

[16]591 F.2d at 1043.

[17]Id.

[18]Mitchell v. Occidental Insurance, Medicare, 619 F.2d 28 (9th Cir. 1980).

[19]Reasonable Charge Reductions Under Part B of Medicare (HRD-81-12, Oct. 22, 1980).

More Action Needed to Reduce Beneficiary Underpayments (HRD-81-126, Sept. 3, 1981).

BACKGROUND

Part B of Medicare covers the costs of a variety of non-institutional health care services. While most part B payments, which totaled about $19.3 billion in fiscal year 1984, are for physician services, the program also covers many other services, including outpatient laboratory tests and X-rays, home health services, durable medical equipment (wheelchairs, hospital beds, etc.) used in the home, and chiropractor services.

Enrollment in part B is voluntary and is financed primarily by premiums paid by beneficiaries (about 25 percent of total costs) and appropriations from general revenues (about 75 percent of total costs). Citizens and legal aliens 65 years of age or older (who have resided in the country for at least 5 years) and certain disabled persons are eligible to enroll in part B.

HCFA administers part B and establishes service coverage and reimbursement policies. HCFA contracts with insurance companies, such as Blue Shield plans and The Travelers Insurance Company, to process and pay claims. These contractors are called carriers.

Most part B claims, including all physician claims, are paid on the basis of "reasonable charges." The law defines the reasonable charge for a service as the lowest of

--the actual charge for the service;

--the customary charge, which is the amount the physician or supplier usually charges for the service; or

--the prevailing charge, which is an amount high enough to cover 75 percent of all the charges in a specific geographic area for the service.

Reasonable charges are normally updated annually to reflect changes in charges. Through fiscal year 1983 these updates occurred on July 1 of each year, and in the future they are to occur on October 1 of each year. Increases in the prevailing charge levels have been limited since 1973 to the increase in an economic index designed to measure changes in wage levels and physician office operating costs. Reasonable charges were frozen by law at the levels in effect on June 30, 1984, for the period July 1, 1984, through September 30, 1985. The administration's budget for fiscal year 1986 proposes extending this freeze for 1 year.

Some types of services, such as home health care and outpatient hospital services, are paid on the basis of reasonable costs. Claims for these services are not paid by carriers, but rather by other contractors called intermediaries, who are primarily responsible for paying claims under part A of Medicare, the hospital insurance program. The same beneficiary appeals process applies to part B claims paid by intermediaries as applies to those paid by carriers.

DUE PROCESS AND THE MEDICARE PART B APPEALS PROCESS

Part B beneficiaries whose claims are denied wholly or partially have had a somewhat limited appeals process available to them--particularly for disputed claims involving less than $100. This condition has raised questions about whether the due process requirements of the Constitution have been met.

Federal courts have addressed this question for several years and have ruled that beneficiaries have neither been given an adequate explanation about why their claims are denied nor always been given an adequate opportunity for a hearing. Although courts have been directing HHS to correct these deficiencies since 1981, the matter has not been resolved. The federal district court in the District of Columbia is currently considering HHS' proposed revisions to the part B appeals process.

Legal requirements and regulatory procedures for beneficiary appeals under part B

The fifth amendment to the Constitution guarantees that no one can be deprived of life, liberty, or property without "due process of law." The Supreme Court has interpreted this constitutional guarantee to mean that a person in jeopardy of serious loss must be given (1) notice of the case against him and (2) a meaningful opportunity to present his/her case.[1]

Medical payments made under Medicare Part B constitute "property" that is protected under the Constitution.[2] Therefore, when a claim for reimbursement is denied, the affected beneficiary is entitled to due process.

Section 1842 of the Social Security Act requires carriers to establish and maintain procedures granting an opportunity for a hearing to part B beneficiaries who are not satisfied with a carrier's handling of a claim where the amount in controversy is

$100 or more.[3] However, the act provides no appeal mechanism for part B beneficiaries where the amount in question is less than $100.

HHS regulations[4] implementing section 1842 require that carriers send part B beneficiaries a written notice stating the initial determination for all claims regardless of the amount involved. After receiving this notice--the Explanation of Medicare Benefits (EOMB)--beneficiaries who are not satisfied with the determination can request the carrier to review their claims. Beneficiaries may also submit additional written information for the carrier's consideration.

A carrier employee, who HCFA directs should be different from the one who initially decided the claim, will make another decision based on this paper review. For claims involving amounts less than $100, the carrier's second decision is final. HHS' regulations make no provision for an oral hearing in such cases.

For appeals involving amounts greater than $100, a beneficiary who remains dissatisfied after the second decision may ask for an oral hearing before a hearing officer designated by the carrier. The hearing officer's decision is final and not subject to review unless the carrier or the hearing officer reopens the proceedings. The HHS regulations provide for no appeal for part B beneficiaries beyond the carrier.

Courts found the Medicare part B appeals process did not meet the requirements of due process

During the past several years, a number of federal court cases have addressed the question of whether the Medicare Part B appeals process, as outlined in the Social Security Act and HHS regulations, meets the requirements of due process. One such case began when the Gray Panthers, a national organization representing elderly citizens, filed a class action suit in 1977 in the U.S. District Court for the District of Columbia.

The Gray Panthers asserted that the denial of an oral hearing to all Medicare beneficiaries disputing less than $100 in reimbursement was an unconstitutional denial of due process. The court ruled in favor of HHS, concluding that the carriers' initial determination notice (EOMB) to beneficiaries and the "paper hearing" satisfied the due process requirements.[5]

On appeal, the U.S. Court of Appeals, District of Columbia Circuit, overturned the district court's decision.[6] The appeals court found that the EOMB used by carriers did not provide an understandable explanation of why benefits were being denied. Specifically, the court found the notice inadequate because it did not specify whether a claim was being denied because the treatment was unnecessary or the charge was unreasonable, nor did it explain the reason for any reduction of actual charges to meet Medicare's reasonable charge criteria.[7]

The court also found that, even though the statute made no provision for a hearing in cases where the amount in question was less than $100, the HHS regulations on the part B appeals process violated the principles of due process by specifically precluding an oral hearing in all such cases. The court concluded that the Congress did not intend to eliminate the opportunity for any type of oral hearing, but wanted only to prevent the expense and inconvenience of "formal hearings" or "full-fair hearings" when such small amounts were in controversy.[8]

The court made clear, however, that just as an oral hearing could not be summarily denied in every case, neither was one required in every case.[9] The appeals court remanded the case to the district court, where the "precise contours" of the notice and hearing required by due process were to be formulated.[10]

In May 1981, the district court ordered HHS to submit a proposal for strengthening the part B appeals process. HHS' July 1981 response included only minor revisions to the EOMB notice and the addition of a toll-free telephone system which would allow beneficiaries to discuss their claims with a professional employee of the carrier. The district court rejected this HHS proposal and in September 1982 ordered HHS to adopt a notice that had been developed by the Gray Panthers and to provide for informal oral hearings for all beneficiaries who have less than $100 in dispute.[11]

Shortly after the district court's decision, the case again went to the appeals court in the fall of 1982. The appeals court considered an EOMB developed by HHS after the district court's last decision and concluded that this improved written notice, together with then current written review procedures and a toll-free telephone system proposed by HHS, should satisfy the requirements of due process for most claims involving less than $100.[12] For a minority of cases, such as those in which the credibility or veracity of the claimant was crucial to the determination, the court restated its earlier conclusion that an informal oral hearing might be required.[13]

The appeals court again remanded the case to the district court, instructing it to determine whether the revised EOMB satisfied the due process requirements and to ensure that the improved telephone system was implemented. The appeals court concluded by stating, "With the utmost cooperation of the parties, beneficiaries under the Medicare program will soon be receiving the process to which they are due."[14]

The district court is currently considering HHS' proposed toll-free phone system along with the revised EOMB.

Whereas the District of Columbia Circuit Court of Appeals found shortcomings with the carriers' explanation of their initial decisions, the U.S. District Court, Eastern District of New York, found problems with the notices sent to beneficiaries after the carrier had reviewed the initial determination. The court found that these review determination letters were unclear and did not contain enough information about why reimbursement was denied or how the reimbursable amounts were calculated.[15]

Specifically, the court stated:

> "The fact is that the letters are written at a level well beyond most in this segment of the population, with no discernable added benefit from complexity in information provided.
>
> "The language used is bureaucratic gobbledegook, jargon, double talk, a form of officialese, federalese and insuranceese, and doublespeak. It does not qualify as English."[16]

The court also concluded that the review determination letters provided insufficient information to enable beneficiaries and their representatives to effectively appeal the carriers' decisions.[17]

The district court ordered HHS to improve the readability and substantive content of the review notices. HHS agreed in advance of the court's decision that the review notices should be improved and began to simplify the notice. According to a representative of the HHS Office of General Counsel, the agency is negotiating with the plaintiff's counsel, and HHS believes the case is close to settlement.

One court, the U.S. Court of Appeals for the Ninth Circuit, has expressed the opinion that the part B appeals process does satisfy the requirements of due process.[18] The court's opinion,

however, was not very persuasive. First, the court had decided the case based on other grounds. The court's comment about the constitutionality of the appeals procedure did not appear to have been raised by the parties as an issue in the case. In addition, the court did not fully explain its rationale for this opinion--the opinion was accompanied by neither analysis of the issue nor citation of authority.

RECOMMENDED IMPROVEMENTS IN CLAIMS PROCESSING STANDARDS NOT IMPLEMENTED

A fair appeals process is important to the equitable treatment of beneficiaries because it allows payment errors to be corrected. However, an accurate carrier claims processing system is also important because it can reduce the number of payment errors and appeals. We addressed the claims processing system in two previous reports,[19] and identified areas where it could be improved.

A serious problem discussed in both reports involved beneficiary claims for physician services when there were large differences between the amount charged by the physician and the amount allowed as reasonable by Medicare. The claims in this category that we reviewed contained numerous errors that were not detected by the carrier and resulted in underpayments to the beneficiary.

We recommended three improvements to the claims processing system (see p. 9) that could help prevent underpayments to beneficiaries. While HCFA acknowledged that some beneficiaries receive less reimbursement than they should and that our recommendations could help correct this problem, the agency believes our recommendations would be too costly to implement. HCFA cites budget constraints and other program priorities as the reasons for not making the recommended changes.

Reasonable charge reduction and beneficiary underpayments

The Medicare program pays for covered physician services by either reimbursing the physician directly (assigned claims) or reimbursing the beneficiary (unassigned claims). The percentage of unassigned claims was about 35 percent in the early years of Medicare and about 43.6 percent in fiscal year 1984.

When the physician accepts assignment, the beneficiary is responsible for paying 20 percent of the Medicare determined reasonable charge (plus any unmet deductible for the year).

When the beneficiary submits the claim and is paid by the program, he or she is also liable for the difference between what the doctor charges and what Medicare allows as the reasonable charge. During fiscal year 1984, the beneficiaries' liabilities on unassigned claims for the differences between actual and allowed charges were about $2.7 billion--up from $882 million in fiscal year 1978.

HCFA requires that part B carriers, in processing claims for physician services, automatically reduce submitted charges to Medicare's reasonable charge. Carriers are also required to establish safeguards that will identify claims with large differences between submitted charges and allowed charges. These claims are to be reviewed manually to help assure that underpayments do not occur.

In October 1980 and again in September 1981, we reported that there was a high risk of underpayment in beneficiary submitted claims with large reasonable charge reductions and that carrier safeguards were ineffective in preventing these underpayments.

One of the carriers discussed in our 1980 report required that claims be manually reviewed when the submitted charge was reduced by 33 percent or more. Further, after a charge was identified for manual review, data entry personnel were required to check the information entered into the computer against the information on the claim. If the data were entered correctly but the submitted charge was greater than $75, the clerk was to submit the claim for manual review by his or her unit leader. If the submitted charge was less than $75, the clerk was to process the claim routinely.

We found that these safeguard procedures did not prevent underpayments. We randomly sampled 50 unassigned claims processed by the carrier in which the submitted charge exceeded the physician's customary or usual charge by 150 percent or more. For example, if a doctor normally charged $100 for a given medical procedure, we looked at cases where the doctor had charged $250 or more for that procedure. We found that in 21, or 42 percent, of the sampled claims, the beneficiaries were underpaid. The most common reasons for the underpayments were (1) wrong procedure codes, (2) failure to include some procedures, and (3) incomplete description of the diagnosis and/or procedures performed.

In one instance, a medical procedure for one physician exceeded the carrier's high charge safeguard on 68 occasions in 1979. In all 68 cases underpayments to either the physician or the beneficiaries were involved, but the carrier's safeguard did not detect any of them. These underpayments were primarily due to an incomplete description of the services provided.

We discussed similar problems with another carrier's claims processing safeguards in our 1981 report.

Prior recommendations and agency actions

To improve the claims processing safeguards for preventing underpayments to beneficiaries, we made three recommendations. In our 1980 report, we pointed out that beneficiaries cannot be expected to know the details of the Medicare claims processing requirements because they receive little guidance on how to fill out claims and have infrequent practice in doing so. Accordingly, we recommended that HHS establish more stringent claims processing standards to prevent underpayments on beneficiary-submitted claims. We also recommended that HHS establish more specific claims processing standards for claims involving large reasonable charge reductions--that is, when claims should be manually reviewed and what specific action is to be taken as part of the review.

In our 1981 report, we further recommended that HCFA--as part of its Contractor Performance Evaluation program and related Carrier Quality Assurance program--specifically address how well carriers review and resolve discrepancies in claims subject to relatively large reasonable charge reductions.

HHS' written comments on our 1980 and 1981 reports, submitted to the Congress as required by 31 U.S.C. 720, show that the agency generally agreed with our recommendations concerning standards for beneficiary-submitted claims. The comments stated that our recommendations would be considered when the claims processing standards were revised. However, in subsequent internal documents, HCFA stated it would be costly to implement the recommended changes and that, because of budget constraints, the increased costs were not justified. HCFA stated that with a "severely reduced administrative budget," the agency felt it necessary to emphasize carrier activities that increase administrative efficiency and the cost effectiveness of operations.

Concerning our September 1981 recommendation, HHS' official comments stated that the agency agreed that some beneficiaries receive less reimbursement for physician services than they

would if their claims were correctly prepared and processed and that additional manual review could identify and correct some of these errors. However, these reviews would be costly, and because of budgetary reductions, the agency did not support our recommended change to the contractor quality assurance programs.

In January, May, and June 1985, we discussed the HHS and HCFA written comments with officials from HCFA's Office of Program Administration and Office of Methods and Systems--the two units responsible for considering and implementing our recommendations. These officials could not provide us with any analysis of the costs to implement our 1980 and 1981 recommendations. However, one official said that the manual review of beneficiary claims, and the possible increase in payments resulting from this review, would be counter to the current program emphasis. He added that because of budget constraints and increased automation in claims processing, there is probably less attention given to beneficiary claims now than there was at the time our recommendations were made.

The HCFA officials said that rather than trying to identify underpayments, HCFA has tried to make carriers and claims information more accessible to beneficiaries who believe they have been underpaid. They cited upgraded toll-free phone service and improved explanation of benefits as examples of this effort.

Because of the widespread concerns about rising Medicare costs, we can understand HCFA's emphasis on identifying and reducing unwarranted program expenditures. However, HCFA has an equally important obligation of paying for services that are covered in order to protect the elderly and disabled from inequitable out-of-pocket expenses. This is especially true in light of the fact that (1) the percentage of claims submitted by beneficiaries is relatively high, (2) beneficiary liability for Medicare reasonable charge reductions is approaching $3 billion, and (3) the problems with the part B appeals process discussed in the first part of this report have not been fully resolved with the courts. Accordingly, we believe our recommended safeguards for identifying and correcting beneficiary underpayments are still valid.

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As requested by your office, we did not obtain written comments from HHS on this report. Also, unless you publicly announce the report's contents earlier, no further distribution will be made until 30 days from its issue date. At that time, we will send copies to the Secretary of HHS and interested congressional committees and make copies available to others upon request.

Sincerely yours,

Richard L. Fogel

Richard L. Fogel
Director

Enclosure