



DEPARTMENT OF DEFENSE

AUDIT REPORT

THIRD PARTY COLLECTION PROGRAM

No. 90-105

August 30, 1990

*Office of the
Inspector General*





INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
400 ARMY NAVY DRIVE
ARLINGTON, VIRGINIA 22202-2884

August 30, 1990

MEMORANDUM FOR ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)
ASSISTANT SECRETARY OF THE ARMY (FINANCIAL
MANAGEMENT)
ASSISTANT SECRETARY OF THE NAVY (FINANCIAL
MANAGEMENT)
ASSISTANT SECRETARY OF THE AIR FORCE (FINANCIAL
MANAGEMENT AND COMPTROLLER)

SUBJECT: Report on the Audit of the Third Party Collection
Program (Report No. 90-105)

This is our final report on the Audit of the Third Party Collection Program (the Program) for your information and use. The Financial Management Directorate made the audit from March through November 1989. The audit covered the period October 1987 through December 1988. The overall audit objectives were to evaluate procedures prescribed by the Military Departments and practices followed by military hospitals to collect from private insurers for inpatient care provided to military dependents and retirees. We also reviewed the DoD internal controls applicable to management of the Program. During FY 1988, about 500,000 military dependent and retiree inpatients were discharged from military hospitals in the United States. For FY 1988, the Military Departments reported Third Party Collection Program claims totaling about \$32.7 million and collections totaling about \$16.2 million. Until recently, the law required that all funds collected under the Third Party Collection Program be returned to the U.S. Treasury. However, the recently enacted National Defense Authorization Act for FY's 1990 and 1991, as well as the FY 1990 Defense Appropriations Act, direct that effective October 1, 1989, amounts collected under the Program shall be used at the local level. These funds are to be credited to the appropriation that supports the maintenance and operation of the facility, and used to improve the services provided by that facility.

The audit showed that the Surgeons General for the Military Departments and military hospitals did not have sufficient guidance and support from the Assistant Secretary of Defense (Health Affairs) (ASD[HA]) to effectively implement and manage the Third Party Collection Program. The audit also showed that military hospitals were failing to collect from health insurance plans for inpatient hospital care costs incurred on behalf of insured military retirees and dependents. In addition, neither ASD(HA) nor the Surgeons General had assured that the Program was effectively implemented and fully executed at military hospitals. We projected that, unless the Third Party Collection Program is

effectively implemented and fully executed, military hospitals will fail to collect approximately \$318.0 million from primary health insurance plans for FY's 1990 through 1994. Moreover, an additional \$191.9 million would be collectible in FY's 1991 through 1995 if legislation were passed enabling DoD hospitals to collect from Medicare supplemental insurance policies.

Further details of the audit are provided in the following paragraphs and in Part II of this report.

Military hospitals were failing to collect from primary health insurance plans for inpatient hospital care costs incurred on behalf of insured military retirees and dependents. As a result, we projected that unless effective programs are implemented and fully executed, military hospitals will fail to collect approximately \$318.0 million for FY's 1990 through 1994. We recommended that the Surgeons General direct commanders at military hospitals to fully implement and resource the Third Party Collection Program. To fully implement the Program, military hospitals will need to establish procedures to identify inpatients who have insurance coverage, to document that inpatients were questioned about insurance coverage, to correctly prepare and submit claims to insurance companies, and to resolve open claims and claims that were unpaid or partially unpaid for inappropriate reasons. We also recommended that the Surgeons General direct commanders to send a questionnaire to each inpatient discharged during FY's 1989 and 1990 with unknown insurance coverage, and to submit claims to insurance companies when appropriate. In addition, we recommended that ASD(HA) and the Surgeons General review quarterly reports submitted by military hospitals to assure that the Program is implemented, and take corrective actions at hospitals that have not effectively implemented the Program (page 7).

The Surgeons General and military hospitals did not have sufficient DoD guidance and support to effectively implement and manage the Third Party Collection Program. Consequently, policies and procedures used to implement the Program were inadequate, military hospitals were confused about the rights and obligations of third party payers and health care beneficiaries, and the systems used to manage the Program were ineffective and burdensome. We recommended that ASD(HA) develop and issue a DoD instruction that covers policies, procedures, and responsibilities for implementing and executing the Program; develop and issue a DoD regulation to clarify the rights and obligations of third party payers and health care beneficiaries; develop the basic systems needed to administer and manage the Program; and correct deficiencies in the automated system for preparing insurance claims. We also recommended that the Surgeons General fully install, at each military hospital, the automated system for preparing insurance claims and other appropriate systems designed by ASD(HA) and give hospital personnel sufficient training to operate these systems (page 15).

Only 7 of the 25 military hospitals visited were collecting from Medicare supplemental insurance policies for inpatient care costs incurred on behalf of insured military retirees and dependents. We project that with appropriate legislation and guidance, military hospitals can collect approximately \$191.9 million from Medicare supplemental insurance policies for FY's 1991 through 1995. We recommended in a supplement to the draft report, that ASD(HA) propose legislation that would authorize military hospitals to collect from Medicare supplemental insurance policies, and if legislation is enacted, issue appropriate guidance (page 21).

Internal controls were evaluated as applicable to the stated audit objectives. The audit identified internal control weaknesses as defined by Public Law 97-255, Office of Management and Budget Circular A-123, and DoD Directive 5010.38. We found that neither the Assistant Secretary of Defense (Health Affairs) nor the Surgeons General had developed adequate internal control procedures for the Program to meet its goals and objectives; for resources to be adequately safeguarded against waste, loss, and misuse; and for reliable Program data to be disclosed in reports. Also, military hospitals had not established adequate internal control procedures to identify inpatients with insurance coverage and document that inpatients were questioned about their health insurance coverage, to ensure that claims were correctly submitted to insurance companies, and to resolve open claims and claims that were unpaid or partially unpaid for inappropriate reasons. All recommendations in this report, if implemented, will correct the weaknesses. A copy of the final report will be provided to the senior official responsible for internal controls within each Military Department.

We provided a draft of this report to the addressees on April 3, 1990, and requested that comments be provided by June 4, 1990. We received comments to the draft report and supplement from the Assistant Secretary of Defense (Health Affairs) on June 22, 1990. We received comments to the draft report from the Army Surgeon General on June 4, 1990; from the Assistant Secretary of the Navy (Manpower and Reserve Affairs) on July 10, 1990; and from the Assistant Secretary of the Air Force (Manpower, Reserve Affairs, Installations and Environment) on July 17, 1990.

The comments of the Assistant Secretary of Defense (Health Affairs), the Army Surgeon General and the Assistant Secretary of the Air Force (Manpower, Reserve Affairs, Installations and Environment) to our draft report conformed to the provisions of DoD Directive 7650.3. No unresolved issues existed on the audit recommendations, internal control deficiencies, or potential monetary benefits. Accordingly, additional management comments on the final report are not required from those officials.

The Assistant Secretary of the Navy (Manpower and Reserve Affairs) concurred with Recommendations A.1., A.3., B.1., and B.2. and concurred conditionally with the potential monetary

benefits. The Navy concurred with Recommendation A.2., which addressed sending a questionnaire to each military retiree and dependent discharged during FY 1989's and 1990 with unknown insurance information, and submitting claims to insurance companies when appropriate. The Navy believes that the questionnaire would require a "...staff effort of heroic proportions." We believe the recommendation is still warranted for reasons discussed in Part II of the report; therefore, we request that the Assistant Secretary of the Navy (Manpower and Reserve Affairs) provide final comments on Recommendation A.2.

The audit identified potential monetary benefits of \$490.2 million (\$509.9 million minus additional personnel costs of \$19.7 million to manage the Program). The Army Surgeon General, the Assistant Secretary of the Navy (Manpower and Reserve Affairs) and the Assistant Secretary of the Air Force (Manpower, Reserve Affairs, Installations and Environment) concurred with the potential monetary benefits of \$298.3 million from primary health insurance plans. The Assistant Secretary of Defense (Health Affairs) concurred with the potential monetary benefits of \$191.9 million from medicare supplemental insurance policies. However, the \$191.9 million can be collected only if legislation is enacted to authorize collection from Medicare supplemental insurance policies.

DoD Directive 7650.3 requires prompt resolution of audit issues. Accordingly, the Assistant Secretary of the Navy (Manpower and Reserve Affairs) should provide final comments on the unresolved issues in this report within 60 days of the date of this memorandum.

We appreciate the courtesies extended to the staff during the audit. The audit team members are listed in Appendix CC. Copies of the final report will be distributed to the activities listed in Appendix DD. If you wish to discuss this final report, please contact Mr. Raymond D. Kidd, Program Director, at (202) 694-1682 (AUTOVON 224-1682) or Mr. Henry F. Kleinknecht, Project Manager, at (202) 694-3461 (AUTOVON 224-3461).



Edward R. Jones
Deputy Assistant Inspector General
for Auditing

cc:
Secretary of the Army
Secretary of the Navy
Secretary of the Air Force
Comptroller of the Department of Defense

REPORT ON THE AUDIT OF
THE THIRD PARTY COLLECTION PROGRAM

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REPORT ON THE AUDIT OF
THE THIRD PARTY COLLECTION PROGRAM

PART I - INTRODUCTION

Background

United States Code, title 10, sec. 1095, enacted as section 2001 of Public Law 99-272, the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), allows the Government to collect from health insurance plans for reasonable inpatient hospital costs incurred on behalf of military retirees and dependents. The statute allows the Government to collect from insurance, medical service, or health plans the reasonable costs of inpatient hospital care incurred by the United States at a military facility to the extent that the insurer would pay if the services were provided by a civilian hospital. No insurance, medical service, or health plan that excludes from coverage or limits payment of charges for certain care shall prevent collection by the United States if that care is provided through a facility of the uniformed services. This program, designed to collect from third party payers, is known as the Third Party Collection Program (the Program).

DoD Directive 5136.1, "Assistant Secretary of Defense (Health Affairs)," January 27, 1989, assigns specific responsibilities, functions, relationships, and authorities for the Assistant Secretary of Defense (Health Affairs) (ASD[HA]). ASD(HA) is the principal staff assistant and advisor to the Secretary of Defense for all Department of Defense health policies, programs, and activities. ASD(HA) is responsible for overall supervision of the health affairs of the Department of Defense and oversees all DoD health resources. Specific responsibilities include developing policies, conducting analyses, issuing guidance on DoD plans and programs, and advising the Secretary of Defense. In addition, ASD(HA) develops systems, standards, and procedures for the administration and management of approved DoD plans and programs. ASD(HA) is the program manager for all DoD health and medical resources; monitors the execution of approved health and medical programs by the DoD Components; and, subject to the direction of the Secretary of Defense, sets priorities and determines the resources needed to achieve DoD-wide program objectives.

DoD Instruction 6010.15, "Coordination of Benefits," September 4, 1987, made the Military Departments responsible for developing procedures to implement the Coordination of Benefits Program (Third Party Collection Program).

During FY 1988, about 500,000 military dependent and retiree inpatients were discharged from military hospitals located in the United States. The Military Departments reported Third Party

Collection Program claims for FY 1988 totaling about \$32.7 million and collections totaling about \$16.2 million (Appendixes A, B, and C).

FY 1988 THIRD PARTY COLLECTION PROGRAM
AMOUNTS CLAIMED AND COLLECTED

<u>Military Departments</u>	<u>Amounts Claimed</u>	<u>Amounts Collected</u>
Army	\$15,522,874	\$7,808,448
Navy	3,278,600	1,511,276
Air Force	13,931,349	6,912,272
 TOTAL	 \$32,732,823	 \$16,231,996

Objectives and Scope

The overall objective was to evaluate the procedures prescribed by the Military Departments and the practices followed by military hospitals to collect from private insurers for inpatient care provided to dependents and retirees. The audit also evaluated the effectiveness of applicable internal management controls. Specific audit objectives were to determine:

- whether DoD provided adequate guidance and support for the Surgeons General and military hospitals to effectively implement and manage the Program;

- whether military hospitals had effectively implemented and adequately resourced the Program;

- whether military hospitals had implemented procedures to identify those inpatients who had insurance coverage and document that inpatients were questioned about their insurance coverage, to ensure that claims were correctly prepared and submitted to insurance companies, and to resolve open claims and claims that were unpaid or partially unpaid for inappropriate reasons;

- whether military hospitals had implemented effective systems to administer and manage the Program;

- whether reporting requirements adequately measured the effectiveness of the Program; and

- whether the Program had the potential for additional collections.

We performed field work at 25 military hospitals. At each hospital, we reviewed claims and amounts collected for inpatients who were discharged during FY 1988 and the first quarter of

FY 1989. We also reviewed Program policies, procedures, guidance, and the systems implemented to administer and manage the Program. Reports generated by the Defense Medical Systems Support Center identified 489,338 military dependent and retiree inpatients who were discharged from military hospitals in the United States during FY 1988. We based our projected collections for the Program on this number. Totals for inpatients discharged during FY 1989 were not available, and military hospitals located outside the United States were not included in our review or projection. For FY 1988, we reviewed 4,313 claims totaling \$11.4 million, or approximately 35 percent of the \$32.7 million claimed. For the first quarter of FY 1989, we reviewed 920 claims totaling \$2.6 million. In addition, at each hospital, we randomly sampled the files of at least 130 inpatients (dependents and retirees only) who were discharged during FY 1988 and the first quarter of FY 1989, and we determined whether the military hospitals had obtained a signed insurance statement from each inpatient. We mailed questionnaires to those inpatients who had not signed insurance statements to determine whether they had health insurance coverage at the time of treatment.

This program audit was made from March through November 1989 in accordance with auditing standards issued by the Comptroller General of the United States as implemented by the Inspector General, DoD, and accordingly, included such tests of internal controls as were considered necessary. Activities visited or contacted during the audit are listed in Appendix BB.

Internal Controls

We evaluated internal controls as applicable to the audit objectives. The audit identified internal control weaknesses as defined by Public Law 97-255, Office of Management and Budget Circular A-123, and DoD Directive 5010.38. The audit found that neither ASD(HA) nor the Surgeons General had developed adequate internal control procedures for the Program to meet its goals and objectives; for resources to be adequately safeguarded against waste, loss, and misuse; and for reports to disclose reliable Program data. The audit also showed that military hospitals had not established adequate internal control procedures to identify inpatients who had insurance coverage and document that inpatients had been questioned about health insurance coverage, to ensure that claims were correctly prepared and submitted to insurance companies, and to resolve open claims and claims that were unpaid or partially unpaid for inappropriate reasons. Internal controls were also inadequate to provide an audit trail verifying that hospitals received checks from insurance companies and deposited them into the U.S. Treasury for inpatients who had insurance coverage. All recommendations in this report, if implemented, will correct the weaknesses.

Prior Audit Coverage

The General Accounting Office (GAO) and the Air Force Audit Agency issued reports that discussed conditions similar to those disclosed by this audit.

GAO Report No. HRD-85-24 (OSD Case No. 6700), "Legislation To Authorize VA Recoveries From Private Health Insurance Would Result In Substantial Savings," February 26, 1985, concluded that no overriding legal or administrative problems prevented the enactment and implementation of a Veterans Administration (VA) cost recovery program. GAO estimated that the VA could have recovered \$98 million to \$284 million from private health insurance in FY 1982 with minimal impact on health insurance premiums. Therefore, GAO recommended that the Congress enact recovery legislation to enable the VA to recover the costs of care provided to privately insured veterans for non-service-connected medical conditions. On April 7, 1986, legislation was enacted that enabled the VA to recover these costs from private health insurance companies.

GAO Report No. NSIAD-90-49 (OSD Case No. 8222), "Recovery of Medical Costs From Liable Third Parties Can Be Improved," April 19, 1990, concluded that many cost recoveries of third party liability cases were not identified and reported. DoD is entitled to recover the cost of medical care provided or paid for by the military services from liable third parties in accident, negligence, and wrongful act cases. GAO estimated that cost recoveries of third party liability could be doubled. In FY 1987, this would have resulted in recoveries totaling about \$50 million. GAO recommended that the Secretaries of the Army, the Navy and the Air Force modify Service regulations to set a consistent, cost-effective minimum threshold for reporting outpatient cases with potential third party liability to Service legal offices and direct the Judge Advocate General of each Service to establish better internal controls for third party liability cases. GAO recommended that the Secretaries of the Army and the Navy develop and implement standard procedures for medical facilities to identify and quickly report potential third party liability cases. GAO recommended that the Secretary of Defense direct the Assistant Secretary of Defense (Health Affairs) to determine which CHAMPUS outpatient cases the Government can recover economically and which diagnostic codes should be excluded from review for third party liability potential. GAO stated that DoD orally concurred with the findings and recommendations in the report.

The Air Force Audit Agency (the Agency) issued Project No. 8325113, "Medical Insurance Billings and Reimbursements in USAF [United States Air Force] Medical Facilities," on July 31, 1989. The Agency determined that Air Force Hospitals did not

comply with Third Party Collection Program requirements and Public Law 99-272. The Agency determined that procedures were inadequate to verify that all inpatients had been questioned about health insurance coverage. The Agency recommended that when an inpatient was treated on or after October 1, 1986, and his or her medical records did not contain an insurance statement, the inpatient should be contacted and claims should be processed for those who did have health insurance coverage. The Agency also recommended that internal control weaknesses in the Program should be identified in annual assessments of internal controls. The Agency recommended that the Air Force Surgeon General issue standard procedures requiring aggressive followup on unpaid claims, and that claims denied for questionable reasons should be forwarded to the Staff Judge Advocate for legal action. The Agency also recommended that Health Services Management Inspection Teams review and assess the Program at military treatment facilities. The Agency estimated that if effective Programs had been implemented, an additional \$5.7 million could have been collected at the 17 military treatment facilities audited. Air Force management agreed to take the necessary corrective actions and stated that it would advise each hospital commander of the findings and recommendations. Military treatment facilities audited by the Agency were excluded from our review, so we did not follow up on the Agency's findings and recommendations.

Other Matters Of Interest

Until recently, the law required that all funds collected under the Third Party Collection Program be returned to the United States Treasury. However, the recently enacted National Defense Authorization Act for FY's 1990 and 1991, as well as the FY 1990 Appropriations Act, direct that effective October 1, 1989, amounts collected under the Program shall be used at the local level. These funds are to be credited to the appropriation that supports the maintenance and operation of a military treatment facility (MTF), and are to be used to improve the services provided at that facility. The Senate Committee on Appropriations directed that ASD(HA) closely monitor this program designed to win back patients from the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). The Senate Committee also stated that it would favor applying these funds to cover shortfalls in the Services' CHAMPUS accounts, if retaining collected funds at MTF's did not win back patients from CHAMPUS.

In addition, ASD(HA) received a \$10 million appropriation in FY 1990 to amend fiscal intermediary (FI) contracts. These amendments would allow the FI's (CHAMPUS contractors) to collect payments and manage the Third Party Collection Program for military hospitals. However, based on the results of our audit, ASD(HA) has decided not to use these funds to hire FI's to manage the Third Party Collection Program. Instead, ASD(HA) will use

these funds to correct the problems identified in our report and to help the Military Departments implement and manage the Program.

PART II - FINDINGS AND RECOMMENDATIONS

A. Collections from Primary Health Insurance Plans

FINDING

Military hospitals were not collecting from primary health insurance plans for inpatient hospital care costs incurred on behalf of insured military retirees and dependents. This occurred because military hospitals had not fully implemented and resourced the Third Party Collection Program (the Program). In addition, military hospitals had not established adequate procedures to identify inpatients with health insurance coverage and to document that inpatients had been questioned about insurance coverage, to correctly prepare and submit claims to insurance companies, and to resolve open claims and claims that were unpaid or partially unpaid for inappropriate reasons. Further, neither the Assistant Secretary of Defense (Health Affairs) (ASD[HA]) nor the Surgeons General for the Military Departments were adequately reviewing quarterly reports submitted by military hospitals to assure that the Program was fully implemented. As a result, only 1 of the 25 military hospitals we visited had effectively implemented the Program. We projected that unless the Program is effectively implemented, military hospitals will fail to collect approximately \$318.0 million from insurance companies for FY's 1990 through 1994.

DISCUSSION OF DETAILS

Background. Each Military Department has its own regulation describing the mission, organization, and responsibilities of its Surgeon General. Each Surgeon General functions as head of the medical service for the respective Military Department, and provides technical and professional supervision over activities of the medical service.

Audit Approach. Audit work was performed at 25 military hospitals. At each hospital, we reviewed the claims submitted to insurance companies and the amounts collected for inpatients who were discharged during FY 1988 and the first quarter of FY 1989. We also obtained lists of military dependent and retiree inpatients who were discharged during the sample period, and we randomly selected a minimum of 130 discharges from each hospital for review. For the sampled inpatients, we determined whether a signed insurance statement was on file, whether the hospital had submitted a claim to an insurance company, and whether the hospital had collected payment. We mailed a questionnaire to inpatients whose coverage we could not determine. A second questionnaire was sent to inpatients who did not respond to our first mailing.

Implementation of Third Party Collection Programs. Our review showed that out of the 25 military hospitals visited, only 1 had effectively implemented its Third Party Collection Program. That hospital, Dwight David Eisenhower Army Medical Center (Eisenhower Army Medical Center), was collecting payments from insurance companies for a significantly higher percentage of military retiree and dependent inpatients than any other military hospital. Eisenhower Army Medical Center collected payments from insurance companies for 949 (9.31 percent) of the 10,198 retiree and dependent inpatients discharged during FY 1988, and for 249 (9.77 percent) of the 2,549 retiree and dependent inpatients discharged during the first quarter of FY 1989. These collections for the two periods totaled \$1.7 million and \$0.4 million, respectively. In comparison, two-thirds (16) of the remaining 24 hospitals were collecting from insurance companies for less than 1 percent of the retiree and dependent inpatients discharged during FY 1988 and the first quarter of FY 1989 (Appendixes D and E).

Adequate Resources. One of the main reasons for ineffective implementation was that the hospitals were not adequately resourcing the Program. Before October 1, 1989, all funds collected under the Program were returned to the United States Treasury. Consequently, although hospital commanders were required to implement the Program, they were reluctant to dedicate already scarce resources to it. Our audit showed that some hospital commanders had not devoted resources to the Program, while others assigned the Program to the hospital treasurer or medical service account officer as a low-priority collateral duty. However, legislative changes effective October 1, 1989, provide that amounts collected under the Program shall be credited to the appropriation that supports the maintenance and operation of the facility providing the care. This change should give commanders an incentive to implement the Program, since it will directly benefit the hospitals. We estimate that to effectively manage the Program, personnel costs for FY's 1990 through 1994 will total about \$19.7 million.

Inpatients' Insurance Coverage. Military hospitals were not adequately identifying inpatients who had health insurance coverage and documenting that inpatients had been questioned about insurance coverage. The military hospitals in our review collected from insurance companies for 1.29 percent of the military retiree and dependent inpatients discharged during FY 1988, and for 1.08 percent of the inpatients discharged during the first quarter of FY 1989 (Appendixes D and E). However, our review showed that 6.11 percent of the sampled inpatients had primary health insurance coverage; this percentage excluded Eisenhower Army Medical Center, which actually collected from

primary health insurance plans for 9.27 percent of the military retirees and dependents discharged during the sample period (Appendix H).

The percentage of inpatients with health insurance coverage identified in our sample may be significantly understated, because we could not require retirees and dependents to complete our questionnaire, and they were reluctant to volunteer health insurance information. Insurance statements documenting that inpatients had been questioned about health insurance coverage were available for only 765 (23 percent) of the 3,307 inpatients sampled (Appendix H). We believe the only practical method for determining the health insurance coverage of previously treated inpatients is by sending those inpatients with unknown health insurance coverage a questionnaire. The use of a questionnaire can result in significant collections for previous treatment. After our review at Fitzsimons Army Medical Center, the hospital mailed a questionnaire to all military retiree and dependent inpatients discharged during FY's 1988 and 1989 who did not have insurance statements on file. As a result of the questionnaire, the hospital processed an additional 302 claims totaling \$0.9 million. As of September 30, 1989, Fitzsimons Army Medical Center had collected an additional \$0.4 million from insurance companies.

Preparing and Submitting Claims. Military hospitals were not correctly preparing and submitting claims to insurance companies. We performed selective followup on open claims by telephoning insurance companies, and found that insurance companies were generally not paying the claims because the hospitals had submitted claims with incorrect user identification or enrollment codes, with incomplete principal diagnoses and other diagnoses, or to the wrong insurance offices. In addition, the audit showed instances where the daily billing rate for the wrong fiscal year was used to calculate the amount of the claim.

Resolving Open Claims. Military hospitals were not resolving open claims and claims that were unpaid or partially unpaid for inappropriate reasons. Our review at the 25 sampled hospitals showed open claims totaling \$2.3 million for FY 1988 and \$0.8 million for the first quarter of FY 1989. This represented about 39.6 percent of the uncollected amounts for FY 1988 and 55.6 percent of the uncollected amounts for the first quarter of FY 1989 (see Appendixes F and G). The audit also showed that military hospitals were doing little to follow up on these open claims and made almost no verbal contact with insurance companies. Verbal contact would probably have been the only way to resolve most of these open claims. For example, during our review at Tripler Army Medical Center, we telephoned the Hawaii Medical Service Association to determine why numerous claims submitted to its office had not been paid. We were informed that

the claims had been paid. However, the payments had been improperly made to the patients, not to the hospital. The insurance company has agreed to make no further payments to patients for hospital care received at Tripler Army Medical Center (TAMC). We briefed the Commander, TAMC on this issue and referred the matter to our DoD Inspector General Regional Office-Pacific (IGRO-Pacific) for resolution. On February 27, 1990, TAMC advised the IGRO-Pacific that the recoveries from the insurance company had been resolved. The insurance company acknowledged that amounts owed to TAMC totaled \$163,600 and said that formal notification would be forwarded to TAMC. We also found that several insurance companies were refusing to pay claims for inpatient care provided by military hospitals because no contractual agreement existed between the military hospital and the insurance company, or because the inpatients did not have to pay for care provided by a military hospital. Insurance companies cannot deny payments for any of these invalid reasons. Appendixes F and G summarize the reasons for nonpayment of claims.

Reviewing Quarterly Reports. Military hospitals submitted quarterly reports on the Program to ASD(HA) through the Surgeons General. However, neither ASD(HA) nor the Surgeons General reviewed these reports to ensure that the Program was fully implemented. The audit showed that although the reporting format for quarterly reports may not have been the most effective means of evaluating Program results (see Finding B), the reports did provide sufficient information to identify hospitals where the Program had not been implemented effectively. For example, the quarterly reports identified 10 military hospitals with no claims for FY 1988 (1 Army, 2 Navy, and 7 Air Force hospitals; see Appendixes A, B, and C).

Projected Collections. The results of our questionnaire and sample showed that 111 (6.11 percent) out of 1,817 of the military retirees and dependents sampled had primary health insurance (Appendix H). However, since our questionnaire was voluntary and many retirees and dependents were reluctant to volunteer health insurance information, this percentage could be significantly understated. Eisenhower Army Medical Center obtained payments from insurance companies for 9.27 percent of the retiree and dependent inpatients discharged during the sample period; for our projection, we averaged the results from our questionnaire and sample with Eisenhower Army Medical Center's results (Appendix H). We used the resulting average of 7.69 percent for our projection, which had a margin of error of plus and minus 1.28 percent with a confidence level of 95 percent. The audit also showed that for claims that were paid by insurance companies, military hospitals collected \$5.6 million (79.55 percent) of the \$7.0 million claimed for FY 1988, and \$1.2 million (80.59 percent) of the \$1.5 million claimed for the first quarter of FY 1989 (see Appendixes J and K). We rounded

this figure to 80 percent. The projected Program collections for each military hospital showed that for FY 1988, military hospitals should have collected a total of about \$66.4 million (see Appendixes L, M, and N), or \$50.2 million more than the actual collections for FY 1988.

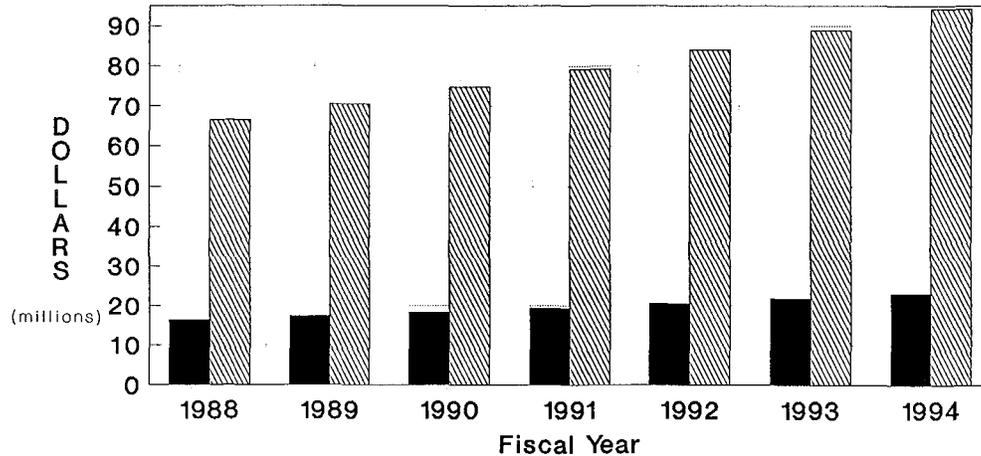
FY 1988 POTENTIAL ADDITIONAL COLLECTIONS FOR THE PROGRAM

<u>Military Department</u>	<u>Amounts Collected</u>	<u>Projected Collections</u>	<u>Potential Additional Collections</u>
Army	\$ 7,808,448	\$31,476,130	\$23,667,682
Navy	1,511,276	11,054,365	9,543,089
Air Force	<u>6,912,272</u>	<u>23,913,544</u>	<u>17,001,272</u>
Total	\$16,231,996	\$66,444,039	\$50,212,043

Unless the Program is implemented effectively, we project that the Army will fail to collect \$149.9 million, the Navy \$60.4 million, and the Air Force \$107.7 million, for a total of \$318.0 million for FY's 1990 through 1994 (see Appendixes O, P, and Q).

The following graph compares the current and projected Program for FY's 1988 through 1994, based on our sample for FY 1988. Amounts have been increased 6 percent annually to reflect increases in the daily billing rate for inpatient hospital care.

PROJECTED COLLECTIONS FY 1988 - 1994 MILITARY HOSPITALS



Current Program
 Projected Program

COLLECTIONS

	<u>FY 1988</u>	<u>FY 1989</u>	<u>FY 1990</u>	<u>FY 1991</u>	<u>FY 1992</u>	<u>FY 1993</u>	<u>FY 1994</u>
Current Program	\$16,231,996	\$17,205,916	\$18,238,271	\$19,332,567	\$20,492,521	\$21,722,072	\$23,025,397
Projected Program	66,444,039	70,430,681	74,656,522	79,135,914	83,884,068	88,917,112	94,252,139
Difference	\$50,212,043	\$53,224,765	\$56,418,251	\$59,803,347	\$63,391,547	\$67,195,040	\$71,226,742

The total additional collections for FY's 1990 through 1994 will be \$318,034,927 (\$56,418,251 + \$59,803,347 + \$63,391,547 + \$67,195,040 + \$71,226,742).

RECOMMENDATIONS FOR CORRECTIVE ACTION

1. We recommend that the Surgeons General for the Army, the Navy, and the Air Force direct commanders at military hospitals to fully implement and resource the Third Party Collection Program. To fully implement the program, military hospitals will need to establish procedures to:

a. identify inpatients who have insurance coverage and document that inpatients have been questioned about insurance coverage;

b. correctly prepare and submit claims to insurance companies; and

c. resolve open claims and claims that were unpaid or partially unpaid for inappropriate reasons.

2. We recommend that the Surgeons General for the Army, the Navy, and the Air Force direct commanders at military hospitals to send a questionnaire to each military retiree and dependent discharged during FY's 1989 and 1990 with unknown insurance information, and submit claims to insurance companies when appropriate.

3. We recommend that the Assistant Secretary of Defense (Health Affairs) and the Surgeons General for the Army, the Navy, and the Air Force review quarterly reports submitted by military hospitals to ensure that the Third Party Collection Program is implemented and fully executed, and take corrective actions at hospitals that have not effectively implemented the Third Party Collection Program.

MANAGEMENT COMMENTS

The Assistant Secretary of Defense (Health Affairs) concurred with the finding and recommendations. The Assistant Secretary stated that quarterly reports submitted by military hospitals would be reviewed to insure that the Third Party Collection Program was implemented and fully executed, and that corrective actions would be taken at hospitals that had not effectively implemented the Program (see Appendix W).

The Army Surgeon General concurred with the finding, recommendations, and potential monetary benefits to Army hospitals of \$144.4 million from Recommendation A.1. The Army stated that when the new DoD instruction on the Program is received, major medical commands would be given a new instruction addressing the areas covered in the audit report. Major medical commands would be requested to instruct military hospitals to send a questionnaire to each military retiree and dependent inpatient discharged during FY's 1989 and 1990 with unknown insurance information, and submit claims to insurance companies when appropriate. Major medical commands would be required to review quarterly reports to ensure that the Program is fully implemented at each military hospital (see Appendix X).

The Assistant Secretary of the Navy (Manpower and Reserve Affairs) concurred with recommendations A.1. and A.3. and concurred conditionally with the potential monetary benefits to Navy hospitals of \$58.2 million from Recommendation A.1. The Navy stated that in anticipation of the forthcoming DoD instruction on the Program, initial guidance on patient identification, claims preparation, and claims resolution had

been released to all commanders of Navy medical treatment facilities. The Navy also stated that it now reviews Program reports each quarter, and considers the results when allocating resources. With regard to the potential monetary benefits, the Navy stated, "We interpose no objection to the \$58.2 million estimated collection rate propounded by DoDIG provided the collections generated from the Program are deposited to the fiscal year of collection vice the year the care was provided." The Navy nonconcurred with Recommendation A.2., which addressed sending a questionnaire to each military retiree and dependent inpatient discharged during FY 1989's and 1990 with unknown insurance information and submitting claims to insurance companies when appropriate. The Navy believes the questionnaire would require a "...staff effort of heroic proportions." (See Appendix Y.)

The Assistant Secretary of the Air Force (Manpower, Reserve Affairs, Installations, and Environment) concurred with the finding, recommendations, and potential monetary benefits to Air Force hospitals of \$95.7 million from Recommendation A.1. The Air Force stated that although the Program was directed by legislation, failure to give the Military Departments adequate resources for personnel, systems, and training made successful implementation impossible. The Air Force said that once these resources were available, all inpatients having third party insurance could be identified, and all claims could be correctly prepared, submitted, and resolved in a timely manner. Questionnaires were being sent by medical facilities to non-active duty inpatients with unknown health insurance coverage, but due to the lack of resources and the magnitude of the task, the process was taking considerable time to accomplish. The Air Force also stated that major commands and the Air Force Surgeon General's staff would review quarterly reports identifying Program results at each medical facility (see Appendix Z).

AUDIT RESPONSE TO MANAGEMENT COMMENTS

We realize that it would require considerable effort for Navy hospitals to send a questionnaire to all military retiree and dependent inpatients discharged during FY's 1989 and 1990 with unknown insurance information. However, we believe that the use of a questionnaire to collect this insurance information can aid Navy hospitals in collecting large amounts of funds from insurance companies and that the recommendation is still warranted, because of the probable rate of return as indicated in the finding. Consequently, we request that the Navy, in its response to this report, reconsider its position and state the specific actions that will be taken and when it expects the actions to be completed.

B. DoD Guidance and Support for the Third Party Collection Program

FINDING

The Surgeons General and military hospitals did not have sufficient DoD guidance and support to effectively implement and manage the Third Party Collection Program. This occurred because the Assistant Secretary of Defense (Health Affairs) (ASD[HA]) had assigned responsibility to the Military Departments for developing procedures to implement the Program, but had not developed an adequate DoD instruction and regulation. In addition, ASD(HA) had not adequately developed the basic systems needed to implement and manage the Program, or identified and corrected deficiencies in the automated system used to prepare insurance claims. At most military hospitals, the Surgeons General had not fully installed the system for preparing insurance claims or given hospital personnel enough training to make the system operational. Consequently, policies and procedures used to implement the Program were inadequate and inconsistent, military hospitals were unclear about the rights and obligations of third party payers and health care beneficiaries, and the systems used to manage the Program were ineffective and burdensome.

DISCUSSION OF DETAILS

System Support. In August 1984, ASD(HA) identified medical quality assurance as a priority requirement for automation in the military health care system. The Deputy Assistant Secretary of Defense (Professional Affairs and Quality Assurance) requested that a microcomputer-based information system be developed and deployed at all DoD hospitals by the end of 1985. In January 1985, a contract was awarded to develop software. The contractor developed the Automated Quality of Care Evaluation Support System (AQCESS) to collect and report clinical, administrative, and managerial information about inpatients for medical quality assurance programs within the DoD. AQCESS was developed in modules and followed a phased plan of implementation. The system also allows users to produce ad hoc AQCESS reports that meet the hospitals' special needs. In addition, software modifications to AQCESS have given the system the ability to store insurance information and to print insurance claims for the Third Party Collection Program. AQCESS modules containing the insurance program have been installed at all military hospitals.

At the time of our audit, a new integrated computer system, the Composite Health Care System (CHCS), was being developed to support many information requirements of health care providers and administrators. CHCS will provide management information reports that support administration, quality assurance, and resource management. The reports also support mobilization and mass casualty operations. If fully funded, CHCS will be installed in more than 700 medical treatment facilities

worldwide, beginning in late 1989 and continuing through 1997. A formal operational test and evaluation for CHCS is scheduled for completion in June 1990.

Implementing and Managing the Program. ASD(HA) had not given the Surgeons General and military hospitals adequate guidance on specific policies and procedures to effectively implement and manage the Third Party Collection Program. ASD(HA) had implemented the Program through a series of policy letters and instructions that provided only general Program guidance. In addition, ASD(HA) had assigned responsibility to the Military Departments for developing procedures to implement the Program. The audit showed that military hospitals had not developed adequate policies and procedures to effectively implement the Program and that the systems to administer and manage the Program, implemented at military hospitals, were ineffective and did not provide the necessary internal controls (Finding A). Based on the results of our audit, ASD(HA) has drafted a new instruction that will specifically define policies, procedures, and responsibilities for the Third Party Collection Program.

Resolving Legal Issues. The Surgeons General and military hospitals were unclear about the rights and obligations of both third party payers and the health care beneficiaries. During the audit, we identified numerous issues that required legal clarification and forwarded these legal issues to the DoD Office of General Counsel for review. For example, can insurers deny payment because patients have no responsibility to pay for hospital care? Can claims be filed against Medicare supplemental insurance policies? Can hospitals bill both the insurance company and the inpatient for subsistence charges? Appendix R includes responses from the General Counsel of the Department of Defense to these and other legal issues. Based on the results of our review, ASD(HA) has drafted a new regulation that will cover these issues, clarify the rights and obligations of third party payers and health care beneficiaries under the governing statute, and establish applicable procedures.

Basic Systems for Program Management. The audit showed that military hospitals had developed and implemented several disordered, ineffective systems to administer and manage the Third Party Collection Program. These systems did not provide the necessary internal controls over the Program. This occurred because ASD(HA) had provided only general Program guidance without developing a functional system that would identify inpatients who had insurance coverage and document that inpatients had been questioned about insurance coverage. ASD(HA) also had not developed a basic management information system to manage the Program, or an effective system to measure and report Program results. These systems together would provide the necessary internal controls over the Program.

Identification of Inpatients Who Had Insurance Coverage. Military hospitals were using ineffective systems to identify inpatients who had insurance coverage, and were not documenting that inpatients had been questioned about insurance coverage. Our sample showed that although 6.11 percent of inpatients had primary insurance coverage, military hospitals collected from insurance companies for only 1.29 percent of military retiree and dependent inpatients discharged during FY 1988 and 1.08 percent of inpatients discharged during the first quarter of FY 1989 (see Appendixes D and E). Insurance statements documenting that inpatients had been questioned about health insurance coverage were available for only 765 (23 percent) of the 3,307 inpatient records sampled (see Appendixes H and I). Military hospitals were using both manual and automated forms to collect insurance information. We found that the different types of forms confused the inpatients and the admissions clerks, caused duplication of work, failed to collect the necessary information, did not include satisfactory Privacy Act Statements, were not maintained in the inpatients' medical records, and were not completed and signed by all inpatients. The simplest way to collect insurance information is to have each inpatient complete and sign a standard manual form. When an inpatient states that he or she does not have insurance coverage, the hospital should maintain the original copy of the form in the inpatient's file. When an inpatient does have insurance coverage, a copy of the form should be maintained in the inpatient's file and the original form should be forwarded to the appropriate billing office. We designed a standard manual form that military hospitals could use to collect the necessary insurance information (see Appendix S).

Basic Management Information System. Military hospitals did not have a management information system to manage the Third Party Collection Program. Military hospitals were using manual ledgers, card files, and other filing systems, both alphabetic and numeric, to manage the Program. These systems made management and review of the Program difficult and time-consuming; did not provide accurate, reliable, and easily accessible information; and did not provide the necessary audit trails or internal controls. At our request, the contractor who had developed the software for AQCESS prepared a program for an ad hoc report; this program could be loaded into the AQCESS system at any military hospital. The report would print a list of all military dependent and retiree inpatients identified in the system who had insurance coverage. The ad hoc report would show the inpatient's register number, name, insurance company, policy number, effective date of policy, Social Security Number, patient category, admission date, and disposition date. The report could be printed for any given period and would be sorted sequentially by patient register number. Appendix T is a copy of one page of the report as printed at Tripler Army Medical Center.

We added six additional columns to this report, showing the date billed, amount billed, amount collected, amount not collected, reason not collected, and cash collection voucher number. These changes could be incorporated into the reporting format; the system could total each column, and an additional system change could allow the user to input the necessary information (using the inpatient's register number as an identification number). With these changes, the AQCESS system could provide all hospitals with an effective management information system for the Third Party Collection Program. When the Composite Health Care System (CHCS) is operational at military hospitals, it could also perform a similar function.

System for Measuring and Reporting Program Results. Military hospitals were not submitting accurate and consistent quarterly reports that provided sufficient information to measure the Program's effectiveness. Consequently, ASD(HA) and the Surgeons General could not adequately identify areas that required corrective action. The audit showed that Air Force hospitals reported claims, and collections relating to those claims, in the fiscal years that the claims were processed. However, Army and Navy hospitals were reporting claims when they were processed and collections when they were received. Consequently, claims could be reported in one fiscal year and collections in the next fiscal year. This made it impossible to reconcile uncollected amounts for either fiscal year. In addition, neither reporting method accurately compared the number of military dependent and retiree inpatients admitted or discharged during a given period to the number of claims and collections for those inpatients. We designed a form that military hospitals, the Surgeons General, and ASD(HA) could use to measure and report Program results (Appendix U).

Deficiencies in the Automated System for Preparing Insurance Claims. ASD(HA) had not identified and corrected deficiencies in the automated system (a function of AQCESS) for preparing insurance claims. The audit showed that the system would not permit users to reprint claims as needed and add or delete information after the claim forms were printed. Consequently, if the computer printed a claim form with the wrong insurance information or an incorrect billing amount, the form had to be retyped. The format of DD Form 2502, "Uniform Billing for Inpatient Hospital Costs," also contained numerous deficiencies that made the system less effective. For a copy of DD Form 2502 and examples of problems with its format, see Appendix V.

Installing the Automated System. The Surgeons General had not fully implemented the automated system for preparing insurance claims or given hospital personnel sufficient training to make the system operational. For example, at the U. S. Air Force Hospital, Fairchild, the system was not operational for over a year because two automated tables were incorrectly coded by the installers. We contacted the AQCESS software contractor

and obtained the necessary information to make the system operational. The software contractor for AQCESS developed the automated system for preparing insurance claims. ASD(HA) made it available to a limited number of hospitals in May 1988 and to all hospitals by September 1988. However, only 4 of the 25 military hospitals we visited were using the automated system to prepare insurance claims. The remaining hospitals were manually typing each claim.

RECOMMENDATIONS FOR CORRECTIVE ACTION

1. We recommend that the Assistant Secretary of Defense (Health Affairs):

a. Develop and issue a DoD instruction that provides specific policies, procedures, and responsibilities for implementing the Third Party Collection Program.

b. Develop and issue a DoD regulation to clarify the rights and obligations of third party payers and health care beneficiaries.

c. Develop and make available the basic systems needed to implement and manage the Third Party Collection Program, including:

(1) a standard manual form to collect insurance information,

(2) a management information system using the Automated Quality of Care Evaluation Support System or the Composite Health Care System to manage the Third Party Collection Program,

(3) an effective system to measure and report Third Party Collection Program results, using the dates that services were rendered as the basis for reporting claims and collections.

d. Correct the deficiencies in the Automated Quality of Care Evaluation Support System for preparing insurance claims, including: permitting users to add or delete information and reprint claims as needed, and correcting the format problems identified in Appendix V.

2. We recommend that the Surgeons General for the Army, the Navy, and the Air Force:

a. Fully install at each military hospital the Automated Quality of Care Evaluation Support System and any other systems developed by the Assistant Secretary of Defense (Health Affairs) to manage the Third Party Collection Program.

b. Give hospital personnel sufficient training to operate the systems.

MANAGEMENT COMMENTS

The Assistant Secretary of Defense (Health Affairs) concurred with the finding and recommendations. The Assistant Secretary stated that draft DoD Instruction 6010.15, "Third Party Collection Program," had been circulated for comments and would be published when the necessary information had been collected and forms had been approved. The Assistant Secretary stated that a DoD regulation clarifying the rights and obligations of third party payers and health care beneficiaries was published on May 29, 1990, as 32 CFR Part 220, "Collection from Third Party Payers of Reasonable Hospital Costs." The Assistant Secretary also stated that appropriate forms were being developed, that software changes to the Automated Quality of Care Evaluation Support System (AQCESS) for the Third Party Collection Program were expected to be completed and deployed by December 1990, and that completion of software changes to the Composite Health Care System (CHCS) was planned for June 1991.

The Army Surgeon General, the Assistant Secretary of the Navy (Manpower and Reserve Affairs), and the Assistant Secretary of the Air Force (Manpower, Reserve Affairs, Installations and Environment) all concurred with the finding and recommendations. They stated that they were developing the systems to support the Program, that systems would be fully installed at each military hospital, and that hospital personnel would be trained to operate the systems.

C. Legislation to Authorize Recoveries from Medicare Supplemental Insurance Policies

FINDING

Only 7 of the 25 military hospitals visited were collecting from Medicare supplemental insurance policies for the cost of inpatient care for insured military retirees and dependents. This occurred because legislation authorizing the Third Party Collection Program (the Program) and guidance provided by the Assistant Secretary of Defense (Health Affairs) (ASD[HA]) did not clearly address the issue of collections from Medicare supplemental insurance policies. As a result, the military hospitals collected only \$46,600 for FY 1988 and the first quarter of FY 1989. We project that with appropriate legislation and guidance, military hospitals can collect approximately \$191.9 million from Medicare supplemental insurance policies for FY's 1991 through 1995.

DISCUSSION OF DETAILS

Background. Medicare supplemental insurance policies are private sector health insurance policies that individuals covered by the Medicare program can purchase. The policies pay for certain expenses, such as the applicable deductibles and copayments, not paid by Medicare.

Collections from Medicare Supplemental Insurance Policies. Our review showed that out of the 25 military hospitals visited, only 7 had collected from Medicare supplemental insurance policies for the cost of inpatient care for insured military retirees and dependents. For the hospitals that made collections, only \$46,600 was collected in FY 1988 and the first quarter of FY 1989. We found that when insurers made payments, the amounts paid generally equaled the annual Medicare deductible amount.

Clarification of Policy. During the audit, we found that both the military hospitals and the private insurance companies were unclear about obligations for payments on Medicare supplemental insurance policies. Consequently, military hospitals did not know what actions to take when insurers denied payments. We forwarded this issue to the General Counsel, Department of Defense for review. Appendix R to the draft report provides the General Counsel's response, which states that nothing in the statute or legislative history answers the question clearly. However, the General Counsel concluded that the statute did not clearly authorize recovery from Medicare supplemental plans.

In addition, although guidance provided by ASD(HA) in DoD Instruction 6010.15, "Coordination of Benefits," September 4, 1987, stated that the Program did not include "income maintenance" or "CHAMPUS supplemental" plans, which are similar

to Medicare supplemental plans, the instruction did not specifically address Medicare supplemental plans.

Projected Collections. The results of our questionnaire showed that 121 (11.5 percent) out of 1,052 of the military retirees and dependents sampled had Medicare supplemental insurance coverage (see Appendix I). We used the 11.5 percent estimate for our projection, which had a margin of error of plus and minus 1.3 percent with a confidence level of 95 percent. The projections for FY's 1991 through 1995 were obtained by multiplying the 11.5 percent by the total number of military retiree and dependent inpatients discharged during FY 1988 (489,338). The result was the total number of insured inpatients (56,274). The total number of insured inpatients was then multiplied by the Medicare deductible for each fiscal year (the amount likely to be reimbursed by the insurers). Our projected collections from Medicare supplemental insurance policies show that military hospitals can collect about \$191.9 million for FY's 1991 through 1995 if legislation authorizes these collections.

POTENTIAL COLLECTIONS FROM MEDICARE
SUPPLEMENTAL INSURANCE POLICIES

<u>Fiscal Year</u>	<u>Total Insured Inpatients</u>		<u>Medicare Deductible</u>	=	<u>Projected Collections</u>
1991	56,274	x	\$600.00	=	\$ 33,764,400
1992	56,274	x	652.00	=	36,690,648
1993	56,274	x	684.60	=	38,525,180
1994	56,274	x	718.83	=	40,451,439
1995	56,274	x	754.77	=	42,473,927
Total					<u>\$191,905,594</u>

The Medicare deductible amounts had not been determined for 1993 through 1995; therefore, to project collections, we estimated that the deductible amount would increase above the 1992 amount by 5 percent annually (the average increase for 1989 to 1992).

RECOMMENDATIONS FOR CORRECTIVE ACTION

1. We recommend that the Assistant Secretary of Defense (Health Affairs) propose legislation that would authorize military hospitals to collect from Medicare supplemental insurance policies.

2. If legislation is enacted, we recommend that the Assistant Secretary of Defense, (Health Affairs) issue appropriate guidance requiring military hospitals to collect from Medicare supplemental insurance policies.

MANAGEMENT COMMENTS

The Assistant Secretary of Defense (Health Affairs) concurred with the finding, recommendations, and potential monetary benefits of \$191.9 million. The Assistant Secretary stated that a draft legislative proposal was currently being circulated to authorize military hospitals to collect from Medicare supplemental insurance policies and that if legislation was enacted, appropriate guidance would be issued.

**AMOUNTS REPORTED ON QUARTERLY REPORTS:
ARMY THIRD PARTY COLLECTION PROGRAM**

ARMY ^{1/} HOSPITALS	FY 1988			FY 1989 (FIRST QUARTER)		
	TOTAL INPATIENTS	TOTAL AMOUNT CLAIMED	TOTAL AMOUNT COLLECTED	TOTAL ^{2/} INPATIENTS	TOTAL AMOUNT CLAIMED	TOTAL AMOUNT COLLECTED
Walter Reed AMC, DC	18,093	\$ 620,099	\$ 315,703	4,523	\$ 132,473	\$ 60,115
Madigan AMC, WA	17,256	672,721	369,980	4,314	132,302	36,907
Wm. Beaumont AMC, TX	16,665	194,167	17,445	4,166	88,357	13,920
Tripler AMC, HI	16,565	1,061,637	243,309	4,141	90,510	106,024
Brooke AMC, TX	15,931	0	0	3,983	0	0
Fitzsimons AMC, CO	11,514	1,094,238	506,677	2,878	330,070	113,511
Fort Bragg, NC	11,029	186,329	89,639	2,757	217,275	40,423
Fort Hood, TX	10,882	325,829	144,614	2,720	37,746	19,265
Eisenhower AMC, GA	10,198	3,016,400	2,135,891	2,549	491,796	404,298
Letterman AMC, CA	9,249	116,115	29,585	2,312	19,464	0
Fort Ord, CA	7,490	188,244	86,795	1,872	45,973	26,899
Fort Benning, GA	7,188	1,015,173	414,097	1,797	0	197,021
Fort Campbell, KY	6,665	399,081	214,814	1,666	90,612	82,522
Fort Belvoir, VA	6,174	320,870	231,637	1,543	86,959	65,119
Fort Sill, OK	6,039	294,408	204,335	1,510	45,202	37,255
Fort Carson, CO	5,407	212,296	101,640	1,351	52,036	56,584
Fort Knox, KY	5,252	553,811	392,047	1,313	67,068	49,673
Fort Riley, KS	5,093	223,130	107,026	1,273	72,708	66,397
Fort Polk, LA	4,974	310,638	97,401	1,243	45,597	14,753
Fort Leonard Wood, MO	4,372	448,931	182,204	1,093	86,744	49,217
Fort Stewart, GA	4,244	255,803	194,191	1,061	71,210	47,908
Fort Jackson, SC	3,675	1,251,832	749,423	918	215,026	129,824
Fort Rucker, AL	2,860	195,487	75,990	715	27,664	27,145
Fort Huachuca, AZ	2,668	532,576	205,769	667	55,570	118,279
Fort Wainwright, AK	2,277	94,407	38,744	569	7,456	1,265
Fort Eustis, VA	2,191	56,716	51,799	547	18,617	11,889
Fort McClellan, AL	1,992	246,935	182,735	498	46,668	28,408
Fort Meade, MD	1,976	1,864	0	494	0	0
Fort Leavenworth, KS	1,912	415,738	108,927	478	82,474	60,453
Fort Dix, NJ	1,703	164,057	46,034	426	18,103	4,247
West Point, NY	1,691	9,702	3,128	422	14,326	0
Fort Lee, VA	1,374	351,425	44,152	343	25,202	11,588
Redstone Arsenal, AL	1,206	374,334	155,511	301	6,058	3,564
Fort Devens, MA	1,052	188,280	28,129	263	4,250	3,755
Fort Irwin, CA	880	932	173	220	0	0
Fort Monmouth, NJ	827	82,594	16,195	206	54,993	0
Fort Harrison, IN	320	46,075	22,709	80	12,732	653
TOTAL	228,884	\$15,522,874	\$7,808,448	57,212	\$2,793,241	\$1,888,881

^{1/} Army Medical Centers (AMC's) are listed by name; other Army hospitals are listed by location.

^{2/} The Defense Medical Systems Support Center could not provide figures on the total number of inpatients discharged during the first quarter of FY 1989. Therefore, we used 25 percent of the FY 1988 figures.

**AMOUNTS REPORTED ON QUARTERLY REPORTS:-
NAVY THIRD PARTY COLLECTION PROGRAM**

NAVAL ^{1/} HOSPITALS	FY 1988			FY 1989 (FIRST QUARTER)		
	TOTAL INPATIENTS	TOTAL AMOUNT CLAIMED	TOTAL AMOUNT COLLECTED	TOTAL ^{2/} INPATIENTS	TOTAL AMOUNT CLAIMED	TOTAL AMOUNT COLLECTED
San Diego, CA	13,034	\$ 389,280	\$ 185,204	3,259	\$ 0	\$ 0
Portsmouth, VA	12,532	757,783	314,471	3,133	59,473	2,427
Bethesda, MD	9,745	178,012	66,957	2,436	70,366	13,745
Oakland, CA	8,853	381,653	125,532	2,213	4,446	0
Jacksonville, FL	5,984	167,755	25,319	1,496	0	0
Charleston, SC	5,695	294,861	148,765	1,424	66,196	9,864
Camp Pendleton, CA	4,592	117,357	69,867	1,148	21,736	3,727
Camp Lejeune, NC	3,388	29,824	23,106	847	4,940	0
Pensacola, FL	3,211	240,456	171,000	803	30,134	0
Bremerton, WA	3,143	140,732	66,665	786	33,592	4,027
Orlando, FL	2,484	164,964	108,447	621	24,206	0
Cherry Point, NC	2,466	6,058	2,313	617	494	0
Great Lakes, IL	1,992	12,948	5,676	498	0	0
Millington, TN	1,979	4,193	278	495	0	0
Twentynine Palms, CA	1,646	0	0	412	0	0
Beaufort, SC	1,509	23,415	15,005	377	0	0
Lemoore, CA	1,417	36,348	22,328	354	11,362	0
Oak Harbor, WA	1,405	20,504	12,054	351	0	0
Groton, CT	1,249	32,154	19,718	312	0	0
Corpus Christi, TX	974	153,317	91,243	244	23,218	2,099
Patuxent River, MD	738	28,194	9,787	185	0	0
Newport, RI	736	47,998	17,678	184	7,410	0
Philadelphia, PA	618	40,542	5,016	155	0	0
Long Beach, CA	530	10,252	4,847	133	2,470	0
Adak, AK	337	0	0	84	0	0
TOTAL	90,257	\$3,278,600	\$1,511,276	22,567	\$360,043	\$35,889

^{1/} Naval hospitals are listed by name and location.

^{2/} The Defense Medical Systems Support Center could not provide figures on the total number of inpatients discharged during the first quarter of FY 1989. Therefore, we used 25 percent of the FY 1988 figures.

AMOUNTS REPORTED ON QUARTERLY REPORTS:-
AIR FORCE THIRD PARTY COLLECTION PROGRAM

AIR FORCE ^{1/} HOSPITALS	FY 1988		FY 1989 (FIRST QUARTER)			
	TOTAL INPATIENTS	TOTAL AMOUNT CLAIMED	TOTAL AMOUNT COLLECTED	TOTAL ^{2/} INPATIENTS	TOTAL AMOUNT CLAIMED	TOTAL AMOUNT COLLECTED
Lackland AFB, TX	18,551	\$ 2,088,785	\$1,002,755	4,638	\$ 229,216	\$ 3,160
Kessler AFB, MS	9,070	814,353	497,224	2,268	354,342	53,798
Andrews AFB, MD	7,517	2,593,834	1,221,885	1,879	96,824	3,571
Travis AFB, CA	7,453	1,170,412	496,926	1,863	93,666	5,834
Eglin AFB, FL	6,692	251,174	86,234	1,673	39,026	3,847
Wright-Patterson AFB, OH	6,526	1,079,274	765,115	1,632	0	0
Scott AFB, IL	6,157	1,556,226	875,853	1,539	74,594	1,501
Carswell AFB, TX	5,029	241,674	101,355	1,257	81,146	7,222
Langley AFB, VA	4,468	56,562	39,455	1,117	96,839	4,744
Offutt AFB, NE	4,152	174,625	102,914	1,038	121,242	1,363
MacDill AFB, FL	3,986	360,210	199,330	997	25,594	0
Elmendorf, AK	3,915	151,916	53,859	979	11,362	1,656
Mather AFB, CA	3,459	66,206	2,982	865	0	0
March AFB, CA	3,211	89,948	19,327	803	0	0
USAF Academy, CO	3,103	58,370	2,211	776	0	0
Luke AFB, AZ	2,914	277,898	128,526	729	47,040	2,313
Homestead AFB, FL	2,811	92,776	50,688	703	1,864	0
Maxwell AFB, AL	2,704	5,126	0	676	169,690	0
Ellsworth AFB, SD	2,687	17,208	0	672	3,728	0
Davis-Monthan AFB, AZ	2,660	158,508	56,244	665	0	0
Dyess AFB, TX	2,627	67,179	10,599	657	24,206	3,637
Barksdale AFB, LA	2,626	50,513	22,497	657	10,374	0
Sheppard AFB, TX	2,622	210,223	142,569	656	92,208	19,630
Tinker AFB, OK	2,455	150,052	111,581	614	37,050	0
Fairchild AFB, WA	2,408	5,040	0	602	4,407	0
Hill AFB, UT	2,096	142,021	64,985	524	117,276	45,918
Nellis AFB, NV	2,079	160,850	78,887	520	91,802	14,639
Shaw AFB, SC	1,964	103,165	29,802	491	85,957	5,303
Kirtland AFB, NM	1,827	49,278	13,071	457	8,892	994
F. E. Warren AFB, WY	1,800	105,793	46,365	450	5,928	4,465
Castle AFB, CA	1,755	12,666	7,892	439	47,918	0
Minot AFB, ND	1,726	0	0	432	988	863
Pease AFB, NH	1,720	0	0	430	0	0
Tyndall AFB, FL	1,643	43,961	17,387	411	28,019	11,033
Dover AFB, DE	1,576	31,404	0	394	0	0
Robins AFB, GA	1,505	78,328	41,834	376	29,640	5,770
George AFB, CA	1,473	65,554	18,241	368	3,952	0
Mountain Home AFB, ID	1,433	27,028	2,982	358	11,958	0
Cannon AFB, NM	1,398	41,008	22,022	350	2,974	1,700
Moody AFB, GA	1,381	50,567	9,266	345	15,808	0
Grand Forks AFB, ND	1,378	24,698	11,651	345	11,352	635
Seymour Johnson AFB, NC	1,364	62,181	18,772	341	0	0

(See footnotes on page 30.)

**AMOUNTS REPORTED ON QUARTERLY REPORTS:-
AIR FORCE THIRD PARTY COLLECTION PROGRAM**

(Continued)

AIR FORCE ^{1/} HOSPITALS	FY 1988			FY 1989 (FIRST QUARTER)		
	TOTAL INPATIENTS	TOTAL AMOUNT CLAIMED	TOTAL AMOUNT COLLECTED	TOTAL ^{2/} INPATIENTS	TOTAL AMOUNT CLAIMED	TOTAL AMOUNT COLLECTED
Beale AFB, CA	1,360	\$ 65,570	\$ 27,895	340	\$ 5,928	\$ 0
Holloman AFB, NM	1,353	71,223	46,147	338	11,362	4,056
Loring AFB, ME	1,290	0	0	323	29,640	0
Whiteman AFB, MO	1,277	40,749	11,234	319	7,440	4,137
Altus AFB, OK	1,191	25,630	17,146	298	5,928	2,864
Blytheville AFB, AR	1,172	0	0	293	0	0
Griffiss AFB, NY	1,152	108,255	76,120	288	139,091	0
Wurtsmith AFB, MI	1,141	61,390	10,126	285	0	0
K. I. Sawyer AFB, MI	1,121	76,830	43,729	280	10,840	1,801
Vandenberg AFB, CA	1,108	0	0	277	1,976	0
Edwards AFB, CA	1,094	19,106	8,878	274	26,676	0
Bergstrom AFB, TX	1,080	101,452	40,687	270	15,580	0
Little Rock AFB, AR	1,041	116,580	75,035	260	13,807	0
Williams AFB, AZ	1,028	51,538	10,633	257	0	0
England AFB, LA	981	20,924	11,890	245	0	0
Chanute AFB, IL	972	40,076	5,875	243	0	0
Laughlin AFB, TX	880	0	0	220	0	0
Patrick AFB, FL	808	189,918	102,176	202	47,039	21,703
Myrtle Beach AFB, SC	637	46,557	30,162	159	4,446	0
Plattsburgh AFB, NY	516	44,280	10,650	129	28,652	8,693
Malmstrom AFB, MT	327	18,174	0	82	0	0
Columbus AFB, MS	270	6,058	3,211	68	0	0
Reese AFB, TX	265	40,445	7,392	66	21,242	1,912
McConnell AFB, KS	212	0	0	53	3,952	0
TOTAL	170,197	\$13,931,349	\$6,912,272	42,555	\$2,450,481	\$248,762

^{1/} Air Force hospitals are listed by Air Force base (AFB).

^{2/} The Defense Medical Systems Support Center could not provide figures on the total number of inpatients discharged during the first quarter of FY 1989. Therefore, we used 25 percent of the FY 1988 figures.

SUMMARY OF AMOUNTS CLAIMED AND COLLECTED BY SAMPLED HOSPITALS (FY 1988)

<u>HOSPITAL ^{1/} OR LOCATION</u>	<u>TOTAL INPATIENTS</u>	<u>TOTAL PROGRAM CLAIMS</u>	<u>TOTAL PROGRAM COLLECTIONS</u>	<u>COLLECTION ^{2/} PERCENTAGE</u>	<u>TOTAL AMOUNT CLAIMED</u>	<u>TOTAL AMOUNT COLLECTED</u>	<u>TOTAL AMOUNT NOT COLLECTED</u>	<u>AVERAGE COLLECTION PER CLAIM</u>
<u>ARMY</u>								
Eisenhower AMC	10,198	1,076	949	9.31	\$ 2,408,390	\$1,732,442	\$ 675,948	\$1,826
Tripler AMC	16,565	420	224	1.35	1,068,666	439,925	628,741	1,964
Madigan AMC	17,256	336	212	1.23	660,883	343,326	317,557	1,619
Fitzsimons AMC	11,514	241	132	1.15	692,315	323,261	369,054	2,449
Walter Reed AMC	18,093	151	81	.45	431,128	213,584	217,544	2,637
Letterman AMC	9,249	71	10	.11	238,038	6,808	231,230	681
Wm. Beaumont AMC	16,665	42	14	.08	140,218	46,798	93,420	3,343
Brooke AMC	15,931	0	0	.00	0	0	0	0
<u>NAVY</u>								
Oakland	8,853	258	203	2.29	433,176	274,644	158,532	1,353
Portsmouth	12,532	190	120	.96	431,348	247,273	184,075	2,061
Camp Pendleton	4,592	58	40	.87	118,189	73,100	45,089	1,828
San Diego	13,034	200	110	.84	477,111	201,620	275,491	1,833
Jacksonville	5,984	95	33	.55	166,532	34,599	131,933	1,048
Newport	736	17	4	.54	47,066	7,081	39,985	1,770
Great Lakes	1,992	10	9	.45	9,786	6,833	2,953	759
Bethesda	9,745	46	7	.07	220,007	17,342	202,665	2,477
<u>AIR FORCE</u>								
Tinker AFB	2,455	90	75	3.05	159,932	117,629	42,303	1,568
Lackland AFB	18,551	605	357	1.92	2,700,605	1,161,005	1,539,600	3,252
Williams AFB	1,028	45	19	1.85	51,538	10,634	40,904	560
Travis AFB	7,453	238	121	1.62	758,100	263,406	494,694	2,177
Homestead AFB	2,811	42	27	.96	85,279	48,827	36,452	1,808
Edwards AFB	1,094	12	8	.73	20,812	12,183	8,629	1,523
Mather AFB	3,459	63	14	.40	122,558	13,362	109,196	954
Fairchild AFB	2,408	7	1	.04	7,837	438	7,399	438
Pease AFB	1,720	0	0	.00	0	0	0	0
TOTAL	213,918	4,313	2,770	1.29	\$11,449,514	\$5,596,120	\$5,853,394	2,020

^{1/} Army Medical Centers (AMC's) are listed by name, Naval hospitals are listed by name and location, and Air Force hospitals are listed by Air Force base (AFB).

^{2/} This percentage represents the total number of program collections divided by the total number of inpatients.

SUMMARY OF AMOUNTS CLAIMED AND COLLECTED BY SAMPLED HOSPITALS (FIRST QUARTER FY 1989)

<u>HOSPITAL ^{1/} OR LOCATION</u>	<u>TOTAL INPATIENTS</u>	<u>TOTAL PROGRAM CLAIMS</u>	<u>TOTAL PROGRAM COLLECTIONS</u>	<u>COLLECTION ^{2/} PERCENTAGE</u>	<u>TOTAL AMOUNT CLAIMED</u>	<u>TOTAL AMOUNT COLLECTED</u>	<u>TOTAL AMOUNT NOT COLLECTED</u>	<u>AVERAGE COLLECTION PER CLAIM</u>
<u>ARMY</u>								
Eisenhower AMC	2,549	285	249	9.77	\$ 671,914	\$ 428,267	\$ 243,647	\$1,720
Tripler AMC	2,878	100	53	1.84	378,731	167,434	211,297	3,159
Madigan AMC	4,314	62	43	1.00	170,402	92,488	77,914	2,151
Fitzsimons AMC	4,141	63	23	.56	187,894	67,659	120,235	2,942
Walter Reed AMC	4,523	14	8	.18	27,552	17,171	10,381	2,146
Letterman AMC	3,983	30	4	.10	60,762	5,773	54,989	1,443
Wm. Beaumont AMC	4,166	9	4	.10	19,760	6,333	13,427	1,583
Brooke AMC	2,312	15	2	.09	39,656	2,728	36,928	1,364
<u>NAVY</u>								
Oakland	2,213	77	58	2.62	175,243	115,725	59,518	1,995
Portsmouth	1,148	14	13	1.13	27,170	20,434	6,736	1,572
Camp Pendleton	184	8	1	.54	7,904	988	6,916	988
San Diego	3,259	35	9	.28	58,622	12,139	46,483	1,349
Jacksonville	1,496	8	3	.20	14,018	5,479	8,539	1,826
Newport	2,436	8	2	.08	25,752	8,192	17,560	4,096
Great Lakes	3,133	3	1	.03	6,058	3,162	2,896	3,162
Bethesda	498	0	0	.00	0	0	0	0
<u>AIR FORCE</u>								
Tinker AFB	274	15	10	3.65	31,122	22,759	8,363	2,276
Lackland AFB	614	29	17	2.77	56,850	20,083	36,767	1,181
Williams AFB	257	14	7	2.72	16,302	7,020	9,282	1,003
Travis AFB	4,638	93	56	1.21	483,128	162,841	320,287	2,908
Homestead AFB	1,863	32	9	.48	90,206	20,995	69,211	2,333
Edwards AFB	703	2	2	.28	6,916	6,181	735	3,091
Mather AFB	602	1	1	.17	972	300	672	300
Fairchild AFB	865	3	1	.12	5,928	2,727	3,201	2,727
Pease AFB	430	0	0	.00	0	0	0	0
TOTAL	53,479	920	576	1.08	\$2,562,862	\$1,196,878	\$1,365,984	2,077

^{1/} Army Medical Centers (AMC's) are listed by name, Naval hospitals are listed by name and location, and Air Force hospitals are listed by Air Force base (AFB).

^{2/} This percentage represents the total number of program collections divided by the total number of inpatients.

SUMMARY OF UNCOLLECTED AMOUNTS FOR SAMPLED HOSPITALS (FY 1988)

<u>REASONS FOR UNPAID CLAIMS</u>	<u>ARMY HOSPITALS</u>	<u>NAVAL HOSPITALS</u>	<u>AIR FORCE HOSPITALS</u>	<u>TOTAL</u>	<u>UNCOLLECTED AMOUNTS (PERCENTAGE)</u>
<u>AMOUNTS OF COLLECTABLE CLAIMS</u>					
Open Claim; Required Additional Followup	\$ 846,113	\$ 797,304	\$ 674,111	\$2,317,528	39.6
Not a Participating Hospital; No Cost to the Patient	118,364	6,983	30,347	155,694	2.7
Payment Reduced or Denied: No Preadmission Review, Concurrent Review, etc.	303,588	59,785	103,423	466,796	8.0
Insurer Paid Patient	<u>41,940</u>	<u>1,864</u>	<u>40,542</u>	<u>84,346</u>	<u>1.4</u>
TOTAL	\$1,310,005	\$ 865,936	\$ 848,423	\$3,024,364	51.7
<u>AMOUNTS OF UNCOLLECTABLE CLAIMS</u>					
MEDICARE/CHAMPUS Supplemental Plans	\$ 426,203	\$ 9,786	\$ 670,273	\$1,106,262	18.9
Coverage Paid Less Than 100 Percent	432,242	117,480	174,570	724,292	12.4
Care Provided Not Covered Under the Policy	69,012	9,320	67,535	145,867	2.5
Policy Expired or Patient Not Covered	121,626	7,456	46,538	175,620	3.0
Policy Not Renewed After April 7, 1986	0	0	14,030	14,030	.2
Health Maintenance Organization	117,432	24,232	203,751	345,415	5.9
Other/Questionable	<u>56,974</u>	<u>6,513</u>	<u>254,057</u>	<u>317,544</u>	<u>5.4</u>
TOTAL	\$1,223,489	\$ 174,787	\$1,430,754	\$2,829,030	48.3
TOTAL UNCOLLECTED	<u>\$2,533,494</u>	<u>\$1,040,723</u>	<u>\$2,279,177</u>	<u>\$5,853,394</u>	<u>100.0</u>

SUMMARY OF UNCOLLECTED AMOUNTS FOR SAMPLED HOSPITALS (FIRST QUARTER FY 1989)

<u>REASONS FOR UNPAID CLAIMS</u>	<u>ARMY HOSPITALS</u>	<u>NAVAL HOSPITALS</u>	<u>AIR FORCE HOSPITALS</u>	<u>TOTAL</u>	<u>UNCOLLECTED AMOUNTS (PERCENTAGE)</u>
<u>AMOUNTS OF COLLECTABLE CLAIMS</u>					
Open Claim; Required Additional Followup	\$352,561	\$120,604	\$286,898	\$ 760,063	55.6
Not a Participating Hospital; No Cost to the Patient	15,808	2,470	7,410	25,688	1.9
Payment Reduced or Denied: No Preadmission Review, Concurrent Review, etc.	110,043	0	5,826	115,869	8.5
Insurer Paid Patient	<u>0</u>	<u>1,482</u>	<u>0</u>	<u>1,482</u>	<u>.1</u>
TOTAL	\$478,412	\$124,556	\$300,134	\$ 903,102	66.1
<u>AMOUNTS OF UNCOLLECTABLE CLAIMS</u>					
MEDICARE/CHAMPUS Supplemental Plans	\$113,239	\$ 1,482	\$ 44,006	\$ 158,727	11.6
Coverage Paid Less Than 100 Percent	115,634	20,634	31,200	167,468	12.3
Care Provided Not Covered Under the Policy	17,784	988	2,964	21,736	1.6
Policy Expired or Patient Not Covered	10,374	988	25,726	37,088	2.7
Policy Not Renewed After April 7, 1986	0	0	0	0	.0
Health Maintenance Organization	17,700	0	29,700	47,400	3.5
Other/Questionable	<u>15,675</u>	<u>0</u>	<u>14,788</u>	<u>30,463</u>	<u>2.2</u>
TOTAL	\$290,406	\$ 24,092	\$148,384	\$ 462,882	33.9
TOTAL UNCOLLECTED	<u>\$768,818</u>	<u>\$148,648</u>	<u>\$448,518</u>	<u>\$1,365,984</u>	<u>100.0</u>

**RESULTS OF QUESTIONNAIRE/SAMPLE
FOR PATIENTS WITH PRIMARY HEALTH CARE INSURANCE**

<u>HOSPITAL ^{1/} OR LOCATION</u>	<u>SAMPLE SIZE</u>	<u>SIGNED INSURANCE STATEMENTS</u>	<u>QUESTION- NAIRES MAILED</u>	<u>QUESTION- NAIRES RETURNED</u>	<u>TOTAL ^{2/} KNOWN COVERAGE</u>	<u>INPATIENTS WITH PRIMARY HEALTH INSURANCE</u>	<u>PERCENTAGE ^{3/} WITH PRIMARY HEALTH INSURANCE</u>
<u>ARMY</u>							
Eisenhower AMC ^{4/}	12,747		0	0	12,747	1,182	9.27
Tripler AMC	153	66	87	28	94	5	5.32
Madigan AMC	134	60	74	32	92	4	4.35
Fitzsimons AMC	130	46	84	36	82	4	4.88
Walter Reed AMC	173	0	173	103	103	7	6.80
Letterman AMC	164	0	164	85	85	6	7.06
Wm. Beaumont AMC	130	0	130	41	41	0	.00
Brooke AMC	171	0	171	97	97	4	4.12
<u>NAVY</u>							
Oakland	134	0	134	56	56	6	10.71
Portsmouth	130	0	130	55	55	6	10.91
Camp Pendleton	142	98	44	17	115	4	3.48
San Diego	134	0	134	49	49	4	8.16
Jacksonville	133	0	133	39	39	2	5.13
Newport	142	0	142	66	66	7	10.61
Great Lakes	135	0	135	44	44	0	.00
Bethesda	132	0	132	70	70	6	8.57
<u>AIR FORCE</u>							
Tinker AFB	130	40	90	29	69	8	11.59
Lackland AFB	130	72	58	24	96	7	7.29
Williams AFB	130	43	87	28	71	6	8.45
Travis AFB	130	102	28	11	113	3	2.65
Homestead AFB	130	73	57	14	87	7	8.05
Edwards AFB	130	48	82	23	71	6	8.45
Mather AFB	130	45	85	30	75	3	4.00
Fairchild AFB	130	72	58	21	93	3	3.23
Pease AFB	130	0	130	54	54	3	5.56
TOTAL ^{4/}	3,307	765	2,542	1,052	1,817	111	6.11

^{1/} Army Medical Centers (AMCs) are listed by name, Naval hospitals are listed by name and location, and Air Force hospitals are listed by Air Force base (AFB).

^{2/} This figure represents the total number of signed insurance statements plus questionnaires returned.

^{3/} This percentage is the number of patients with primary health insurance divided by the total known coverage figure.

^{4/} Figures for Eisenhower AMC represent the actual number of inpatients with insurance coverage and are not included in the totals.

**RESULTS OF QUESTIONNAIRE/SAMPLE
FOR PATIENTS WITH MEDICARE SUPPLEMENTAL INSURANCE**

<u>HOSPITAL ^{1/} OR LOCATION</u>	<u>SAMPLE SIZE</u>	<u>SIGNED INSURANCE STATEMENTS</u>	<u>QUESTION- NAIRES MAILED</u>	<u>QUESTION- NAIRES RETURNED</u>	<u>TOTAL ^{2/} KNOWN COVERAGE</u>	<u>INPATIENTS WITH MEDICARE SUPPLEMENTAL INSURANCE</u>	<u>PERCENTAGE ^{3/} WITH MEDICARE SUPPLEMENTAL INSURANCE</u>
<u>ARMY</u>							
Eisenhower AMC ^{4/}							
Tripler AMC	153	66	87	28	28	0	.00
Madigan AMC	134	60	74	32	32	2	6.25
Fitzsimons AMC	130	46	84	36	36	6	16.67
Walter Reed AMC	173	0	173	103	103	18	17.48
Letterman AMC	164	0	164	85	85	17	20.00
Wm. Beaumont AMC	130	0	130	41	41	2	4.88
Brooke AMC	171	0	171	97	97	6	6.19
<u>NAVY</u>							
Oakland	134	0	134	56	56	9	16.07
Portsmouth	130	0	130	55	55	8	14.55
Camp Pendleton	142	98	44	17	17	3	17.65
San Diego	134	0	134	49	49	8	16.33
Jacksonville	133	0	133	39	39	2	5.13
Newport	142	0	142	66	66	10	15.15
Great Lakes	135	0	135	44	44	3	6.82
Bethesda	132	0	132	70	70	9	12.86
<u>AIR FORCE</u>							
Tinker AFB	130	40	90	29	29	2	6.90
Lackland AFB	130	72	58	24	24	2	8.33
Williams AFB	130	43	87	28	28	2	7.14
Travis AFB	130	102	28	11	11	1	9.09
Homestead AFB	130	73	57	14	14	1	7.14
Edwards AFB	130	48	82	23	23	1	4.35
Mather AFB	130	45	85	30	30	2	6.67
Fairchild AFB	130	72	58	21	21	2	9.52
Pease AFB	130	0	130	54	54	5	9.26
TOTAL	3,307	765	2,542	1,052	1,052	121	11.50

^{1/} Army Medical Centers (AMCs) are listed by name, Naval hospitals are listed by name and location, and Air Force hospitals are listed by Air Force base (AFB).

^{2/} This figure does not include inpatients with signed insurance statements because the statements did not identify Medicare Supplemental Insurance coverage.

^{3/} This percentage is the number of inpatients with Medicare Supplemental Insurance coverage divided by the total known coverage.

^{4/} We did not send a questionnaire to inpatients treated at Eisenhower AMC.

SUMMARY OF PERCENTAGES COLLECTED BY SAMPLED HOSPITALS (FY 1988)

<u>HOSPITAL * OR LOCATION</u>	<u>TOTAL INPATIENTS</u>	<u>TOTAL PROGRAM CLAIMS</u>	<u>TOTAL PROGRAM COLLECTIONS</u>	<u>TOTAL AMOUNT CLAIMED</u>	<u>AMOUNT CLAIMED FOR COLLECTIONS</u>	<u>AMOUNT COLLECTED</u>	<u>PERCENTAGE COLLECTED</u>
<u>ARMY</u>							
Eisenhower AMC	10,198	1,076	949	\$ 2,408,390	\$2,151,333	\$1,732,442	80.53
Tripler AMC	16,565	420	224	1,068,666	554,495	439,925	79.34
Madigan AMC	17,256	336	212	660,883	406,307	343,326	84.50
Fitzsimons AMC	11,514	241	132	692,315	392,019	323,261	82.46
Walter Reed AMC	18,093	151	81	431,128	240,999	213,584	88.62
Letterman AMC	9,249	71	10	238,038	18,640	6,808	36.52
Wm. Beaumont AMC	16,665	42	14	140,218	58,716	46,798	79.70
Brooke AMC	15,931	0	0	0	0	0	.00
<u>NAVY</u>							
Oakland	8,853	258	203	433,176	307,488	274,644	89.32
Portsmouth	12,532	190	120	431,348	277,127	247,273	89.23
Camp Pendleton	4,592	58	40	118,189	89,372	73,100	81.79
San Diego	13,034	200	110	477,111	241,806	201,620	83.38
Jacksonville	5,984	95	33	166,532	46,600	34,599	74.25
Newport	736	17	4	47,066	7,456	7,081	94.97
Great Lakes	1,992	10	9	9,786	7,922	6,833	86.25
Bethesda	9,745	46	7	220,007	24,698	17,342	70.22
<u>AIR FORCE</u>							
Tinker AFB	2,455	90	75	159,932	145,486	117,629	80.85
Lackland AFB	18,551	605	357	2,700,605	1,635,503	1,161,005	70.99
Williams AFB	1,028	45	19	51,538	22,382	10,634	47.51
Travis AFB	7,453	238	121	758,100	313,148	263,406	84.12
Homestead AFB	2,811	42	27	85,279	58,251	48,827	83.82
Edwards AFB	1,094	12	8	20,812	15,220	12,183	80.05
Mather AFB	3,459	63	14	122,558	18,640	13,362	71.68
Fairchild AFB	2,408	7	1	7,837	916	438	47.82
Pease AFB	1,720	0	0	0	0	0	.00
TOTAL	213,918	4,313	2,770	\$11,449,514	\$7,034,524	\$5,596,120	79.55

* Army Medical Centers (AMC's) are listed by name, Naval hospitals are listed by name and location, and Air Force hospitals are listed by Air Force base (AFB).

SUMMARY OF PERCENTAGES COLLECTED BY SAMPLED HOSPITALS (FIRST QUARTER FY 1989)

<u>HOSPITAL * OR LOCATION</u>	<u>TOTAL INPATIENTS</u>	<u>TOTAL PROGRAM CLAIMS</u>	<u>TOTAL PROGRAM COLLECTIONS</u>	<u>TOTAL AMOUNT CLAIMED</u>	<u>AMOUNT CLAIMED FOR COLLECTIONS</u>	<u>AMOUNT COLLECTED</u>	<u>PERCENTAGE COLLECTED</u>
<u>ARMY</u>							
Eisenhower AMC	2,549	285	249	\$ 671,914	\$ 570,220	\$ 428,267	75.11
Tripler AMC	4,141	63	23	187,894	91,166	67,659	74.22
Madigan AMC	4,314	62	43	170,402	99,760	92,488	92.71
Fitzsimons AMC	2,878	100	53	378,731	189,646	167,434	88.29
Walter Reed AMC	4,523	14	8	27,552	20,664	17,171	83.10
Letterman AMC	2,312	15	2	39,656	4,194	2,728	65.05
Wm. Beaumont AMC	4,166	9	4	19,760	6,916	6,333	91.57
Brooke AMC	3,983	30	4	60,762	6,916	5,773	83.47
<u>NAVY</u>							
Oakland	2,213	77	58	175,243	136,647	115,725	84.69
Portsmouth	3,133	3	1	6,058	3,262	3,162	96.93
Camp Pendleton	1,148	14	13	27,170	24,700	20,434	82.73
San Diego	3,259	35	9	58,622	14,740	12,139	82.35
Jacksonville	1,496	8	3	14,018	5,704	5,479	96.06
Newport	184	8	1	7,904	988	988	100.00
Great Lakes	498	0	0	0	0	0	.00
Bethesda	2,436	8	2	25,752	8,854	8,192	92.52
<u>AIR FORCE</u>							
Tinker AFB	614	29	17	56,850	27,664	20,083	72.60
Lackland AFB	4,638	93	56	483,128	205,444	162,841	79.26
Williams AFB	257	14	7	16,302	9,880	7,020	71.05
Travis AFB	1,863	32	9	90,206	22,724	20,995	92.39
Homestead AFB	703	2	2	6,916	6,916	6,181	89.37
Edwards AFB	274	15	10	31,122	24,206	22,759	94.02
Mather AFB	865	3	1	5,928	2,964	2,727	92.00
Fairchild AFB	602	1	1	972	972	300	30.86
Pease AFB	430	0	0	0	0	0	.00
TOTAL	53,479	920	576	\$2,562,862	\$1,485,147	\$1,196,878	80.59

* Army Medical Centers (AMC's) are listed by name, Naval hospitals are listed by name and location, and Air Force hospitals are listed by Air Force base (AFB).

**PROJECTED PROGRAM COLLECTIONS,
ARMY THIRD PARTY COLLECTION PROGRAM (FY 1988)**

<u>ARMY *</u> <u>HOSPITALS</u>	<u>TOTAL</u> <u>INPATIENTS</u>	<u>INSURANCE</u> <u>COVERAGE</u> <u>(PERCENTAGE)</u>	<u>PROJECTED</u> <u>INPATIENTS'</u> <u>INSURANCE</u> <u>COVERAGE</u>	<u>INSURANCE</u> <u>BILLING</u> <u>RATE</u>	<u>AVERAGE</u> <u>BED</u> <u>DAYS</u>	<u>COLLECTIONS</u> <u>AT 100</u> <u>PERCENT</u>	<u>PROJECTED</u> <u>COLLECTIONS</u> <u>AT 80 PERCENT</u>
Walter Reed AMC, DC	18,093	7.69	1,391	\$466	8.13	\$ 5,271,247	\$ 4,216,998
Madigan AMC, WA	17,256	7.69	1,327	466	4.63	2,863,079	2,290,463
Wm. Beaumont AMC, TX	16,665	7.69	1,282	466	4.40	2,627,667	2,102,133
Tripler AMC, HI	16,565	7.69	1,274	466	4.62	2,742,494	2,193,995
Brooke AMC, TX	15,931	7.69	1,225	466	6.91	3,944,876	3,155,901
Fitzsimons AMC, CO	11,514	7.69	885	466	7.44	3,069,809	2,455,848
Fort Bragg, NC	11,029	7.69	848	466	3.80	1,501,869	1,201,495
Fort Hood, TX	10,882	7.69	837	466	3.27	1,275,172	1,020,138
Eisenhower AMC, GA	10,198	7.69	784	466	5.50	2,009,972	1,607,977
Letterman AMC, CA	9,249	7.69	711	466	6.90	2,286,947	1,829,558
Fort Ord, CA	7,490	7.69	576	466	3.60	966,266	773,013
Fort Benning, GA	7,188	7.69	553	466	3.77	971,095	776,876
Fort Campbell, KY	6,665	7.69	513	466	3.38	807,289	645,831
Fort Belvoir, VA	6,174	7.69	475	466	3.20	707,993	566,394
Fort Sill, OK	6,039	7.69	464	466	3.78	818,030	654,424
Fort Carson, CO	5,407	7.69	416	466	3.62	701,418	561,135
Fort Knox, KY	5,252	7.69	404	466	3.90	734,009	587,207
Fort Riley, KS	5,093	7.69	392	466	3.50	638,784	511,027
Fort Polk, LA	4,974	7.69	383	466	3.13	557,908	446,326
Fort Leonard Wood, MO	4,372	7.69	336	466	3.52	551,487	441,189
Fort Stewart, GA	4,244	7.69	326	466	3.34	507,965	406,372
Fort Jackson, SC	3,675	7.69	283	466	5.34	703,252	562,601
Fort Rucker, AL	2,860	7.69	220	466	3.38	346,414	277,131
Fort Huachuca, AZ	2,668	7.69	205	466	3.60	344,192	275,353
Fort Wainwright, AK	2,277	7.69	175	466	2.90	236,632	189,306
Fort Eustis, VA	2,191	7.69	168	466	3.64	285,796	228,637
Fort McClellan, AL	1,992	7.69	153	466	3.75	267,690	214,152
Fort Meade, MD	1,976	7.69	152	466	2.52	178,443	142,754
Fort Leavenworth, KS	1,912	7.69	147	466	3.12	213,774	171,019
Fort Dix, NJ	1,703	7.69	131	466	3.91	238,618	190,895
West Point, NY	1,691	7.69	130	466	3.54	214,516	171,613
Fort Lee, VA	1,374	7.69	106	466	4.32	212,707	170,166
Redstone Arsenal, AL	1,206	7.69	93	466	4.12	178,056	142,445
Fort Devens, MA	1,052	7.69	81	466	4.07	153,434	122,747
Fort Irwin, CA	880	7.69	68	466	2.29	72,215	57,772
Fort Monmouth, NJ	827	7.69	64	466	3.87	114,691	91,753
Fort Harrison, IN	320	7.69	25	466	2.56	29,356	23,485
TOTAL	228,884		17,601			\$39,345,163	\$31,476,130

* Army Medical Centers (AMC's) are listed by name; other Army hospitals are listed by location.

**PROJECTED PROGRAM COLLECTIONS,
NAVY THIRD PARTY COLLECTION PROGRAM (FY 1988)**

<u>NAVAL * HOSPITALS</u>	<u>TOTAL INPATIENTS</u>	<u>INSURANCE COVERAGE (PERCENTAGE)</u>	<u>PROJECTED INPATIENTS' INSURANCE COVERAGE</u>	<u>INSURANCE BILLING RATE</u>	<u>AVERAGE BED DAYS</u>	<u>COLLECTIONS AT 100 PERCENT</u>	<u>PROJECTED COLLECTIONS AT 80 PERCENT</u>
San Diego, CA	13,034	7.69	1,002	\$466	5.0	\$ 2,312,039	\$ 1,849,631
Portsmouth, VA	12,532	7.69	964	466	4.5	2,016,411	1,613,129
Bethesda, MD	9,745	7.69	749	466	6.5	2,283,872	1,827,098
Oakland, CA	8,853	7.69	681	466	4.4	1,402,249	1,121,799
Jacksonville, FL	5,984	7.69	460	466	3.6	763,403	610,722
Charleston, SC	5,695	7.69	438	466	3.7	761,228	608,982
Camp Pendleton, CA	4,592	7.69	353	466	5.3	863,920	691,136
Camp Lejeune, NC	3,388	7.69	261	466	3.4	415,223	332,179
Pensacola, FL	3,211	7.69	247	466	2.9	329,093	263,274
Bremerton, WA	3,143	7.69	242	466	3.9	433,628	346,902
Orlando, FL	2,484	7.69	191	466	3.8	336,477	269,182
Cherry Point, NC	2,466	7.69	190	466	2.6	231,530	185,224
Great Lakes, IL	1,992	7.69	153	466	3.5	246,989	197,591
Millington, TN	1,979	7.69	152	466	3.0	209,209	167,367
Twentynine Palms, CA	1,646	7.69	127	466	2.5	147,463	117,970
Beaufort, SC	1,509	7.69	116	466	3.4	185,479	148,383
Lemoore, CA	1,417	7.69	109	466	2.9	146,243	116,994
Oak Harbor, WA	1,405	7.69	108	466	2.4	118,823	95,058
Groton, CT	1,249	7.69	96	466	3.1	136,961	109,569
Corpus Christi, TX	974	7.69	75	466	3.7	127,398	101,919
Patuxent River, MD	738	7.69	57	466	2.7	70,348	56,278
Newport, RI	736	7.69	57	466	3.5	92,048	73,639
Philadelphia, PA	618	7.69	48	466	3.0	67,103	53,683
Long Beach, CA	530	7.69	41	466	4.7	88,696	70,957
Adak, AK	337	7.69	26	466	2.7	32,124	25,699
TOTAL	90,257		6,941			\$13,817,957	\$11,054,365

* Naval hospitals are listed by name and location.

**PROJECTED PROGRAM COLLECTIONS,
AIR FORCE THIRD PARTY COLLECTION PROGRAM (FY 1988)**

AIR FORCE * HOSPITALS	TOTAL INPATIENTS	INSURANCE COVERAGE (PERCENTAGE)	PROJECTED INPATIENTS' INSURANCE COVERAGE	INSURANCE BILLING RATE	AVERAGE BED DAYS	COLLECTIONS AT 100 PERCENT	PROJECTED COLLECTIONS AT 80 PERCENT
Lackland AFB, TX	18,551	7.69	1,427	\$466	9.0	\$ 5,983,043	\$ 4,786,434
Kessler AFB, MS	9,070	7.69	697	466	7.1	2,307,692	1,846,154
Andrews AFB, MD	7,517	7.69	578	466	6.0	1,616,248	1,292,999
Travis AFB, CA	7,453	7.69	573	466	6.4	1,709,320	1,367,456
Eglin AFB, FL	6,692	7.69	515	466	3.9	935,261	748,209
Wright-Patterson AFB, OH	6,526	7.69	502	466	5.7	1,333,012	1,066,410
Scott AFB, IL	6,157	7.69	473	466	6.1	1,345,895	1,076,716
Carswell AFB, TX	5,029	7.69	387	466	4.8	865,038	692,030
Langley AFB, VA	4,468	7.69	344	466	3.9	624,439	499,551
Offutt AFB, NE	4,152	7.69	319	466	3.7	550,518	440,414
MacDill AFB, FL	3,986	7.69	307	466	3.8	542,792	434,233
Elmendorf, AK	3,915	7.69	301	466	4.5	631,330	505,064
Mather AFB, CA	3,459	7.69	266	466	4.2	520,610	416,488
March AFB, CA	3,211	7.69	247	466	4.9	563,831	451,064
USAF Academy, CO	3,103	7.69	239	466	4.0	444,789	355,831
Luke AFB, AZ	2,914	7.69	224	466	3.9	407,255	325,804
Homestead AFB, FL	2,811	7.69	216	466	4.0	402,933	322,347
Maxwell AFB, AL	2,704	7.69	208	466	4.8	465,115	372,092
Ellsworth AFB, SD	2,687	7.69	207	466	2.6	250,353	200,283
Davis-Monthan AFB, AZ	2,660	7.69	205	466	3.8	362,224	289,779
Dyess AFB, TX	2,627	7.69	202	466	3.1	291,833	233,466
Barksdale AFB, LA	2,626	7.69	202	466	4.2	395,236	316,189
Sheppard AFB, TX	2,622	7.69	202	466	4.8	451,010	360,808
Tinker AFB, OK	2,455	7.69	189	466	3.3	290,320	232,256
Fairchild AFB, WA	2,408	7.69	185	466	3.2	276,133	220,907
Hill AFB, UT	2,096	7.69	161	466	3.3	247,866	198,293
Nellis AFB, NV	2,079	7.69	160	466	3.3	245,856	196,685
Shaw AFB, SC	1,964	7.69	151	466	3.8	267,447	213,957
Kirtland AFB, NM	1,827	7.69	140	466	3.6	235,697	188,557
F. E. Warren AFB, WY	1,800	7.69	138	466	2.9	187,061	149,649
Castle AFB, CA	1,755	7.69	135	466	3.4	213,830	171,064
Minot AFB, ND	1,726	7.69	133	466	3.5	216,482	173,185
Pease AFB, NH	1,720	7.69	132	466	4.1	252,711	202,169
Tyndall AFB, FL	1,643	7.69	126	466	4.0	235,510	188,408
Dover AFB, DE	1,576	7.69	121	466	3.2	180,725	144,580
Robins AFB, GA	1,505	7.69	116	466	4.1	221,122	176,898
George AFB, CA	1,473	7.69	113	466	3.1	163,635	130,908
Mountain Home AFB, ID	1,433	7.69	110	466	3.1	159,192	127,353
Cannon AFB, NM	1,398	7.69	108	466	3.9	195,382	156,305
Moody AFB, GA	1,381	7.69	106	466	3.5	173,210	138,568
Grand Forks AFB, ND	1,378	7.69	106	466	2.8	138,267	110,614
Seymour Johnson AFB, NC	1,364	7.69	105	466	3.2	156,414	125,131

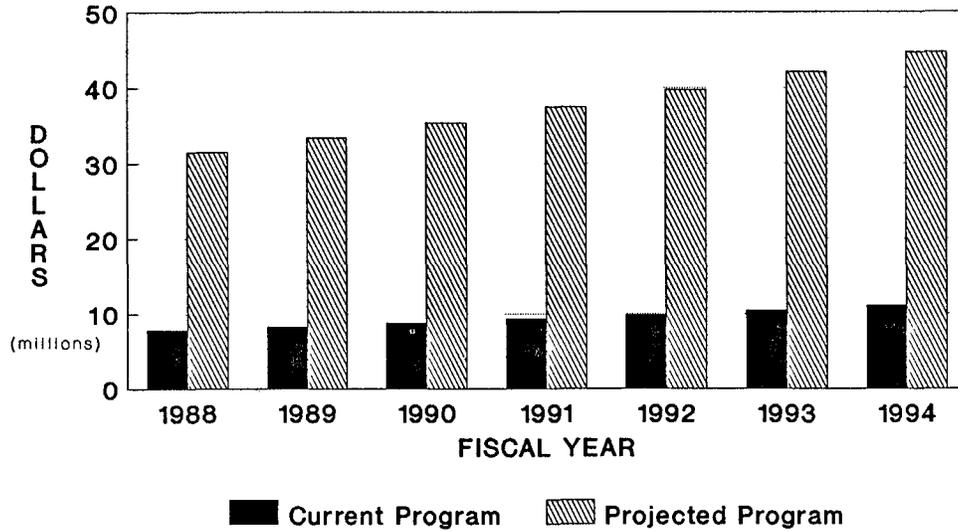
(Air Force hospitals continued on page 52.)

PROJECTED PROGRAM COLLECTIONS
AIR FORCE THIRD PARTY COLLECTION PROGRAM (FY 1988)
(Continued)

AIR FORCE * HOSPITALS	TOTAL INPATIENTS	INSURANCE COVERAGE (PERCENTAGE)	PROJECTED INPATIENTS' INSURANCE COVERAGE	INSURANCE BILLING RATE	AVERAGE BED DAYS	COLLECTIONS AT 100 PERCENT	PROJECTED COLLECTIONS AT 80 PERCENT
Beale AFB, CA	1,360	7.69	105	466	3.1	151,082	120,866
Holloman AFB, NM	1,353	7.69	104	466	3.4	164,850	131,880
Loring AFB, ME	1,290	7.69	99	466	3.3	152,551	122,041
Whiteman AFB, MO	1,277	7.69	98	466	2.5	114,405	91,524
Altus AFB, OK	1,191	7.69	92	466	4.1	174,988	139,990
Blytheville AFB, AR	1,172	7.69	90	466	3.6	151,197	120,957
Griffiss AFB, NY	1,152	7.69	89	466	3.9	161,001	128,801
Wurtsmith AFB, MI	1,141	7.69	88	466	3.0	122,665	98,132
K. I. Sawyer AFB, MI	1,121	7.69	86	466	3.1	124,532	99,625
Vandenberg AFB, CA	1,108	7.69	85	466	4.6	182,646	146,117
Edwards AFB, CA	1,094	7.69	84	466	3.8	148,975	119,180
Bergstrom AFB, TX	1,080	7.69	83	466	4.5	174,160	139,328
Little Rock AFB, AR	1,041	7.69	80	466	3.0	111,914	89,531
Williams AFB, AZ	1,028	7.69	79	466	2.5	92,097	73,678
England AFB, LA	981	7.69	75	466	3.2	112,494	89,996
Chanute AFB, IL	972	7.69	75	466	5.5	191,576	153,261
Laughlin AFB, TX	880	7.69	68	466	3.1	97,759	78,207
Patrick AFB, FL	808	7.69	62	466	3.9	112,925	90,340
Myrtle Beach AFB, SC	637	7.69	49	466	4.4	100,439	80,352
Plattsburgh AFB, NY	516	7.69	40	466	4.1	75,813	60,651
Malmstrom AFB, MT	327	7.69	25	466	2.3	26,952	21,561
Columbus AFB, MS	270	7.69	21	466	3.5	33,864	27,092
Reese AFB, TX	265	7.69	20	466	3.3	31,338	25,070
McConnell AFB, KS	212	7.69	16	466	3.3	25,070	20,056
TOTAL	170,197		13,088			\$29,891,930	\$23,913,544

* Air Force hospitals are listed by Air Force base (AFB).

PROJECTED COLLECTIONS FY 1988 - 1994 ARMY HOSPITALS



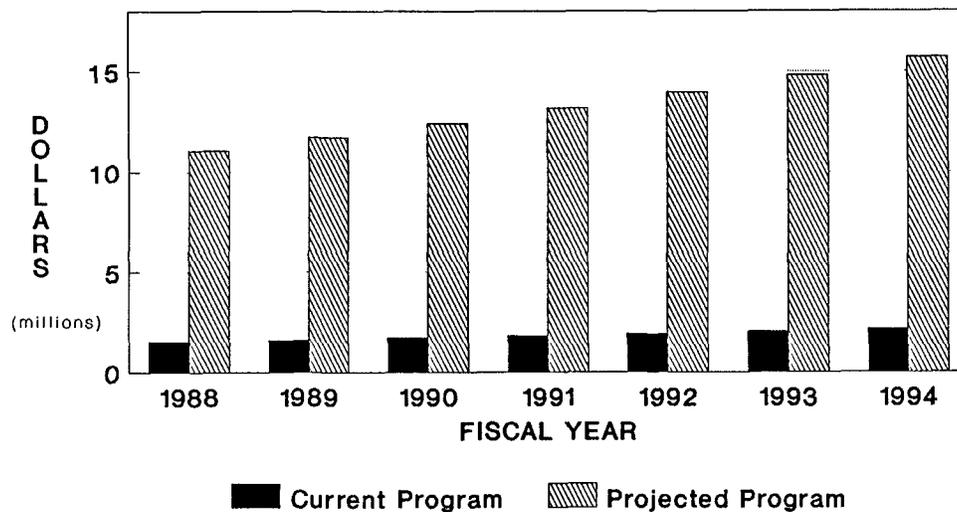
COLLECTIONS ^{1/}

	FY 1988	FY 1989	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994
Current Program	\$ 7,808,448	\$ 8,276,955	\$ 8,773,572	\$ 9,299,987	\$ 9,857,986	\$10,449,465	\$11,076,433
Projected Program	31,476,130	33,364,698	35,366,580	37,488,574	39,737,888	42,122,162	44,649,492
Difference	\$23,667,682	\$25,087,743	\$26,593,008 ^{2/}	\$28,188,587 ^{2/}	\$29,879,902 ^{2/}	\$31,672,697 ^{2/}	\$33,573,059 ^{2/}

^{1/}Current and potential program collections are based on FY 1988 findings and have been increased 6 percent annually to reflect increases in insurance billing rates.

^{2/}The total additional collections for FY's 1990 through 1994 will be \$149,907,253 (\$26,593,008 + \$28,188,587 + \$29,879,902 + \$31,672,697 + \$33,573,059).

PROJECTED COLLECTIONS FY 1988 - 1994 NAVAL HOSPITALS



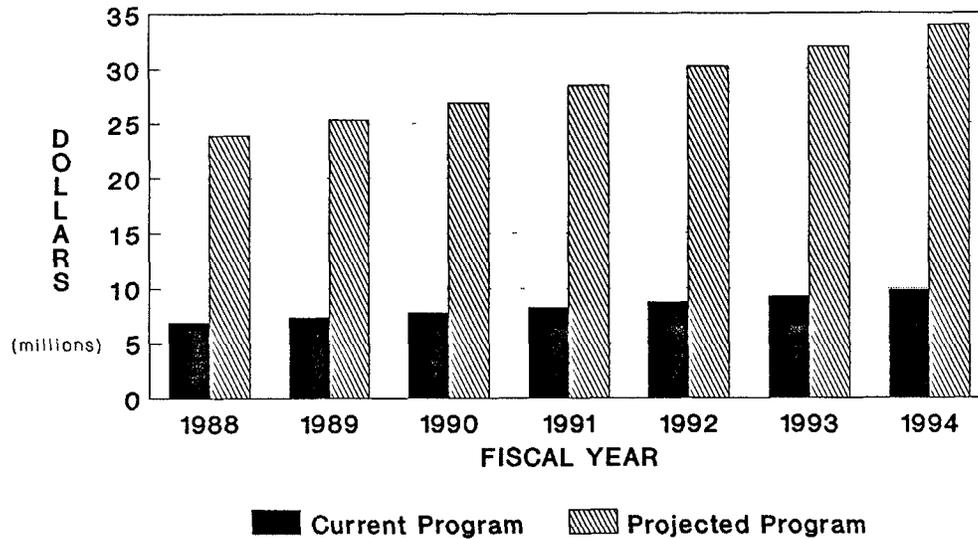
COLLECTIONS ^{1/}

	<u>FY 1988</u>	<u>FY 1989</u>	<u>FY 1990</u>	<u>FY 1991</u>	<u>FY 1992</u>	<u>FY 1993</u>	<u>FY 1994</u>
Current Program	\$ 1,511,276	\$1,601,953	\$ 1,698,070	\$ 1,799,954	\$ 1,907,951	\$ 2,022,428	\$ 2,143,774
Projected Program	\$11,054,365	\$11,717,627	\$12,420,685	\$13,165,926	\$13,955,881	\$14,793,234	\$15,680,828
Difference	\$9,543,089	\$10,115,674	\$10,722,615 ^{2/}	\$11,365,972 ^{2/}	\$12,047,930 ^{2/}	\$12,770,806 ^{2/}	\$13,537,054 ^{2/}

^{1/}Current and potential program collections are based on FY 1988 findings and have been increased 6 percent annually to reflect increases in insurance billing rates.

^{2/}The total additional collections for FY's 1990 through 1994 will be \$60,444,377 (\$10,722,615 + \$11,365,972 + \$12,047,930 + \$12,770,806 + \$13,537,054).

PROJECTED COLLECTIONS FY 1988 - 1994 AIR FORCE HOSPITALS



COLLECTIONS ^{1/}

	<u>FY 1988</u>	<u>FY 1989</u>	<u>FY 1990</u>	<u>FY 1991</u>	<u>FY 1992</u>	<u>FY 1993</u>	<u>FY 1994</u>
Current Program	\$ 6,912,272	\$ 7,327,008	\$ 7,766,629	\$ 8,232,626	\$ 8,726,584	\$ 9,250,179	\$ 9,805,190
Projected Program	23,913,544	25,348,357	26,869,258	28,481,413	30,190,298	32,001,716	33,921,819
Difference	\$17,001,272	\$18,021,349	\$19,102,629 ^{2/}	\$20,248,787 ^{2/}	\$21,463,714 ^{2/}	\$22,751,537 ^{2/}	\$24,116,629 ^{2/}

^{1/}Current and potential program collections are based on FY 1988 findings and have been increased 6 percent annually to reflect increases in insurance billing rates.

^{2/}The total additional collections for FY's 1990 through 1994 will be \$107,683,296 (\$19,102,629 + \$20,248,787 + \$21,463,714 + \$22,751,537 + \$24,116,629).

CLARIFICATION OF LEGAL ISSUES



DEPARTMENT OF DEFENSE
OFFICE OF GENERAL COUNSEL
WASHINGTON D C 20301-1600
March 10, 1989

MEMORANDUM FOR HENRY F. KLEINKNECHT, OFFICE OF THE INSPECTOR
GENERAL, DoD

SUBJECT: Coordination of Benefits Payments to Military Hospitals

This is in response to your memorandum of March 3 to Karen M. Yannello of the OGC Fiscal and Inspector General Division requesting an opinion on the legality of a number of objections expressed by some third party payers to requests under 10 U.S.C. § 1095 for payments for inpatient hospital care provided by military hospitals to beneficiaries who also have third party health insurance.

In simple terms, 10 U.S.C. § 1095, enacted as § 2001 of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), Pub. L. 99-272, gives the government the right to collect from health insurance plans for care provided to an insured person by a military hospital to the extent the payer would pay were the services provided by a civilian hospital. The statute has been implemented through DoD Instruction 6010.15, 32 CFR Part 220. Significant difficulties have been encountered in putting into operation an effective system for § 1095 collections. Among these is that some third party payers have asserted certain objections to payment. This memorandum analyzes the legal sufficiency of several such objections.

No obligation to pay or services provided by the government

Two common health plan exclusions are when the enrolled person has no legal obligation to pay and when the care is provided by a governmental entity. These exclusions are not valid under § 1095. The statute establishes the government's right to collect "to the extent that the person would be eligible to receive reimbursement . . . if the person were to incur such costs on the person's own behalf." 10 U.S.C. § 1095(a) (emphasis added). A basic statutory characteristic of the military health services system is that beneficiaries have no obligation to pay (except nominal amounts). Recognizing this, Congress specifically expressed the government's right to collect in terms to make clear that it should be considered as if the beneficiary had an obligation to pay. Thus, the fact that the beneficiary has no actual obligation to pay, a fact that is part of the basic statutory nature of the military system, has been made expressly irrelevant by § 1095.

CLARIFICATION OF LEGAL ISSUES
(Continued)

2

A governmental entity exclusion is similarly invalid. The statute disallows any provision of an insurance agreement "having the effect of excluding from coverage or limiting payment of charges for certain care if that care is provided through a facility of the uniformed services." 10 U.S.C. § 1095(b) (emphasis added). Congress disallowed not only insurance agreement provisions which expressly exclude military facilities, but also provisions which have that effect. An exclusion of government facilities has the effect of excluding military facilities and is expressly disallowed.

Congressional intent regarding the elimination of these exclusions was made even more clear by the legislative history. The House Committee Report stated:

The principal reason that military medical facilities do not presently attempt to collect for the cost of care is that many insurance contracts contain exclusionary clauses. These exclusionary clauses relieve the insurance carrier of liability for payment where the policy holder has no legal obligation to pay or where the care is provided in a government facility, notwithstanding the fact that the insurance carrier would have provided reimbursement for the cost of care for the same individual if that care were provided in a nongovernment hospital. [The legislation] would assert the government's authority to collect for the cost of such care notwithstanding any exclusionary clauses that might be included in the policy.

H. Rept. No. 99-300, 99th Cong., 1st Sess. 8-9.

The same conclusion applies to any similar exclusion expressed in slightly different words, such as that no charge would be made if the person had no health insurance.

Utilization review activities

An increasingly common feature of health plans is the incorporation of mechanisms, adopted in recognition of concerns regarding both costs and quality of care, to avoid unnecessary services. Such utilization review mechanisms include: pre-admission screening, under which hospital admissions must be approved in advance; concurrent review, which encourages timely discharge from the hospital; second surgical opinions, which requires a second medical opinion that surgery is needed; retrospective review, which involves examining medical records after the fact for verification of necessity; and other activities. These mechanisms typically include some payment consequences, such as a total or partial denial of a claim, for deviations from the specified requirements.

CLARIFICATION OF LEGAL ISSUES
(Continued)

3

The statute does not disallow reasonable utilization review activities. As noted above, the government's right to collect is "to the extent that" payment would be made if the care had been provided in a nongovernment facility. The legislative history elaborated on this notion in the context of utilization review activities:

The right to collect could be asserted only to the extent that the benefit were covered by the insurance plan and would be subject to the terms and conditions of the plan. . . . [T]o the extent that insurance plans have conditions that require, for example, pre-admission screening and second opinions before surgery, the Department of Defense would be expected to comply in order to collect under those contracts.

H. Rept. 99-300, supra, at 9.

This legislative intent also comes through in one of the provisions of the statute. As provided by § 1095(c), appropriate records of military hospitals "shall be made available for inspection and review by representatives of the payer." The legislative history concerning this provision begins to reveal a broader theme regarding allowable preconditions to payment:

The private sector has made great strides in recent years in the area of medical care cost containment and been at the forefront of innovative ways to moderate the rapidly escalating cost of medical care. As a part of that cost containment effort, third-party payers routinely audit provider records for appropriateness of care, length of stay and similar utilization indicators. Third-party payers would, therefore, be afforded a similar opportunity to inspect and review military medical treatment facility records for those cases for which collection is sought.

H. Rept. No. 99-300, supra, at 10. Thus, rather than looking at utilization review activities as some sort of excuse not to pay, the legislative history shows Congressional approval of these cost containment activities and a desire for the military facilities to honor them.

This point of view was further underscored in the Conference Report on the legislation. The Report said the military facility's charges should never exceed the prevailing rate that the third party payer would otherwise pay. The Report further stated:

CLARIFICATION OF LEGAL ISSUES
(Continued)

4

The conferees want to ensure that Department of Defense collection practices are consistent with and do not impede cost containment initiatives undertaken by the private sector.

H. Conf. Rept. No. 99-453, 99th Cong., 1st Sess. 394.

In view of the statutory requirement to permit review of military facility medical records and the legislative intent to accommodate innovative private sector utilization review activities, it is the opinion of this office that a third party payer may, consistent with § 1095, require military facilities to honor reasonable utilization review activities generally required in its health plan.

Participating provider agreement

Some third party payers have asserted as a precondition to any payments under § 1095 the establishment of a participating provider agreement with each military hospital that will submit claims for payment. The statute and legislative history do not specifically address this issue, but they do, based on the above discussion, permit some generalizations to guide analysis on this issue. The basic generalization that comes through is a distinction between general preconditions that are contrary to the basic nature of military facilities or which would defeat the broad purpose of the statute, which are disallowed, and specific utilization review activities of the third party payer, which are allowed.

Because some potential provisions of an intended agreement might fall on the allowable side of the line drawn by this distinction, it cannot be said that all agreements are necessarily improper. However, several things can be said. One is that the assertion of a requirement that a military facility sign the same participating provider agreement the third party payer requires of nongovernment facilities is not valid under § 1095. This statutory interpretation is clearly established in the Department's regulation:

Participating hospital agreements are premised on compliance with State and local laws and regulations by a State nonprofit health care corporation. Since Federal entities are governed by Federal statutes and regulations, DoD medical treatment facilities should not enter into local participating hospital agreements.

32 CFR § 220.4(c). This provision is consistent with the concept, clearly rooted in the statute, that third party payers may not assert objections or preconditions contrary to the basic nature of military facilities.

CLARIFICATION OF LEGAL ISSUES
(Continued)

5

Similarly, standing alone, refusal to pay because of some generalized insistence on the pre-establishment of a written agreement is not allowed under § 1095. The basic rights and responsibilities of the parties are sufficiently set forth in the statute and regulation that technical insistence on a signed agreement before the payer will consider processing claims would not, without something much more concrete behind it, appear in keeping with the basic statutory purpose of § 1095.

However, as noted above, third party payers may follow their normal utilization review and similar cost containment rules. Special agreements between military facilities and third party payers spelling out procedures to facilitate payments in accordance with § 1095 are not disallowed by the statute or regulation. Rather, the operative notion should be to focus on what terms and conditions the third party payer is attempting to have the military facility accept. If those are valid under § 1095, then the payer has a right to apply them. In that context, an agreement between the parties as to efficient procedures should be looked at as a matter of reasonable administrative process.

Conclusions

To recap, our conclusions regarding the application of § 1095 are:

1. General objections based on the patient having no duty to pay, the care being provided by a government entity or similar exclusions are not valid.

2. Third party payers may apply their generally applicable utilization review activities.

3. Military facilities may not be required to sign the same participating provider agreements normally required of nongovernment hospitals. Nor may third party payers refuse to consider § 1095 claims based solely on the technical absence of a signed agreement. However, agreements as to procedures for the effective handling of § 1095 claims are allowed and probably desirable.

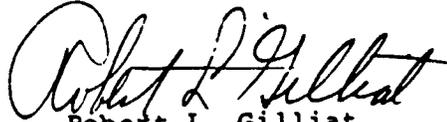
4. As a general rule, any objection or precondition that defeats the broad statutory purpose of collecting from third party payers or is contrary to the basic nature of military facilities would not be valid under § 1095.

5. As a general rule, the application of procedural requirements necessary and proper to the operation of permissible utilization review activities would be allowed.

CLARIFICATION OF LEGAL ISSUES
(Continued)

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I hope you will find this memorandum responsive to your request. If you have any further questions, please feel free to contact John Casciotti of this office (5-1078).



Robert L. Gilliat
Assistant General Counsel
(Personnel & Health Policy)

CLARIFICATION OF LEGAL ISSUES
(Continued)



DEPARTMENT OF DEFENSE
OFFICE OF GENERAL COUNSEL
WASHINGTON DC 20301 1600
October 3, 1989

MEMORANDUM FOR HENRY F. KLEINKNECHT, PROJECT MANAGER, FINANCIAL
MANAGEMENT DIRECTOR, OFFICE OF INSPECTOR GENERAL,
DEPARTMENT OF DEFENSE

THROUGH: Karen M. Yannello, Senior Attorney, OAGC(F&IG)

SUBJECT: Coordination of Benefits Program Under 10 U.S.C. § 1095

This is in response to your memorandum of September 15, 1989, in which you presented eleven questions arising from your continuing review of the coordination of benefits program under 10 U.S.C. § 1095, and DoD Instruction 6010.15, "Coordination of Benefits." These issues are addressed in turn.

1. Medicare supplemental insurance policies.

The issue is whether § 1095 authorizes collections by the U.S. government from third party payers under Medicare supplemental insurance policies. These are private sector health insurance policies available for purchase by individuals covered by the Medicare program and designed to pay for certain expenses, such as the applicable beneficiary deductibles and copayments, not paid by the Medicare program. Notwithstanding that § 1095 does not apply to Medicare, your question is whether, for care provided in a military hospital, DoD can collect from a Medicare supplemental insurer the same amount the insurer would have had to pay had the same care been provided in a non-federal hospital.

Nothing in the statute or legislative history provides a clear answer to this question. However, applying the general rule of § 1095 to this situation suggests that § 1095 recovery does not apply to Medicare supplemental insurance policies. That general rule is that DoD's authority to recover from the third party payer is "to the extent" that the third party payer's program covers the health care services provided. 10 U.S.C. § 1095(a)(1). Although third party payer programs may not have provisions that "have the effect of excluding" care provided in military hospitals, 10 U.S.C. § 1095(b), the government's right to collect is generally "subject to the terms and conditions of the plan." H. Rept. 300, 99th Cong., 1st Sess. 9.

CLARIFICATION OF LEGAL ISSUES
(Continued)

It is our view that the most defensible legal analysis would consider as an essential element of a Medicare supplemental insurance plan the term and condition that its coverage is secondary to that of Medicare. By its nature as a supplemental insurance plan, it defines itself and likely its coverages, limitation, terms and conditions as functions of the underlying Medicare program to which it is a supplement. To attempt to deal with a Medicare supplemental insurance policy as freestanding and independent of Medicare, we believe, would stray from the intended scope of § 1095. Thus, although not free from doubt, we interpret § 1095, which does not authorize recovery from Medicare, as also not authorizing recovery from Medicare supplemental insurance carriers.

2. CHAMPUS supplemental insurance policies.

The question is whether § 1095 collections may be made from a CHAMPUS supplemental insurance policy up to the amount the policy would have paid had the care been provided in a non-federal facility. Analogous to the discussion above regarding Medicare supplemental insurance, we believe that to attempt to deal with a CHAMPUS supplemental insurance policy as freestanding and independent of CHAMPUS would stray from the intended scope of § 1095. One of the basic attributes of CHAMPUS is that Congress intended that it be secondary to military hospitals, as evidenced by the nonavailability statement requirements built on 10 U.S.C. § 1079(a)(7). CHAMPUS supplemental policies are intended, in turn, to be secondary to CHAMPUS. To hold these supplemental policies liable for care provided in military hospitals would be a fundamental change in the nature of the policies. Consistent with the statutory intent that § 1095 collections be "subject to the terms and conditions of the plan," we interpret § 1095 as inapplicable to CHAMPUS supplemental insurance policies.

3. HMO plans.

The question is whether § 1095 is applicable to a health maintenance organization (HMO) plan. Again, the general rule of § 1095 is that DoD can collect to the extent the third party payer would pay if the patient were to incur such costs personally. The legislative history of § 1095 indicates how this general rule applies in the context of an HMO plan. The House Committee Report states:

. . . [P]rivate insurers would not be liable for services that are not covered by their policies. Similarly, in recognition of the unique nature of health maintenance organizations, collection from a health maintenance organization of the reasonable cost of care

CLARIFICATION OF LEGAL ISSUES

(Continued)

provided at military medical facilities would be undertaken only when the care is covered emergency care as defined in the health maintenance organization's contract.

H. Rept. 300, supra at 10.

It is our interpretation of § 1095 that it authorizes collections from HMO plans only to the extent those HMO plans generally cover services (e.g., emergencies) provided by health care facilities not affiliated with the HMO. This interpretation applies whether the HMO's make up is in the nature of a single site facility or an individual practice association with many sites of care.

4. Newborn infants.

Your question is whether there is any legal reason for military hospitals treating newborn infants differently than other patients for purposes of the coordination of benefits program. From a legal standpoint, particular categories of patients should not be treated differently solely for coordination of benefits purposes. Rather, coordination of benefits practices should follow normal hospital operations.

Applying this notion to newborn infants, however, is a little tricky because newborns are treated somewhat differently than other patients in certain contexts. For example, under CHAMPUS, a newborn is not counted as a separate patient for purposes of calculating the beneficiary's copayment amount unless the newborn remains in the hospital after the mother is discharged. DoD Directive 6010.8-R, para. 4.F.2.b(3). This, provision, however, relates only to beneficiary copayments; it does not merge the mother's and child's hospitalizations for purposes of provider billings and payments. It is our understanding the military hospitals have an analogous practice of counting newborns separately for the purpose of not collecting a separate subsistence charge, but they are counted for purposes of measuring overall workload of the hospital. We presume that hospitalizations and days of hospital care relating to newborn infants are included in the formulas that produce the per diem amounts that are used for purposes of billing paying patients and third parties. In other words, if our understandings are correct, the only special treatment of newborns relates to the calculation of the copayments; a dependent mother need not pay a second copayment for the baby. In all other respects, newborn infants are like any other patients.

In view of this, it is our conclusion that there is no reason based on any legal rationale for hospitals not including

CLARIFICATION OF LEGAL ISSUES
(Continued)

newborn infants in the coordination of benefits program. Thus, in the usual inpatient delivery case, claims under the coordination of benefits program would be made relating to the hospital care provided both the mother and baby.

5. Authorization of assignment.

Your question is whether the military hospital must obtain a signed assignment of benefits form from the patient before billing the third party payer. It is our view that as a strictly legal matter, the right of the United States to collect pursuant to § 1095 is not dependent upon any action by the beneficiary in support of the government's claim. Thus, as a strictly legal matter, we would answer your question in the negative.

However, as a practical matter, putting in place a standard procedure of seeking a signed assignment of benefits form might facilitate collections by documenting, in a manner with which the third party payer is familiar, that the patient received the care and that the claim from the military hospital is the one and only claim the third party payer will receive for all that is covered by the claim. In addition, if military hospitals adopt the change implied in your question #11 and defer collection of subsistence charges for beneficiaries who have other primary insurance, assignment of benefits could be required as a condition of deferring collection of subsistence charges. Again, this presumably would facilitate processing by the third party payer by documenting that payment of the military hospital's claim will satisfy all obligations arising from that hospitalization.

6. Release of information.

Your question is whether military hospitals are legally required to obtain written authorization from the patient to release information about the hospitalization to the third party payer. The answer is that under the Privacy Act, 5 U.S.C. § 552a, and DoD's implementing regulation; see 32 CFR § 286a.41(e), no specific release authorization by the patient is needed if the release of information from medical records for the purpose of the coordination of benefits program is established as a "routine use" in the appropriate published system of records notice. Such a routine use would be quite appropriate in view of the specific statutory requirement that third party payers have access to information about the hospitalization regarding which the claim is being made. 10 U.S.C. § 1095(c).

7. Require patients to disclose other health insurance.

CLARIFICATION OF LEGAL ISSUES
(Continued)

Your question is whether military hospitals may require, presumably as a precondition to nonemergency hospital admissions, patients to disclose whether they have other health insurance coverage and to identify the applicable third party payer. It is our view that the Department of Defense has the legal authority to establish such a requirement as a reasonable and appropriate method of carrying out the coordination of benefits program under 10 U.S.C. § 1095.

8. One form.

Your question is whether there would be any legal problem in establishing a single form to accomplish the several functions mentioned above: assignment of benefits, authorized release of information and disclosure of other health insurance. Assuming that program officials follow applicable forms approval procedures, we see no legal problem in handling these tasks through a consolidated DoD form.

9. Erroneous payments to patients.

Your question is what should be DoD's position with respect to situations in which the third party payer made payment to the patient rather than to the government in connection with care covered by § 1095. The statute says "the United States shall have the right to collect from a third party payer" 10 U.S.C. § 1079(a)(1). It is our view that a third party payer's obligation under this section is not satisfied by the third party payer paying the patient. Not only would payment to the patient not satisfy § 1095, it is also very doubtful that any valid claim (above and beyond reimbursement for the subsistence charge) could be made by the patient to the third party payer. Typically, an insured person can only be reimbursed by the insurer for expenses actually incurred; a patient who did not pay for the health care services would not be entitled to reimbursement from the third party payer.

Thus, payments from the third party payer to the patient (above and beyond any payment by the patient of the military hospital subsistence charge) would not be appropriate under § 1095 and would probably also not be appropriate under the third party payer's policy or program. The latter issue, of course, would be between the third party payer and the patient. As far as DoD's posture is concerned, it is that: payment to the patient does not satisfy § 1095; the § 1095 claim must be paid by the third party payer to DoD; DoD has no responsibility to, and should not attempt to, collect from a patient the money erroneously paid to him or her by the third party payer; it is up to the third party payer to resolve any issue regarding a refund from its beneficiary of any erroneous payments.

CLARIFICATION OF LEGAL ISSUES
(Continued)

10. Collection of delinquent accounts.

Your question relates to the proper procedures for military hospitals to effect collections of claims which third party payers, without valid reason, fail to pay. The answer is that established DoD procedures for collecting delinquent accounts should be followed. Those procedures, which include mechanisms to take offsets against any amounts that might be owed by the government to the third party payer whose account is delinquent, to refer delinquent claims to designated collection agencies and to take legal action to enforce the government's right to collect, are already in place under the auspices of the various accounting and finance systems throughout the military services. They are governed by DoD Directive 7045.13, "DoD Credit Management and Debt Collection Program" and DoD Instruction 7045.18, "Collection of Indebtedness Due the United States," and are under the policy direction of the Assistant Secretary of Defense (Comptroller). From the standpoint of the medical system, the approach should be to, first, validate that the claim is proper and delinquent, and second, refer the matter to the appropriate accounting and finance office for processing under applicable delinquent claims procedures.

11. Double billing for subsistence charges.

You note that currently, military hospitals bill third party payers the full daily rate for care provided, notwithstanding that a small portion of that amount per day, represented by the subsistence charge, has already been collected from the patient (the same as it is for patients without other primary insurance). Your question is whether this double billing is legally appropriate. It is our view that this double billing is of very dubious legal defensibility and should be discontinued.

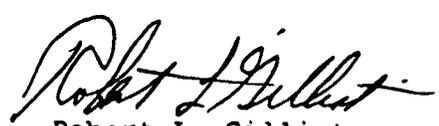
Section 1095 allows DoD to collect "the reasonable costs of inpatient hospital care incurred by the United States." The published daily billing rate is precisely that. But to the extent some amount has already been collected, that amount can no longer be considered a cost "incurred by the United States." Subsistence charges under 10 U.S.C. § 1075 or § 1078 must be considered as representing costs that are also incorporated into the daily billing rate. Thus, we conclude that these charges can not be collected twice.

One legally appropriate option for resolving this, consistent with part of the apparent intent behind questions 5 and 9, above, to reduce confusion about who pays for what, would be for military hospitals to defer collection of subsistence charges from patients who indicate that they have

CLARIFICATION OF LEGAL ISSUES
(Continued)

other primary insurance. The full amount can then be collected from the third party payer. In any case in which it later appears that third party payment is, in fact, unavailable, the patient could then be billed for the subsistence charge. Another legally appropriate option would be to subtract the subsistence charge from the total charge before billing the third party payer. The third party payer then would be expected to separately pay DoD and the patient (assuming both bill the third party payer).

I hope you find this responsive to your questions. If anything further is needed, please do not hesitate to contact John Casciotti of this office.



Robert L. Gilliat
Assistant General Counsel
(Personnel & Health Policy)

**RECOMMENDED MANUAL FORM FOR COLLECTING
INSURANCE INFORMATION**

THIRD PARTY COLLECTION PROGRAM - INSURANCE INFORMATION		REPORT CONTROL SYMBOL	Form Approved OMB No Expires
Public reporting burden for this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Washington Headquarters Services, Directorate for Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington VA 22202-4302, and to the Office of Management and Budget, Paperwork Reduction Project (XXXX-XXXX), Washington, DC 20503			
Privacy Act Statement			
AUTHORITY:		Title 10 USC, Sec 1095 and EO 9397, November 1943 (SSN)	
PRINCIPAL PURPOSE(S):		Used by Military Departments to collect from private insurers for inpatient care provided to military dependents and retirees. The military hospital providing the services is hereby authorized all monetary benefits relating to inpatient care for insured persons.	
ROUTINE USE(S):		The information provided shall be used by the Military Departments, Department of Defense, and other authorized employees of the Federal Government and may be released to an insured person's insurance company	
DISCLOSURE:		Voluntary; however, failure to provide complete information may result in the denial of benefits	
SECTION I - TO BE COMPLETED BY ALL INPATIENTS			
1. NAME OF PATIENT (Last, First, Middle Initial)		2. SOCIAL SECURITY NUMBER	3. DATE OF BIRTH (YYMMDD)
4. ADDRESS (Street, City, State and Zip Code)		5. HOME TELEPHONE NUMBER (Include Area Code)	
		6. OFFICE TELEPHONE NUMBER (Include Area Code)	
7. DO YOU HAVE ANY TYPE OF HEALTH/HOSPITALIZATION INSURANCE? (X one)		8. CERTIFICATION. I certify that to the best of my knowledge and belief, all of my statements are true, correct, complete, and made in good faith. A false statement may be punished by fine or imprisonment (Title 18 USC, Sec. 1001).	
a YES - I do have primary or supplemental health/hospitalization insurance			
b NO - I do not have health/hospitalization insurance (other than coverage provided by the Military Depts, CHAMPUS or Medicare)		a. SIGNATURE	b. DATE SIGNED (YYMMDD)
SECTION II - TO BE COMPLETED BY INPATIENTS ANSWERING ITEM 7.a.			
9. PRIMARY HEALTH/HOSPITALIZATION INSURANCE WAS COVERED BY (X as applicable)			
a PRIVATE PLAN		b EMPLOYEE/FEDERAL PLAN	
c FORMER EMPLOYER'S PLAN		d SPOUSE'S EMPLOYER'S PLAN	
(1) Name and Address of Plan (Include Zip Code)		(2) Group Number	
		(3) Plan Number	
10. SUBSCRIBER INFORMATION (If subscriber to the health/hospitalization insurance plan is other than the patient)			
a NAME (Last, First, Middle Initial)		b SOCIAL SECURITY NO:	c EMPLOYER
11. SUPPLEMENTAL HEALTH INSURANCE WAS COVERED BY (X as applicable)			
a MEDICARE SUPPLEMENT		b CHAMPUS SUPPLEMENT	
c. OTHER (Specify)			
(1) Name and Address of Plan (Include Zip Code)		(2) Group Number	
		(3) Plan Number	
SECTION III - TO BE COMPLETED BY THE ADMISSIONS CLERK/HOSPITAL OFFICIAL			
12. HAS THIS ADMISSION BEEN IDENTIFIED AS A THIRD PARTY LIABILITY CASE? (PL 87-693) (X one)		YES	NO
13. DOES THE INSURER REQUIRE A PREADMISSION OR CONCURRENT REVIEW? (X one. If "Yes," forward to the appropriate hospital official.)		YES	NO
14. SIGNATURE OF ADMISSIONS CLERK/HOSPITAL OFFICIAL		15. REGISTER NUMBER/ADMISSION DATE (YYMMDD) (Patient Stamp)	

DOD INSURANCE REPORT
FROM 01 OCT 1988 TO 30 JUN 1989

REG #	NAME	SSN	FAT CAT	ADM DATE	DISP DATE	DATE BILLED	AMOUNT BILLED	AMOUNT COLLECTED	AMOUNT NOT COLLECTED	REASON NOT COLLECTED	CASH COLLECTION VOUCHER #
0179508	INPATIENT #1 NAME OF INSURANCE CO: POLICY #:	XXX-XX-XXXX	N31	18NOV88	30NOV88						
	EFFECTIVE DATE: 15 AUG 1982										
0179748	INPATIENT #2 NAME OF INSURANCE CO: HMSA POLICY #: 2675	XXX-XX-XXXX	A41	21NOV88	23NOV88						
	EFFECTIVE DATE: 01 SEP 1988										
0180156	INPATIENT #3 NAME OF INSURANCE CO: HMSA POLICY #: H605792	XXX-XX-XXXX	F43	28NOV88	28NOV88						
	EFFECTIVE DATE: 01 JAN 1987										
0180341	INPATIENT #4 NAME OF INSURANCE CO: HMSA POLICY #: F231937251	XXX-XX-XXXX	F31	30NOV88	21DEC88						
	EFFECTIVE DATE: 01 JAN 1983										
0180429	INPATIENT #5 NAME OF INSURANCE CO: KAISER POLICY #: 0585875	XXX-XX-XXXX	N41	01DEC88	04DEC88						
	EFFECTIVE DATE: 01 APR 1986										
0180504	INPATIENT #6 NAME OF INSURANCE CO: KAISER POLICY #: 667546	XXX-XX-XXXX	A31	02DEC88	13DEC88						
	EFFECTIVE DATE: 01 MAY 1988										
0180656	INPATIENT #7 NAME OF INSURANCE CO: AETNA POLICY #: 60054-0517	XXX-XX-XXXX	A31	05DEC88	05DEC88						
	EFFECTIVE DATE:										
0180802	INPATIENT #8 NAME OF INSURANCE CO: USAA LIF POLICY #: 2504346	XXX-XX-XXXX	A41	06DEC88	07DEC88						
	EFFECTIVE DATE: 02 FEB 1982										
0180994	INPATIENT #9 NAME OF INSURANCE CO: POLICY #:	XXX-XX-XXXX	N31	09DEC88	14DEC88						
	EFFECTIVE DATE: 15 AUG 1982										
0181002	INPATIENT #10 NAME OF INSURANCE CO: HMSA POLICY #: 13727060	XXX-XX-XXXX	N31	09DEC88	12DEC88						
	EFFECTIVE DATE: 01 SEP 1979										
0181160	INPATIENT #11 NAME OF INSURANCE CO: HMSA POLICY #: F252882717	XXX-XX-XXXX	F43	12DEC88	12DEC88						
	EFFECTIVE DATE: 01 OCT 1980										
0181168	INPATIENT #12 NAME OF INSURANCE CO: MUTUAL OMAHA POLICY #: 000080609	XXX-XX-XXXX	A31	12DEC88	13DEC88						
	EFFECTIVE DATE:										
0181365	INPATIENT #13 NAME OF INSURANCE CO: HMSA POLICY #: 14242622	XXX-XX-XXXX	A43	14DEC88	21DEC88						
	EFFECTIVE DATE: 01 JUL 1982										

SAMPLE PRINTOUT FROM RECOMMENDED SYSTEM FOR ADMINISTRATION OF THE THIRD PARTY COLLECTION PROGRAM

APPENDIX T

RECOMMENDED FORM FOR QUARTERLY REPORTS

REPORTING PERIOD _____ Medical Treatment Facility (MTF) _____

REPORTING PERIOD	NON-ACTIVE DUTY INPATIENT DISPOSITIONS	NUMBER OF CLAIMS	NUMBER OF COLLECTIONS	# COLLECTIONS/ # DISPOSITIONS (PERCENTAGE)	AMOUNTS CLAIMED	AMOUNTS COLLECTED	AMOUNTS NOT COLLECTED*
<u>Prior Fiscal Years</u>							
I) FY _____	# _____	# _____	# _____	_____ %	\$ _____	\$ _____	\$ _____
II) FY _____	# _____	# _____	# _____	_____ %	\$ _____	\$ _____	\$ _____
<u>Current Fiscal Year</u>							
III) FY _____	# _____	# _____	# _____	_____ %	\$ _____	\$ _____	\$ _____

REASONS FOR UNCOLLECTED AMOUNTS

*** AMOUNTS NOT COLLECTED SUBDIVIDED BY REASON**

	I FY _____	II FY _____	III FY _____
#1 - Open claim (requires follow-up action by medical treatment facility for resolution)	\$ _____	\$ _____	\$ _____
OPEN CLAIMS: THIRD PARTY REDUCED/DENIED PAYMENT FOR INVALID REASONS (Requires additional debt collection or legal action) (#2-#6)	\$ _____	\$ _____	\$ _____
#2 - MTF not a participating hospital	\$ _____	\$ _____	\$ _____
#3 - Plan excludes military hospitals or beneficiaries	\$ _____	\$ _____	\$ _____
#4 - Patient had no obligation to pay	\$ _____	\$ _____	\$ _____
#5 - Insurer paid patient directly	\$ _____	\$ _____	\$ _____
#6 - Other (explain) _____	\$ _____	\$ _____	\$ _____
CLOSED CLAIMS: THIRD PARTY PAID IN FULL OR REDUCED/DENIED PAYMENTS (No further action required because unpaid amount is not a valid claim) (#7-#12)	\$ _____	\$ _____	\$ _____
#7 - Amount of coverage (for example, plan pays less than 100%)	\$ _____	\$ _____	\$ _____
#8 - Patient not covered, care provided not covered, or policy expired	\$ _____	\$ _____	\$ _____
#9 - MEDICARE, CHAMPUS, supplemental income plans	\$ _____	\$ _____	\$ _____
#10- HMO (for example, nonemergency out-of-plan care not covered)	\$ _____	\$ _____	\$ _____
TOTAL	\$ _____	\$ _____	\$ _____
#11- MTF did not comply with utilization review procedures (for example, pre-admission screening, concurrent review, second surgical opinions, etc.)	\$ _____	\$ _____	\$ _____
#12- Other (explain), for example: third party provided lower prevailing rate than amount billed _____	\$ _____	\$ _____	\$ _____

NOTES: 1/ All activity for amounts claimed and collected shall be reported in the fiscal year that services were rendered. For example, care provided in FY 1989 shall be reported as an FY 1989 claim and collection, regardless of the year payment is received. This requires cutoff billing for all inpatients at the end of each fiscal year.

2/ Each quarterly report shall be cumulative for the current and prior fiscal years.

UNIFORM BILLING FOR INPATIENT HOSPITAL COSTS

APPROVED OMB NO. 0938-0279

1.		2.			3. PATIENT CONTROL NUMBER				4. TYPE OF BILL									
5. BC/B5 PROV NO		6. FEDERAL TAX NO		7. MEDICARE NO.		8. MEDICAID NO		9.										
10. PATIENT'S LAST NAME			FIRST NAME	INITIAL	11. PATIENT'S ADDRESS			CITY	STATE	ZIP								
12. BIRTH DATE	13. SEX	14. M	15. DATE		16. HR	17. TYPE	18. SRC	19. A.H.	20. D.H.	21. STAT	22. STATEMENT COVERS PERIOD		23. COV'D	24. N-CD	25. C-I-D	26. L-R-D	27.	
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50. DESCRIPTION					51. R CODE	52. S UNITS	53. TOTAL CHARGES	54.	55.	56.	57.	58.	59.	60.	61.	62.	63.	64.
57. PAYER	58. REL INFO	59. ASG BEN	60. DEDUCTIBLE	61. CO-INSURANCE	62. EST. RESPONSIBILITY	63. PRIOR PAYMENTS	64. EST. AMOUNT DUE	65.	66.	67.	68.	69.	70.	71.	72.	73.	74.	75.
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UNIFORM BILLING FOR INPATIENT HOSPITAL COSTS
(Continued)

The following are problems with the format of information on the Uniform Billing for Inpatient Hospital Costs (DD Form 2502):

- The information printed in Block 1 should give the hospital address for mailing of payments.

- The information printed in Block 11 should be one printed line, not two.

- The information printed in Block 34 should be the insurance company's address, not the patient's address.

- For the information printed in Block 50, "Pro Fee" numbers should be moved one space to the right.

- The information printed in "Block 57" needs to be moved up one line.

ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS) COMMENTS



HEALTH AFFAIRS

ASSISTANT SECRETARY OF DEFENSE

WASHINGTON D C 20301

22 JUN 1990

MEMORANDUM FOR INSPECTOR GENERAL, DEPARTMENT OF DEFENSE

SUBJECT: Draft Report on the Audit of the Third Party Collection Program (Project No. 9FR-0031)

We have reviewed the subject draft report and concur with the findings and recommendations. Specific comments on each finding and recommendation are enclosed. In addition, we concur with the estimated monetary benefits identified in Appendix M of the draft report.

We appreciate the efforts expended by your staff in performing a comprehensive review of this important program. The findings and recommendations in the draft report provide excellent guidance for improving the Third Party Collection program. Since we received the initial briefing on the results of the field work, members of my staff have worked closely with your staff to begin implementation of the recommendations in the draft report.


Enrique Mendez, Jr., M.D.

Enclosure:
As stated

ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS) COMMENTS
(Continued)

Comments on Draft Report on the Audit of the
Third Party Collection Program (Project No. 9FR-0031)

Finding A. Collections from Health Insurance Plans. Military hospitals were failing to collect from health insurance plans for inpatient hospital care costs incurred on behalf of insured military retirees and dependents. Concur.

Recommendation 1. That the Surgeons General for the Army, the Navy, and the Air Force direct commanders at military hospitals to fully implement and resource the Third Party Collection Program. Concur.

Recommendation 2. That the Surgeons General for the Army, the Navy, and the Air Force direct commanders at military hospitals to send a questionnaire to each military retiree and dependent discharged during FY 1989 and FY 1990 with unknown insurance information, and submit claims to insurance companies when appropriate. Concur.

Recommendation 3. That ASD(HA) and the Surgeons General review quarterly reports submitted by military hospitals, to ensure that the Program is implemented and fully executed, and take corrective actions at hospitals that have not effectively implemented the Program. Concur.

Finding B. DoD Guidance and Support for the Third Party Collection Program. The Surgeons General and military hospitals did not have sufficient DoD guidance and support to effectively implement and manage the Third Party Collection Program. Concur.

Recommendation 1a. ASD(HA) develop and issue a DoD Instruction that provides specific policies, procedures, and responsibilities for implementing the Third Party Collection Program. Concur. A draft DoD Instruction 6010.15, Third Party Collection Program, has been circulated for comments and will be published when the necessary information collection/forms approval is obtained.

Recommendation 1b. ASD(HA) develop and issue a DoD regulation to clarify the rights and obligations of third party payers and health care beneficiaries. Concur. A regulation clarifying the rights and obligations of third party payers and health care beneficiaries was published on May 29, 1990, as final rule 32 CFR Part 220, Collection from Third Party Payers of Reasonable Hospital Costs.

ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS) COMMENTS
(Continued)

Final Report
Rec. No.

Comments on Draft Report or the Audit of the
Third Party Collection Program (Project No. 9FR-0031)
(Continued)

Recommendation 1c. ASD(HA) develop and make available the basic systems needed to implement and manage the Third Party Collection Program. Concur. The standard form to collect insurance information requires minor modification and final approval by the Office of Management and Budget (OMB) which is estimated to be complete within 90-120 days. The software changes to the Automated Quality of Care Evaluation Support System (AQCESS) for the Third Party Collection program are expected to be completed and deployed by December, 1990. The software changes to the Composite Health Care System (CHCS) for the Third Party Collection program are planned to be completed by June 1991.

Recommendation 1d. Correct the deficiencies in the Automated Quality of Care Evaluation Support System (AQCESS) for preparing insurance claims. Concur. The software changes to AQCESS are planned to be completed and deployed by December 1990.

Recommendation 2a. That the Surgeons General for the Army, the Navy, and the Air Force fully install at each military hospital the Automated Quality of Care Evaluation Support System (AQCESS) and any other systems developed by the Assistant Secretary of Defense (Health Affairs) to manage the Third Party Collection Program. Concur, except at those locations where the Composite Health Care System (CHCS) is operational, it would not be appropriate to fully install AQCESS since CHCS would already provide the necessary capability.

Recommendation 2b. That the Surgeons General for the Army, the Navy, and the Air Force give hospital personnel sufficient training to operate the systems. Concur.

Finding C. Legislation to Authorize Recoveries from Medicare Supplemental Insurance Policies. Only 7 of the 25 military hospitals visited were collecting from Medicare supplemental insurance policies for inpatient care costs incurred on behalf of insured military retirees and dependents. This occurred because legislation authorizing the Third Party Collection Program and guidance provided by the ASD(HA) did not clearly address the issue of collections from Medicare supplemental insurance policies. Concur.

Recommendation 1a. That the ASD(HA) propose legislation that would authorize military hospitals to collect from Medicare supplemental insurance policies. Concur. A draft legislative proposal is currently being circulated for comment. 1.

Recommendation 1b. If legislation is enacted, that the ASD(HA) issue appropriate guidance requiring military hospitals to collect from Medicare supplemental insurance policies. Concur. 2.

ARMY SURGEON GENERAL COMMENTS



REPLY TO
ATTENTION OF

DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL
5109 LEESBURG PIKE
FALLS CHURCH, VA 22041-3258



4 JUN 1990

DASG-IRO

ALCIDE M. LANOUE

MEMORANDUM THRU CHIEF OF STAFF, ARMY Deputy Surgeon General ^{Robert M. Emmerichs}
ASSISTANT SECRETARY OF THE ARMY (MANPOWER AND ^{Assistant Secretary}
RESERVE AFFAIRS) ^{(Military Personnel Management} 11 JUN 1990 ^{and Equal Opportunity Policy)}

FOR DIRECTOR OF FINANCIAL MANAGEMENT, INSPECTOR GENERAL,
DEPARTMENT OF DEFENSE, ATTN: NANCY BUTLER, WASHINGTON,
D.C. 20310

SUBJECT: Draft Report on the Audit of the Third Party
Collection Program (Project No. 9FR-0031)

1. This is in response to your memorandum, 3 April 1990, subject as above.
2. The draft report has been reviewed and the following comments are enclosed.
3. Thank you for the opportunity to review the report before its publication. Should you request further information, please contact our Auditor, Mr. Samih H. Helmy at 756-0248.

FOR THE SURGEON GENERAL:

ALCIDE M. LANOUE
Major General, MC
Deputy Surgeon General

Encl

CF:
SAIG-PA
SAFM-ROR
OASD(HA)

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APPENDIX X
Page 1 of 5

ARMY SURGEON GENERAL COMMENTS
(Continued)

DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL
COMMENT TO IG DOD DRAFT AUDIT REPORT
PROJECT NO.
THIRD PARTY COLLECTION PROGRAM

FINDING A:

Additional Comments:

We concur with this finding. Military hospitals did not fully implement the program primarily because they were not adequately resourced to do any more with the program than was done. Although commanders were required to implement the program, they were hesitant to commit already meager resources to a program that offered very little in return for the effort that was required to make it work. Since the conclusion of the audit, significant changes have taken place and provided a focus for commanders to fully implement the program. Additionally, funds were included in the Department of Defense (DOD) Appropriations Act, FY 1990 to increase collections from third party payers. Consistent with the audit findings, these funds are being used to improve resourcing, which was sorely needed to improve the program.

Recommendation: A-1

We recommend that The Surgeons General for the Army, the Navy, and the Air Force direct Commanders at military hospitals to fully implement and resource the Third Party Collection Program. To fully implement the program, military hospitals will need to establish procedures to:

- a. Identify inpatients who have insurance coverage and document that inpatients have been questioned about insurance coverage;
- b. Ensure that claims are correctly prepared and submitted to insurance companies; and
- c. Resolve open claims and claims that were unpaid or partially unpaid for inappropriate reasons.

Corrective Action: Concur.

- a. OASD(HA) is currently in the process of finalizing and publishing the new Department of Defense Instruction (DODI), anticipated date of completion is by 31 December 1990. Upon receipt of the new DODI, Major Medical Commands will be provided new implementation instructions to include instructions on how to:

ARMY SURGEON GENERAL COMMENTS
(Continued)

(1) Identify those inpatients who have insurance coverage and obtain documentation that inpatients have been questioned about insurance coverage.

(2) Ensure that claims are correctly prepared and submitted to insurance companies.

(3) Procedures on resolving open claims and claims that were unpaid or partially unpaid for inappropriate reasons.

Target completion date for providing new implementation instructions is 45 days after receipt of the new DODI.

b. In this regard, it should be stated that AQCESS functions allow insurance information to be recorded during registration or from questionnaires. Periodic reports can be generated to track inpatients without insurance information. The system can also print the claims automatically based on treatment information. As a result of inputting claim and Explanation of Benefits (EOB) information, the system can generate reports to identify and assist with management of open, unpaid or partially unpaid claims.

Recommendation: A-2

We recommend that The Surgeons General for the Army, the Navy, and the Air Force direct Commanders at military hospitals to send a questionnaire to each military retiree and dependent discharged during FY 1989 and FY 1990 with unknown insurance information, and submit claims to insurance companies when appropriate.

Corrective Action: Concur.

Recommendation A-2. Concur. The Army Surgeon General will request the Major Medical Commands to instruct military hospitals to send questionnaire to each military retiree and dependent discharged during FY 1989 and FY 1990 with unknown insurance information and submit claims to insurance companies when appropriate. Target completion date for FY 1989 questionnaire is approximately 30 November 1990. Target completion date for FY 1990 questionnaire is anticipated 31 December 1990.

Recommendation A-3.

We recommend that ASD(HA) and The Surgeons General for the Army, the Navy and the Air Force review quarterly reports submitted by military hospitals to ensure that the Program is implemented and fully executed, and take corrective actions at hospitals that have not effectively implemented the Program.

ARMY SURGEON GENERAL COMMENTS
(Continued)

Corrective Action: Concur.

1. Major Medical Commands will be required to review quarterly reports to ensure the program is fully executed and implemented at each military hospital. Target completion date for completing review is the 15th day following the end of each quarter. DASG-RMP will review the reports for analytical trends, percentages of collection/non-collections and will inform the Major Commands of discrepancies before providing quarterly reports to OASD(HA).

2. Questionnaires can be programmed and automatically printed for inpatients without insurance information for initial and follow-up mail-outs. Using data from questionnaires and treatment data recorded on AQCESS for FY 1989 and FY 1990, the appropriate claims can be automatically generated.

FINDING B.

Additional Comments:

1. Military hospitals did not have adequately developed management systems, policies or procedures with which to implement the program. The new DODI is anticipated to be completed by 30 September 1990. We also concur with the recommendations for this finding. The use of the AQCESS system with appropriate modifications will provide solutions for many of the problems identified in the report.

2. The corrections of format problems identified in Appendix L, the ability to modify and reprint claims, and the corrections of deficiencies in preparing insurance claims have either been fixed or are identified as a Systems Change Request (SCR). The appropriate funding and priority are needed for the SCR to be implemented as a software change.

RECOMMENDATION B-1:

We recommend that The Surgeon General for the Army, the Navy and the Air Force:

a. Fully install at each military hospital the Automated Quality-of-Care Evaluation Support System and any other systems developed by the Assistant Secretary of Defense (Health Affairs) to manage the Third Party Collection Program.

b. Give hospital personnel sufficient training to operate the systems.

ARMY SURGEON GENERAL COMMENTS
(Continued)

CORRECTIVE ACTION: Concur.

1. A standard form will be programmed into AQCESS to be printed by the system on demand. Input can be entered into the system from the form or from the patient during registration or telephone conversation. AQCESS uses date of service for the basis of reporting claims and collections.

2. Additional training will be provided through the Army Office for Defense Medical Information Systems (Army-DMIS) or centrally through the Defense Medical Systems Support Center (DMSSC). The availability of personnel and funding would have to be addressed. Software modifications will be made to generate the manual forms, to generate new reports and to provide other needs. These modifications are relatively straight forward software applications and should not be difficult to implement. Target date of completion is 3d Quarter, FY 1991.

MONETARY BENEFITS: Concur.

1. We agree with the projected monetary benefits described in the finding, however, it is not clear whether legislation authorizing hospitals to collect from medicare supplemental insurance policies is a viable option.

2. The clarification of legal issues included in Appendix H of the draft report indicates recovery from Medicare supplemental insurance is not likely as long as the collection program does not apply to Medicare. In this regard, the potential collections identified in the finding are speculative at best.

ASSISTANT SECRETARY OF THE NAVY
(MANPOWER AND RESERVE AFFAIRS) COMMENTS



DEPARTMENT OF THE NAVY
OFFICE OF THE SECRETARY
WASHINGTON, D C 20350-1000

15 JUL 1990

Susan
MEMORANDUM FOR THE INSPECTOR GENERAL, DEPARTMENT OF DEFENSE

Subj: COMMENTS ON DEPARTMENT OF DEFENSE INSPECTOR GENERAL DRAFT
REPORT ON THE AUDIT OF THE THIRD PARTY COLLECTION PROGRAM
(PROJECT NO. 9FR-0031)

In response to Tab A, Tab B provides comments on the subject
audit.

Barbara S Pope
BARBARA SPYRIDON POPE
Assistant Secretary of the Navy
(Manpower and Reserve Affairs)

TAB A - DODIG Draft Report
TAB B - Comments on Department of Defense Inspector General
Draft Report on the Audit of the Third Party Collection
Program

ASSISTANT SECRETARY OF THE NAVY
(MANPOWER AND RESERVE AFFAIRS) COMMENTS
(Continued)

Department of the Navy Response
to
Department of Defense Inspector General
Draft Report of 03 April 1990
on
Audit of the Third Party Collection Program
(Project No. 9FR-0031)

Finding: Collections from Health Insurance Plans

Military hospitals had not fully implemented and resourced the Third Party Collection Program and as a result were not identifying inpatients with health insurance coverage and submitting claims to the insurance companies for recompensation for medical services provided.

The DODIG recommended:

1. The Surgeons General direct commanders at military hospitals to fully implement and resource the Third Party Collection Program.

Department of the Navy Position:

Concur. In anticipation of the forthcoming DoD Instruction 6010.15 which reinforces procedures for this Program, a personal message to all Navy medical treatment facility commanding officers was released by the Bureau of Medicine and Surgery which requested the commanders' support. Initial guidance on patient identification, claims preparation, and claims resolution was included. We interpose no objection to the \$58.2 million estimated collection rate propounded by DoDIG provided the collections generated from the Program are deposited to the fiscal year of collection vice the year the care was provided. This will allow the activities to fully benefit from all collections generated.

2. The Surgeons General send a questionnaire to each military retiree and dependent discharged during FY 89 and FY 90 with unknown insurance information and submit claims to insurance companies when appropriate.

Department of the Navy Position:

Do Not Concur. Implementation of a survey and collection program for past years would severely disrupt current collection efforts, squandering limited resources on an uncertain plan which would not benefit this claimancy.

The auditors estimated that in FY 88 approximately 90,000 inpatients at Navy facilities alone were potentially eligible for this Program. Combining this with an equal or greater number for FY 89 yields a quantity of surveys and an accompanying staff effort of heroic proportions. The auditors admit in the report

ASSISTANT SECRETARY OF THE NAVY
(MANPOWER AND RESERVE AFFAIRS) COMMENTS
(Continued)

that patients are frequently reluctant to volunteer insurance information when personally interviewed (much less by mail). Also, many insurance companies require timely submission of claims for payment. Experience at the collections level also confirms the auditors' low return on survey results. The probability of contacting the patient by mail up to two years after discharge is very small due to the transient nature of our patient population.

Under current accrual accounting methods, deposits received from previous years are posted to that year's funds. Any collections received as a result of this audit would therefore be posted to the Treasury (the policy prior to FY 90), and not contribute to either offsetting the cost of collection or the facilities' operating funds.

The auditors suggest that to fully implement the Program as designed, current staffing levels must be increased. Under the current DoD-wide hiring freeze, many facilities are facing staff reductions by attrition and are unable to commit additional personnel to this Program regardless of the potential benefit. To force a retroactive correction of events is to misdirect the focus of our efforts. We should commit our resources, however limited, to rigorous implementation of a strong current Program.

3. That the Surgeons General review quarterly reports submitted by military hospitals to ensure the Program is implemented and fully executed, and take corrective actions at hospitals that have not effectively implemented the Program.

Department of the Navy Position:

Concur. Quarterly reviews of Program reports are now conducted and are considered in formulation of activity resource allocation.

ASSISTANT SECRETARY OF THE NAVY
(MANPOWER AND RESERVE AFFAIRS) COMMENTS
(Continued)

Department of the Navy Response
to
Department of Defense Inspector General
Draft Report of 03 April 1990
on
Audit of the Third Party Collection Program
(Project No. 9FR-0031)

Finding: DoD Guidance and Support for the Third Party Collection Program

The military hospitals did not have sufficient DoD guidance and support to effectively implement and manage the Third Party Collection Program.

The DODIG recommended:

1. The Assistant Secretary of Defense (Health Affairs) develop and issue an instruction for implementing the Program, develop and issue a regulation to clarify the rights and obligations of third party payers and health care beneficiaries, and develop and make available the basic systems needed to implement and manage the Program.

Department of the Navy Position:

Concur. Anticipated DoD guidance will be fully implemented at all claimancy activities. Additionally, the Navy has participated in system design and changes to the Automated Quality of Care Evaluation Support System Medical Services Accounting module to significantly enhance support of this Program.

2. The Surgeons General install at each military hospital the systems developed by the Assistant Secretary of Defense (Health Affairs) to manage the Program and give sufficient training to operate the systems.

Department of the Navy Position:

Concur. The Navy has installed Automated Quality of Care Evaluation Support System Medical Services Accounting at fourteen of thirty-four medical treatment facilities. DoD has recently provided the Bureau of Medicine and Surgery with an additional \$1.3 million to implement this program. These funds will be used to purchase the necessary hardware to upgrade all Navy medical treatment facilities with a fully functional Automated Quality of Care Evaluation Support System Medical Services Accounting system during the remainder of this fiscal year and early next fiscal year. Travel and training costs will be targets of these funds.

ASSISTANT SECRETARY OF THE AIR FORCE
(MANPOWER, RESERVE AFFAIRS, INSTALLATIONS AND ENVIRONMENT) COMMENTS



OFFICE OF THE ASSISTANT SECRETARY

DEPARTMENT OF THE AIR FORCE
WASHINGTON DC 20330-1000

17 JUL 1990

MEMORANDUM FOR ASSISTANT INSPECTOR GENERAL FOR AUDITING
OFFICE OF THE INSPECTOR GENERAL
DEPARTMENT OF DEFENSE

SUBJECT: DOD(IG) Draft Report on the Audit of the Third Party
Collection Program (Project No. 9FR-0031) - INFORMATION
MEMORANDUM

The attached response is in reply to your memorandum for the Assistant Secretary of the Air Force (Financial Management and Comptroller) requesting comments on the findings and recommendations made in subject report. POC for this program is Captain Stan Polson, HQ USAF/SGHC, Bolling AFB DC 20332-6188, (202) 767-5060.


J. G. COOPER
Assistant Secretary of the Air Force
(Manpower, Reserve Affairs,
Installations and Environment)

1 Atch
Air Force Response to
Draft DoD(IG) Audit Report

cc: AF/CV
AF/CVA

ASSISTANT SECRETARY OF THE AIR FORCE
(MANPOWER, RESERVE AFFAIRS, INSTALLATIONS AND ENVIRONMENT) COMMENTS
(Continued)

FINDING A. Collections from Health Plans

Military hospitals were failing to collect from health insurance plans for inpatient hospital costs incurred on behalf of insured military retirees and dependents. This occurred because military hospitals had not fully implemented and resourced the Third Party Collection Program (the Program). In addition, military hospitals had not established adequate procedures to identify inpatients with health insurance coverage and to document that inpatients had been questioned about insurance coverage, to ensure that claims were correctly prepared and submitted to insurance companies, and to resolve open claims and claims that were unpaid or partially unpaid for inappropriate reasons. Further, neither the Assistant Secretary of Defense (Health Affairs) (ASD(HA)) nor the Surgeons General for the Military Departments were adequately reviewing quarterly reports submitted by military hospitals to assure that the Program was fully implemented. As a result, only 1 of the 25 military hospitals we visited had effectively implemented the Program. We projected that unless the Program is effectively implemented, military hospitals will fail to collect approximately \$318.0 million from insurance companies for FY's 1990 through 1994.

Concur. Although this program was directed by legislation, the failure to resource the Military Departments for personnel, systems, and training requirements made full and successful implementation virtually impossible. This fact coupled with the lack of incentive (i.e., retention of collections) at the military hospitals, guaranteed this program low priority in meeting the medical mission at military hospitals.

RECOMMENDATION

A.1. We recommend that the Surgeons General for the Army, the Navy, and the Air Force direct commanders at military hospitals to fully implement and resource the Third Party Collection Program. To fully implement the Program, military hospitals will need to establish procedures to:

- a. identify inpatients who have insurance coverage and document that patients have been questioned about insurance coverage;
- b. ensure that claims are correctly prepared and submitted to insurance companies; and
- c. resolve open claims and claims that were unpaid or partially unpaid for appropriate reasons

CONCUR. The Air Force Medical Service has every intention of meeting the intent of the legislation directing this program. We feel we have provided a reasonable effort given constraints as

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outlined above. Once these limitations are resolved, we see no reason why all patients having third party insurance cannot be identified and all claims cannot be prepared, submitted, and resolved in a proper manner.

Estimated Completion Date - 31 December 1990

RECOMMENDATION

A.2. We recommend that the Surgeons General for the Army, the Navy, and the Air Force direct commanders at military hospitals to send a questionnaire to each military retiree and dependent discharged during FY 1989 and FY 1990 with unknown insurance information, and submit claims to insurance companies when appropriate.

CONCUR. This recommendation was included in the Air Force Audit Agency (AFAA) Report of Audit (Project 8325113). The Air Force Surgeon General directed by letter (Atch 1) each inpatient medical facility to identify all nonactive duty inpatients which may have third party health insurance. These questionnaires are being sent by our medical facilities. Due to lack of resources and the magnitude of this task, this process is taking considerable time to accomplish.

Estimated Completion Date - 31 December 1990. This task is very much contingent on acquiring personnel support and system software support for this program. Our primary effort has been to stay current with FY 90 workload in this program.

RECOMMENDATION

A.3. We recommend that ASD(HA) and the Surgeons General for the Army, Navy, and Air Force review quarterly reports submitted by military hospitals to ensure that the Program is implemented and fully executed, and take corrective actions at hospitals that have not effectively implemented the Program.

CONCUR. Although quarterly reports are consolidated and reviewed by Major Command (MAJCOM) by the Air Force Surgeon General staff, it is in aggregate form and not identifiable by each medical facility. With the implementation of a new DoD instruction, the Surgeon General will issue supplemental instructions requiring reporting by specific medical facility, as well as, a MAJCOM aggregate.

Estimated Completion Date - 30 September 1990.

FINDING B. DoD Guidance and Support for the Third Party Collection Program

The Surgeons General and military hospitals did not have sufficient DoD guidance and support to effectively implement and manage the Third Party Collection Program. This occurred because the Assistant Secretary of Defense (Health Affairs) (ASD(HA)) had

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assigned responsibility to the Military Departments for developing procedures to implement the Program, but had not developed an adequate DoD instruction and regulation. In addition, ASD(HA) had not adequately developed the basic systems needed to implement and manage the Program, or identified and corrected deficiencies in the automated system used to prepare insurance claims. At most military hospitals, the Surgeons General had not fully installed the system for preparing insurance claims or given hospital personnel enough training to make the system operational. Consequently, policies and procedures used to implement the Program were inadequate and inconsistent, military hospitals were unclear about the rights and obligations of third party payers and health care benefits, and the systems used to manage the Program were ineffective and burdensome.

CONCUR. Guidance from the Air Force Surgeon General was somewhat inadequate for this program. Due to a lack of ASD(HA) guidance, training, knowledge of health insurance claims processing procedures, guidance to the medical hospitals was not as detailed as necessary for a successful program. As with any new program, a learning curve exists. This program required a knowledge level of our billing personnel that had not previously been required. Corrective action has been initiated with a major rewrite on this program in AFR 168-4, Administration of Medical Activities, Chapter 10 (Atch 2) which was published 27 April 1990 and will continue to be updated with program changes. Additional AF/SG guidance (Atch 3) has been disseminated to MTF's to provide guidance on recent changes as directed by the National Defense Authorization Act (Public Law 101-189, section 727) which entitles military hospitals to retain program collections.

RECOMMENDATION

B.1. Reply required by ASD(HA).

B.2. We recommend that the Surgeons General for the Army, Navy, and Air Force:

a. Fully implement at each military hospital the Automated Quality of Care Evaluation Support System and any other systems developed by the Assistant Secretary of Defense (Health Affairs) to manage the Third Party Collection Program.

b. Give hospital personnel sufficient training to operate the systems.

CONCUR. The Air Force Surgeon's General staff has been actively involved with ASD(HA) and National Data Corporation (NDC) (system software contractor) in developing program changes which will provide an improved, effective, and user friendly billing and tracking module for the Automated Quality of Care Evaluation Support System. User implementing instructions and training will be provided to ensure effective program management.

Estimated Completion Date - 31 December 1990. This is contingent on software funding by ASD(HA) and software release by NDC.

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POTENTIAL MONETARY BENEFITS

<u>Recommendation</u> <u>Reference</u>	<u>Description of Benefit</u>	<u>Amount and/or</u> <u>Type of Benefits</u>
A.1	Program Results: Fully implementing and resourcing the Program will result in additional collections for FY's 1990 through 1994 of \$318 million (minus additional personnel costs of \$11.8 million to manage the Program).	Additional collections by military hospitals of \$306.2 million (Army \$144.4 million, Navy \$58.2 million, and Air Force \$103.6 million); recurring benefits.

CONCUR in part. The collection amount is a reasonable "best guess" based on an acceptable sample size. However, we NONCONCUR with the estimated additional personnel costs associated with this program. This report estimates 34 persons at \$22,591 needed for a total cost of \$4.08 million over this period. Air Force has approval to hire 99 persons at a total cost of \$12.0 million over this period. Therefore, net program benefits should be decreased an estimated \$8.0 million for the Air Force.

NOTE: All other referenced benefits as referenced in Appendix M of subject report are included in response above.

**SUMMARY OF POTENTIAL MONETARY
AND OTHER BENEFITS RESULTING FROM AUDIT**

<u>Recommendation Reference</u>	<u>Description of Benefits</u>	<u>Amount and/or Type of Benefits</u>
A.1.	Program Results: Fully implementing and resourcing the Program will result in additional collections of \$318 million (minus additional personnel costs of \$19.7 million to manage the Program) for FY's 1990 through 1994.	Additional collections by military hospitals of \$298.3 million (Army \$144.4 million, Navy \$58.2 million, and Air Force \$95.7 million); recurring benefits.
A.2.	Program Results: Establishing procedures will improve the Program's effectiveness.	Additional collections included in Recommendation A.1.
A.3.	Internal Controls: Reviewing quarterly reports will identify military hospitals that have ineffective programs.	Additional collections included in Recommendation A.1.
B.1.	Program Results: Additional guidance and support will improve the Program's effectiveness.	Additional collections included in Recommendation A.1.
B.2.	Program Results: Fully installing operational systems will improve the Program's effectiveness.	Additional collections included in Recommendation A.1.
C.1.	Program Results: Legislation authorizing collections from Medicare supplemental insurance policies will result in additional collections of \$191.9 million for FY's 1991 through 1995.	Additional collections by military hospitals of \$191.9 million; recurring benefits.
C.2.	Program Results: Additional guidance will improve the Program's effectiveness.	Additional collections included in Recommendation C.1.

ACTIVITIES VISITED OR CONTACTED

Office of the Secretary of Defense

Office of the Assistant Secretary of Defense (Health Affairs),
Washington, DC

Department of the Army

Office of the Surgeon General, Washington, DC
U.S. Army Health Services Command, Fort Sam Houston, TX
Brooke Army Medical Center, Fort Sam Houston, TX
Dwight David Eisenhower Army Medical Center, Fort Gordon, GA
Fitzsimons Army Medical Center, Aurora, CO
Letterman Army Medical Center, San Francisco, CA
Madigan Army Medical Center, Tacoma, WA
Tripler Army Medical Center, Oahu, HI
Walter Reed Army Medical Center, Washington, DC
William Beaumont Army Medical Center, El Paso, TX

Department of the Navy

Office of the Surgeon General, Washington, DC
Naval Hospital, Bethesda, MD
Naval Hospital, Great Lakes, IL
Naval Hospital, Portsmouth, VA
Naval Hospital, San Diego, CA
Naval Hospital, Camp Pendleton, CA
Naval Hospital, Jacksonville, FL
Naval Hospital, Newport, RI
Naval Hospital, Oakland, CA

Department of the Air Force

Office of the Surgeon General, Bolling Air Force Base,
Washington, DC
USAF Hospital Homestead, Homestead Air Force Base, FL
USAF Hospital Fairchild, Fairchild Air Force Base, WA
USAF Hospital Pease, Pease Air Force Base, NH
David Grant USAF Medical Center, Travis Air Force Base, CA
USAF Hospital Tinker, Tinker Air Force Base, OK
Wilford Hall USAF Medical Center, Lackland Air Force Base, TX
USAF Hospital Edwards, Edwards Air Force Base, CA
USAF Hospital Mather, Mather Air Force Base, CA
USAF Hospital Williams, Williams Air Force Base, AZ

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Senate Committee on Armed Services
Senate Committee on Governmental Affairs
Senate Ranking Minority Member, Committee on Armed Services
House Committee on Appropriations
House Subcommittee on Defense, Committee on Appropriations
House Ranking Minority Member, Committee on Appropriations
House Committee on Armed Services
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House Subcommittee on Legislation and National Security,
Committee on Government Operations