RESTRICTED — Not to be released outside the General Accounting Office except on the basis of specific approval by the Office of Congressional Relations.

H344
110357

REPORT BY THE

Comptroller General

OF THE UNITED STATES

RELEASED
RELEASED

Stronger Management Needed To Improve Employee Organization Health Plans' Payment Practices

PLG00925

The Office of Personnel Management has not done an effective job of guiding and overseeing the Employee Organization Plans participating in the Federal Employees Health Benefits program. The Office has allowed the plans to make claim payments without determining whether the claims represented medically necessary services or developing sound, comprehensive systems to determine the reasonableness of charges as the contracts require.

The plans have paid claims for services not covered and have made payments without determining if claims represented reasonable charges for medically necessary services. Payments outside the scope of the contracts unnecessarily inflate the premium cost to plans' enrollees and to the Government.

The Office of Personnel Management should require the plans to adhere fully to their contracts and pay reasonable amounts for covered services.

110357

110357

HRD-79-87
SEPTEMBER 7, 1979

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

B-164562

The Honorable Gladys Noon Spellman
Chairwoman, Subcommittee on Compensation
and Employee Benefits
Committee on Post Office and
Civil Service
House of Representatives

HSE02908

Dear Madam Chairwoman:

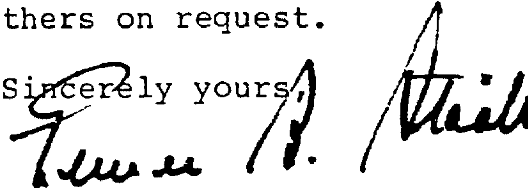
This report is in response to your request for a general review of the activities of the Office of Personnel Management and three Employee Organization Plans participating in the Federal Employees Health Benefits program. You asked us to place specific emphasis on (1) what the Office was doing to assure that the plans complied with their contracts and did not pay excessive benefits, (2) how the plans complied with their contracts, and (3) what policies and procedures the plans had to help control health insurance costs.

Our review showed that the Office of Personnel Management needs to better assure that the plans pay benefits in accordance with their contracts. We are making several recommendations to the Office's Director to improve program management and help the plans pay benefits more in line with their contracts. (See pp. 45 and 46.)

Better management and claim payment practices could help hold down the costs of health insurance. We believe that the Office of Personnel Management's comments on our recommendations did not indicate a commitment to administer the program in ways that could help hold down such costs. We also believe that, at a time of widespread concern over high health insurance costs, the Office's apparent commitment to "business as usual" is not in the best interest of the Government, the program, Federal employees, or the public.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 10 days from its issue date. At that time we will send copies to interested parties and make copies available to others on request.

Sincerely yours,



Comptroller General
of the United States

REPORT BY THE
COMPTROLLER GENERAL
OF THE UNITED STATES

STRONGER MANAGEMENT NEEDED
TO IMPROVE EMPLOYEE
ORGANIZATION HEALTH
PLANS' PAYMENT PRACTICES

D I G E S T

The Office of Personnel Management should act to improve claim payment practices of the Employee Organization Plans participating in the Federal Employees Health Benefits program. More guidance and oversight should be directed toward having the plans make sure that they pay only covered benefits and that the amounts paid are reasonable. The Office should contract only with plans that can and do adhere to contractually required claim payment practices.

Although the Office of Personnel Management is supposed to monitor the plans to assure contract compliance, it has allowed the plans to make claim payments without determining whether the claims represented medically necessary services, as required by the contracts. (See ch. 2.) It has also allowed the plans to pay claims without developing sound, comprehensive systems to determine the reasonableness of charges. (See ch. 3.)

The three Employee Organization Plans GAO reviewed had not given their claim processors comprehensive criteria to help determine if a claim represented a medically necessary service or hospitalization. Consequently, the processors had to rely frequently on their own judgment. As a result, claim processors differed among themselves on how identical claims should be adjudicated. (See pp. 9 to 23.)

The plans have paid claims without having information necesssary to demonstrate medical necessity. GAO found paid claims that

--appeared to represent noncovered routine physical examinations (see pp. 12 and 22),

--had been paid with no indication of symptoms or diagnoses (see pp. 12 and 22),

--had diagnoses or symptoms that were not clearly related to the tests provided (see pp. 12 and 15),

--were for hospitalizations that appeared either unnecessary or too long (see pp. 13, 16, and 23), and

--were paid as emergencies when the patients' diagnoses did not indicate emergencies (see p. 14).

Plans' payment systems did not fully comply with the contracts. Plans are required to develop reasonable charge allowances and pay only up to those amounts except in unusual circumstances. To varying degrees, however, the plans

--had no formal method to determine if charges for services other than surgery and dentistry were reasonable (see pp. 31 to 34),

--did not use adequate information to develop reasonable charge allowances (see pp. 29, 30, and 32 to 33), and

--did not require demonstration of unusual circumstances before paying amounts higher than their formally established allowances (see pp. 35 to 41).

After GAO's review the plans took some steps to address both the claim adjudication and payment problems. (See pp. 23 and 41.)

The Office of Personnel Management has been aware of some of these problems, but it has provided little formal guidance to help the plans determine medical necessity or reasonable allowances. On the other hand, the

Office's knowledge of plan practices has been limited because (1) program auditors have concentrated their periodic plan reviews on the plans' administrative expenses, rather than the plans' claim payment practices, and (2) program management has generally relied on the plans and enrollees to provide information on problems.

Cooperation between managers and auditors within the Office of Personnel Management has been insufficient. Better cooperation and more comprehensive reviews of the plans' claim payment activities are needed. (See pp. 24 to 27 and 42 to 43.)

Good payment practices by the Employee Organization Plans are important because plan enrollments have been growing. In 1978 almost 22 percent of the Federal Employees Health Benefits program enrollment was in the employee plans, an increase of 7 percent since 1975. Additionally, as many as six new employee-sponsored plans may join the program in 1980. (See pp. 5 and 6.)

Better oversight and guidance by the Office of Personnel Management can help assure that plan premiums are not inflated by unnecessary claim payments. This would benefit the Government, which pays part of the premiums, as well as plan membership as a whole. (See pp. 3, 4, and 44.)

GAO recommends that the Director, Office of Personnel Management:

- --Provide definitive guidance to Employee Organization Plans participating, or applying for participation, in the Federal Employees Health Benefits program on the contractual provisions on (1) medical necessity and (2) customary and reasonable allowances.

- --Establish means for increased coordination between program auditors and managers to provide effective oversight of the plans' operations.

--Require program auditors to evaluate the plans' development and application of medical necessity criteria and customary and reasonable payment systems as part of their periodic audits.

--Require adherence to the medical necessity and customary and reasonable payment provisions of the contracts as conditions of the plans' continued participation in the program.

--Require plans applying for admission to the program to demonstrate their potential to adhere to the medical necessity and customary and reasonable payment provisions of program contracts as a condition for admission. (See pp. 45 and 46.)

OFFICE OF PERSONNEL MANAGEMENT AND HEALTH PLANS' COMMENTS AND GAO'S EVALUATION

The Office of Personnel Management said that:

--It had already provided guidance to the plans on paying reasonable charges, but was reluctant to provide guidance on medical necessity.

--The plans already applied customary and reasonable and medical necessity criteria, and it monitored the plans on this through its audits.

--Its auditors and managers sought to cooperate.

--Overall, the plans compared favorably to other plans in the program and to those in the private sector. (See app. I.)

In GAO's opinion, the Office of Personnel Management's comments indicate a lack of commitment to guiding and monitoring the Employee Organization Plans to assure that they comply with contract provisions which can help control program costs. GAO found that the plans interpreted the

customary and reasonable contractual provision differently and did not apply the contracts' medical necessity requirements fully.

Since the audit function is an important monitoring tool, GAO believes the Office of Personnel Management needs to improve the working relationships between its program managers and auditors. Further, the Office's comparison of rates for the three health plans GAO reviewed with other program and private sector plans, without consideration of other factors, such as benefits provided, is misleading, and it does not address the Office's responsibility for assuring that the plans are in full contract compliance. (See pp. 46 to 49.)

The three plans' comments (see apps. II to IV) showed that they were attempting to correct several of the problems GAO noted. Generally, however, the plans that addressed the question of insurance costs said they were doing what they could to hold down costs. One argued that it wanted to provide its members with full benefits as provided for in the contract. GAO agrees that members are entitled to full contractual benefits. It must be recognized, however, that there are contractual limitations to health benefits which the plans are obligated to adhere to.

Contents

		Page
DIGEST		i
CHAPTER		
1	INTRODUCTION	1
	Federal Employees Health Benefits program	1
	Administration of the Employee Organization Plans	4
	Growth of the Employee Organization Plans	5
	Scope of review	6
2	OPM NEEDS TO ASSURE THAT THE PLANS PAY ONLY FOR COVERED BENEFITS	8
	Plans need to develop and apply comprehensive criteria to determine medical necessity	9
	Plans' actions after our review	23
	Need for OPM guidance and oversight	24
3	OPM NEEDS TO ASSURE THAT PLANS PAY ONLY CUSTOMARY AND REASONABLE AMOUNTS	28
	Plans need to improve development and expand scope of allowance systems	28
	Plans need to justify paying more than customary allowances	35
	Plans' actions after our review	41
	Need for OPM guidance and oversight	42
4	CONCLUSIONS, RECOMMENDATIONS, AND OPM COMMENTS AND OUR EVALUATION	44
	Conclusions	44
	Recommendations to the Director, OPM	45
	OPM comments and our evaluation	46
APPENDIX		
I	Letter dated June 19, 1979, from the Deputy Director for Benefits Policy, OPM	50
II	Letter dated June 19, 1979, from the Director, AFGE Insurance Department	54

		Page
APPENDIX		
III	Letter dated June 5, 1979, from the Director, APWU Hospital Plan	58
IV	Letter dated June 19, 1979, from the Director, NALC Health Benefit Plan	61

ABBREVIATIONS

AFGE	American Federation of Government Employees
APWU	American Postal Workers Union
CRVS	California Relative Value Studies
FEHB	Federal Employees Health Benefits
GAO	General Accounting Office
HIAA	Health Insurance Association of America
NALC	National Association of Letter Carriers
OPM	Office of Personnel Management

CHAPTER 1

INTRODUCTION

This report discusses the Office of Personnel Management's (OPM's) 1/ administration of the Federal Employees Health Benefits (FEHB) program plans sponsored by employee organizations. It focuses on OPM's oversight of Employee Organization Plans and on the operations of three such health benefit plans--those sponsored by the

--American Federation of Government Employees (AFGE),

--American Postal Workers Union (APWU), and

--National Association of Letter Carriers (NALC).

Our review was made at the request of the Chairwoman, Subcommittee on Compensation and Employee Benefits, House Committee on Post Office and Civil Service. The Subcommittee was interested in this subject because of increasing Federal enrollments in the Employee Organization Plans and because of various employee organizations' interest in sponsoring new health benefit plans through the FEHB program. The Subcommittee selected the three plans to be reviewed.

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

The FEHB program, established by the Federal Employees Health Benefits Act of 1959 (5 U.S.C. 8901), provides health insurance coverage for enrollees (Government employees and annuitants) and their dependents. The Government and enrollees share the program's cost. Total program obligations were about $3 billion in fiscal year 1978 and are estimated to be $3.2 billion in fiscal year 1979. In mid-1978, the

---

1/The Civil Service Reform Act of 1978 (Public Law 95-454, Oct. 13, 1978) and Reorganization Plan No. 2, both effective in January 1979, divided Civil Service Commission functions among OPM, the Merit Systems Protection Board, and the Federal Labor Relations Authority. Administration of the FEHB program is now the responsibility of OPM. Although the Commission was responsible for the program during most of our review, we shall refer throughout this report to OPM. Under the Commission, the FEHB program was the responsibility of the Bureau of Retirement, Insurance, and Occupational Health; under OPM, the program is the responsibility of the Associate Director/Compensation.

program covered about 3.4 million enrollees and 6.6 million of their dependents or survivors. OPM contracts for coverage through the following types of health benefit plans:

--Service Benefit Plan: This Government-wide plan is available to all eligible Federal employees regardless of their agency, occupation, or location. The plan, which is administered by the national Blue Cross and Blue Shield organization, generally provides benefits through direct payments to doctors and hospitals. This plan covered about 1.9 million enrollees and paid benefits of about $1.6 billion in calendar year 1978.

--Indemnity Benefit Plan: This Government-wide plan provides benefits by cash reimbursement to enrollees or directly to doctors and hospitals. The plan, which is administered by Aetna Life Insurance Company, is open to all eligible employees regardless of their agency, occupation, or location. This plan covered about 484,000 enrollees and paid benefits of about $320 million in calendar year 1978.

--Employee Organization Plans: The 12 health benefit plans sponsored by employee organizations provide benefits by cash reimbursements to enrollees or directly to doctors or hospitals. To join any of these plans, an employee must generally also become a member of the sponsoring organization. Seven of the plans are open to most or all Federal employees and annuitants; the other five restrict membership to employees in a specific agency, occupation, or location. 1/ These plans covered about 734,000 enrollees and paid benefits of about $591 million in calendar year 1978.

1/The Employee Organization Plans open to most or all Federal employees and annuitants are: the American Federation of Government Employees Health Benefit Plan, Alliance Health Benefit Plan, American Postal Workers Union Plan, Government Employees Hospital Association Benefit Plan, Mail Handlers Benefit Plan, National Association of Letter Carriers Health Benefit Plan, and Postmasters Benefit Plan. Plans with restricted membership are: the Canal Zone Benefit Plan, Foreign Service Benefit Plan, Government Employees Benefit Association Health Benefit Plan, Rural Carrier Benefit Plan, and Special Agents Mutual Benefit Association Health Benefit Plan.

--Comprehensive Prepayment Plans: For 1979 there are 74 comprehensive plans, each of which is available only to Federal employees living in the geographic area served by the plan. These plans provide comprehensive medical services by physicians and technicians practicing in common medical centers or benefits in the form of direct payments to physicians with whom the plans have agreements. The plans also provide hospital benefits. In calendar year 1978 the 68 plans in the program covered about 320,000 enrollees and received premium payments of about $259 million.

The Government's share for health insurance premiums is based on the average of six FEHB plans' premium rates. Public Law 93-246 (5 U.S.C. 8906) sets the Government contribution for health benefits at 60 percent of the average of the subscription charges for the highest level of benefits offered by the six plans, including the two largest Employee Organization Plans--NALC and APWU. Additionally, the act limits the Government's contribution to 75 percent of the subscription charge.

The Government contribution is very sensitive even to small overstatements or understatements of the rates. The following table and calculations show how the Government contribution for calendar year 1978 would have been computed according to the act and how a $2 overstatement by one of the six carriers would have increased the Government's costs by about $15.1 million during that year.

Computation of 1978
Standard Government Contribution

Plan	Total biweekly high-option family premium	Total biweekly high-option self-only premium
Service Benefit Plan	$ 51.55	$ 22.15
Indemnity Benefit Plan	40.41	18.47
National Association of Letter Carriers	43.74	17.56
American Postal Workers Union	44.77	18.03
Kaiser-northern California	39.76	15.56
Kaiser-southern California	46.63	18.06
	$266.86	$109.83

1978 Biweekly Standard
Government Contributions

Family option: $266.86 ÷ 6 = $44.477 X 60% = $26.69
Self-only option: $109.83 ÷ 6 = $18.305 X 60% = $10.98

If any one plan's 1978 premium had been lower by $2 biweekly, the following revised computation of the biweekly standard Government contribution would have resulted:

Family option: $264.86 ÷ 6 = $44.143 X 60% = $26.49
Self-only option: $107.83 ÷ 6 = $17.972 X 60% = $10.78

Thus, had any plan's biweekly premium been overstated by $2, the biweekly standard Government contribution would have been overstated by 20 cents for the family and self-only options.

The cost to the Government of a $2 overstatement would be as follows:

Overstated cost per pay period		Pay periods per year		Government's annual overstated cost per enrollee		Program enrollment (note a) Family	Self		Annual overstated cost to the Government
						(millions)			
$0.20	X	26	=	$5.20	X	2.0		=	$10.4
.20	X	26	=	$5.20	X		0.9	=	4.7
									$15.1

a/This example excludes about 408,000 low-option enrollees and 102,000 high-option enrollees. These enrollees were excluded because the maximum biweekly Government contribution to their plans was already at least $.20 below $26.69 or $10.98. Because of this, reducing the biweekly Government contribution by $.20 would not affect the Government's cost for these 510,000 enrollees.

It is thus especially important that the six plans used in the computation have rates which accurately reflect contractual liabilities.

ADMINISTRATION OF THE EMPLOYEE ORGANIZATION PLANS

Since 1960, OPM has contracted annually with the Employee Organization Plans to provide health insurance to the plans' members through the FEHB program. Each plan contracts separately with OPM, and each has its own benefit structure and premium rates. Although benefits differ from plan to plan, all the contracts generally require that the plans provide benefits only for services which are "medically

necessary" and only to the extent that the charges for the services are "customary and reasonable."

OPM, through its Employee Organization Plans Division and its Office of Audits, is responsible for overseeing the Government's contracts with the plans. An important aspect of this responsibility is the annual contract negotiation with each plan. During the negotiations, OPM and the plans agree to specific terms and conditions each party is obligated to meet in the next contract year. Both covered and specifically excluded health services are incorporated into the contracts. Later, descriptions of covered and noncovered services are included in the plans' health benefit brochures. The brochures are contractually binding statements of benefits and exclusions that plans are obligated to follow as parties to the FEHB program contracts.

OPM begins the yearly negotiations by calling upon the participating plans to submit their benefit and rate proposals for the next contract year. Since 1976, the call for proposed benefits and rates has expressed the need to hold down premium costs. OPM has directed the plans to pursue "vigorous cost containment efforts" and has required the plans to submit descriptions of what they were doing to hold down health insurance costs. OPM has suggested to the plans that cost containment should include claim and contract administration, informational activities with providers of health care, and education of enrollees. Other OPM functions include auditing the plans periodically and reviewing claim disputes that may arise between a plan and its members.

GROWTH OF THE EMPLOYEE ORGANIZATION PLANS

Enrollments and benefit payments in the Employee Organization Plans have increased since the FEHB program's inception in 1960. The growing number of employee organizations that are generally open to all Federal employees, as well as changes effected by recent legislation, should enable these plans to serve more enrollees and increase their future premium collections.

For the first contract period (July 1, 1960, to Oct. 31, 1961), the Employee Organization Plans enrolled about 227,500 members--about 13 percent of the total FEHB program enrollment. During that period, the plans paid benefits of almost $45 million. In 1975, the plans had an enrollment of 469,912--almost 15 percent of the total FEHB program enrollment--and paid benefits of about $285 million. In 1978 the plans enrolled 734,000 members--about 22 percent of

the program's total enrollment. Enrollments and benefit payments have also risen in the three plans covered by this report.

Plan	Enrollments during 1975	Enrollments during 1978	Benefits paid during 1975	Benefits paid during 1978
			(thousands)	
AFGE	14,912	23,462	$ 7,416	$ 14,019
APWU	152,553	196,679	97,947	180,535
NALC	152,155	171,658	96,055	155,129

One factor contributing to the growth of the Employee Organization Plans has been the growing number of associate members. Usually, under an associate membership, or its equivalent, a member pays dues, but does not participate in the organization other than as an insured person. Since the program began in 1960, the number of organizations accepting associate members, or their equivalent, has risen from three to seven. The three plans we reviewed are open to all or most Federal employees and annuitants.

Future growth of Employee Organization Plans may come partly as a result of Public Law 95-368, enacted in September 1978. The act included a provision to permit qualified new plans sponsored by employee organizations to enter the FEHB program for the first time since 1963. An OPM official has estimated that, in 1980, as many as six new plans may join the program, thereby giving Federal employees additional employee-sponsored plans from which to select.

SCOPE OF REVIEW

We reviewed the operations of three Employee Organization Plans--those sponsored by AFGE, APWU, and NALC--to assess their compliance with their contracts, especially in relation to benefit payments, and to determine how they tried to hold down claim costs. We also reviewed OPM's oversight and administration of the plans' contracts. The three plans made almost 60 percent of the total benefit payments made by all the Employee Organization Plans in 1977.

At each plan we reviewed claim processing policies and procedures, criteria used to adjudicate claims, and samples of members' folders containing claims incurred in 1977. Our samples were not designed to permit statistically reliable projections of results to all claims at each plan, since we believed that reviewing samples large enough to permit

confident projections would be too costly. Rather, our focus was on the plans' payment systems and OPM's oversight of those systems. Our medical adviser reviewed claims on which we had medical questions, and we discussed all claims we questioned with responsible plan officials.

We reviewed records and/or spoke with officials at (1) OPM, (2) AFGE headquarters, and (3) the Joseph E. Jones Agency (AFGE's claims processing agent)--all in Washington, D.C., (4) APWU health plan headquarters and claims office, Silver Spring, Maryland, (5) NALC health plan headquarters and claims office, Reston, Virginia, (6) the home office of Mutual of Omaha (the AFGE plan's underwriter), Omaha, Nebraska, and (7) the Health Insurance Association of America, New York, New York.

CHAPTER 2

OPM NEEDS TO ASSURE THAT THE PLANS

PAY ONLY FOR COVERED BENEFITS

OPM has provided little guidance and oversight to assure that the plans' claim processing systems can adequately address the medical necessity requirement and some other exclusions of the contracts. To comply with the contracts, the plans must have a way to determine that a claim represents a medically necessary service and that it is not for a service specifically excluded from coverage.

Covered services are those which are provided for in the contracts and for which the plans are obligated to reimburse members or providers. To be covered, a service must not be specifically excluded and must generally be medically necessary for the diagnosis or treatment of an illness or injury. Routine physical examinations and routine eye examinations are typical specific contract exclusions. The requirement for medical necessity is broad--it affects the scope of all covered services. For example, some time spent in a hospital might not be medically necessary if the patient did not require the acute care setting that provides nurses, physicians, and ancillary services. An entire hospital stay might not be medically necessary if the patient were admitted only for tests that could have been safely performed outside the hospital.

Although some plans in the FEHB program have developed criteria for regular use in alerting claim processors to treatments that may not be medically necessary, OPM has not assured that the three plans we reviewed develop, or obtain, and use such criteria. The three plans lacked comprehensive criteria to help them address the medical necessity aspect of their contracts. When the plans had criteria, they often did not apply them. Consequently, the plans have not screened all claims effectively. The plans' claim processing systems permitted claims to be paid without sufficient information to establish that they represented covered services.

It is important that the plans in the FEHB program pay only for covered services because of the large and growing amounts of money involved. Additionally, premiums charged by APWU and NALC, the two largest Employee Organization Plans, are used in computing the Government's contribution to the FEHB program. Therefore, if their rates are inflated by

excessive benefit payments, costs to the Government are increased unnecessarily. (See pp. 3 and 4.)

PLANS NEED TO DEVELOP AND APPLY COMPREHENSIVE CRITERIA TO DETERMINE MEDICAL NECESSITY

Using comprehensive criteria or guidelines to determine medical necessity or to alert a plan to services or supplies that might be medically unnecessary is one means of screening for noncovered services. The three plans generally lacked these criteria, and OPM had done nothing to help the plans obtain or develop them.

The plans did have a few limited guidelines to help determine if a service was medically necessary, but claim processors often did not use them. Instead, the processors relied on their own concepts of medical necessity. Our review of paid claims showed the plans generally needed to make better efforts to

--require diagnoses as a condition of claim payment;

--relate tests to diagnoses or symptoms to assure medical necessity;

--assure that hospitalizations were medically necessary and of reasonable duration;

--identify claims representing possible routine physical examinations; and

--assure that services paid under medical emergency clauses of the contracts were, in fact, emergencies.

AFGE plan

A pertinent part of the AFGE policy on medical necessity is stated in a claim manual provided to the plan's claim processors: 1/

1/AFGE claims are processed by the Washington, D.C., agent of the plan's underwriter, Mutual of Omaha. The agent, the Joseph E. Jones Agency, which receives claims after they have been checked for members' eligibility by the AFGE plan office, is responsible for determining benefit payments.

> "Situations such as lengthy hospital confinements, excessive medical treatment, unnecessary surgical procedures * * * and services which may not be accepted medical treatment must be carefully evaluated before a determination or denial is made."

The AFGE plan, however, lacked the criteria necessary to enforce this policy effectively and comply with a provision in its contract which excluded "routine preventive care and services such as periodic check ups."

For example, it had little information by which to evaluate hospital length of stay for particular surgical procedures or diagnoses. Also, it had no guidelines to help its processors identify claims for medically unnecessary hospital admissions. The plan had access to medical consultants at its underwriter's home office. We found little evidence, however, that the plan used these consultants very much. For example, in a recent audit, OPM auditors noted that none of 427 claims they had reviewed showed evidence of medical referral. In our sample of 52 members' folders, we found no evidence that any claims had been referred. The AFGE claim supervisor told us it was plan practice to assume that hospitalizations, tests, and services ordered by a doctor were generally medically necessary because they had been ordered by a doctor.

AFGE claim processors had to rely on their own judgment to a large degree. Generally, they lacked formal medical education and acquired their claim processing knowledge from on-the-job training. The agent's processors had access to reference material, including medical dictionaries, prescription drug information, the "Merck Manual of Diagnosis and Therapy," and the plan's contract. Except for the prescription drug reference materials, however, the information did not appear very useful for routine claim adjudication. For example, although the "Merck Manual" includes laboratory test indications for a variety of diagnoses, the manual is technical, and its foreword indicates that the material is intended for physicians, rather than laymen. Additionally, the plan's underwriter, Mutual of Omaha, gave the Joseph E. Jones Agency some guidelines on medical necessity. The Jones Agency representative said, however, that processors were not usually provided these guidelines because the agent did not consider them useful enough to incorporate into the agent's manual for routine claim processing.

We interviewed 4 of 16 claim processors to determine how they would process illustrative claims. Our questions concerned appropriate lengths of hospital stays, the relationship of tests to diagnoses, and other matters that a claim processor would often confront. The processors' answers showed they did not consistently interpret plan policy for screening claims for medically necessary services.

One of several questions we asked about determining the appropriate length of a hospital stay was, "What would you consider a reasonable length of stay for a 40-year-old patient hospitalized for an abdominal hysterectomy?" The four processors answered this question differently. One said she did not know and would consult her supervisor. The other three gave answers of 2 to 3 weeks, 2 weeks, and 5 days. According to the Professional Activity Study data, 1/ the national average length of stay for this procedure in 1976 was 8.2 days. The processors provided similarly disparate answers on another length-of-stay question. They also stated their general belief that persons would not be in the hospital unless they were sick enough to be there.

We also asked the processors how they would pay illustrative claims that our medical adviser had said included tests which were not medically indicated by the information provided. Generally, the processors considered the tests justified. Additionally, processors sometimes disagreed with each other on whether the tests seemed medically indicated by the diagnoses.

In commenting on excerpts from our draft report, AFGE said we had failed to mention that the four processors were relatively new employees. However, at the time of our review, AFGE had only two processors who had been hired before two of the processors we interviewed, and one of them was on maternity leave. All of the persons we interviewed were full-fledged claim processors whose work was not subject to any formal review. Our sample of four processors was, on average, more experienced than AFGE processors as a group. The fact that AFGE processors have not had long experience further supports the need for usable, comprehensive criteria for screening claims for medical necessity.

1/The Commission on Professional and Hospital Activities periodically publishes length-of-stay statistics for about 2,100 hospitals that have participated in the Professional Activity Study. The statistics provide length-of-stay information for various diagnoses and surgeries by age group and region of the country.

We reviewed a sample of 52 members' claim folders to help analyze how the plan determined whether services were covered. The folders contained 125 explanations of the benefits provided. An explanation of benefits could represent one or more claims and one or more checks to the member or providers of health care. Of the 125 explanations, 25 involved questionable payments and 6 involved errors. 1/

The following are examples of payments that we deemed questionable because the services did not appear medically necessary or did not appear covered because of other exclusions based on the information available to the plan when payment was made.

--The claim diagnoses were radiculitis, leg pain, and diabetes. Services provided included a complete physical examination, three laboratory tests, an electrocardiogram, tonometry, and a sigmoidoscopy. The charges for these procedures were $122. Our medical adviser said that, based on the information available to the plan, some procedures did not appear medically necessary. The responsible plan official partially agreed, stating that the sigmoidoscopy was questionable but that the rest of the claim was payable without question because a diagnosis had been provided.

--The claim lacked a diagnosis but included charges for an office visit, breast examination, pap test, and pelvic examination. The plan representative agreed with our medical adviser that this claim appeared to represent a routine checkup--a specific contractual exclusion.

The plan representative frequently disagreed with our opinion that certain claim payments were questionable

---

1/We defined "questionable payments" as those made without enough information to determine if the claim was for a covered service. We defined "errors" as instances of a plan's failure to adhere to its contract or its policy developed pursuant to its contract. For example, an official at one plan explained that its policy required claimants, at least once a year, to provide diagnoses for ongoing treatments. If there had been no diagnosis for a year and the plan had made a payment, we classified the payment as an error. Plan representatives did not always agree with our determinations.

because the documentation was not adequate to demonstrate medical necessity. For example, in commenting on some specific claims we had questioned, the plan representative noted that the plan (1) would pay for some questionable tests rather than holding up payment while investigating a claim, (2) assumed tests were related to a diagnosis even when processors did not fully know the purpose of the tests, and (3) would not question any charges submitted on an emergency room bill. In assessing the length of stay on one hospital claim, the plan official assumed the patient should have been in the hospital even though there was no evidence of treatment given for the last 7 days of the stay.

APWU plan

The contract between OPM and APWU excludes coverage of any "services and supplies not medically necessary for the diagnosis or treatment of an illness or injury" as well as "routine physical checkups and examinations." The plan has developed a manual which includes guidelines for its claim processors to use in checking claims for medical necessity. Many guidelines, however, were general and did not lend themselves to a practical application for determining medical necessity. Additionally, the plan made available to processors numerous reference materials, including medical dictionaries and textbooks.

The plan needs more specific criteria to help its claim processors identify possibly unnecessary diagnostic hospital stays and overly long hospital stays for surgeries and illnesses. The plan had no specific criteria addressing length of or necessity for hospitalizations. According to our medical adviser, the plan's criteria for determining medical emergencies were liberal in that some conditions listed as emergencies often were not emergencies.

The plan's guidelines for relating diagnoses and symptoms to diagnostic tests were limited to nine sets of tests and procedures. The manual contained the following instruction to the claim processors:

> "It is not possible to provide a list of tests, other than those few shown, that are necessary to be performed and are specifically related to definite symptoms of illness. A doctor performs or has tests performed that to [the] doctor are necessary in arriving at a diagnosis or in determining [a] course of treatment for a particular illness or injury. A particular

test that may appear to be routine and unrelated to [a] layman may not be considered routine and unrelated to the doctor. Therefore, unless obvious that a test(s) is routine and unrelated, then a test(s) should be paid."

Some of the guidance provided in the APWU manual was too general to be useful to claim processors. For example, the discussions of noncovered "custodial care" defined this term, but gave no detailed guidance to help claim processors detect a hospital stay for custodial care.

APWU's manual contained guidelines for paying medical emergency claims. The contract defined a medical emergency as "the sudden and unexpected onset of a condition requiring immediate non-surgical care." The manual listed over 60 conditions that would be covered as medical emergencies. Although most appeared to be true medical emergencies, our medical adviser stated that some were not generally regarded as such by the medical profession. For instance, the plan manual stated that nosebleeds and flu were considered medical emergencies. Some claims involving headaches, nosebleeds, backaches, stomachaches, and muscle pain of an unspecified nature or severity were paid as emergencies. Our medical adviser said many of these did not appear to be emergencies. It is important that the plan provide emergency benefits only for bona fide emergencies because the plan's emergency benefits are more liberal than benefits for routine medical care. For example, the plan's 1978 contract provided full payment for medical emergencies, but did not cover the first visit to a doctor for each illness.

The plan employed a physician consultant to provide guidance on claims about which the plan had a question. Plan officials told us that they referred about 25 claims a week to this part-time adviser. Most referrals were surgical claims for which the appropriate amount to pay was questionable.

APWU's plan is self-underwritten and maintains its own in-house claim processing system. Nearly all its claim processors have been promoted in-house, primarily from the file department, to their processing positions. They generally lacked medical training. New claim processors did receive 6 weeks of formal classroom training. The course included instruction in medical terminology and use of reference materials, as well as training in claim processing. After completing the course and passing a written examination, trainees process claims under the supervision

of experienced processors. They remain under supervision until the supervisor determines that they have reached an acceptable competence level.

We interviewed 4 of the plan's 90 claim processors and 1 of its 5 claim supervisors to find out how they would make medical necessity judgments. Their responses to our questions were generally consistent with the plan's policies and practices. The respondents said, however, that they had no specific length-of-stay reference materials and that they would judge length of stay based on experience. All said they would refer claims on which the length of stay seemed high to their supervisor.

We asked the processors about some illustrative claims with specific diagnoses and several laboratory tests. Our medical adviser had said that some of the listed tests probably were not related to the diagnosis or that the tests probably indicated a routine examination. Although all the processors knew that laboratory tests and the diagnosis or symptoms should relate, they did not recognize when the laboratory tests in our example cases seemed unrelated to the diagnoses. Also, none questioned a claim that our medical adviser had classified as a probable routine physical examination.

We reviewed a sample of 186 members' claim folders to help analyze how the plan determined whether services were covered. The folders contained 614 explanations of the benefits provided. An explanation of benefits could represent one or more claims and one or more checks to the plan's members or providers of health care. Of the 614 explanations, 80 involved questionable payments and 16 involved errors. 1/ The following are examples of the types of claims we questioned because information available to the plan when it paid the claims was not sufficient to indicate the medical necessity of services provided.

--The diagnosis on one claim was "pylorspasm, menopausal." The claim included office visits and laboratory tests totaling $45. Our medical adviser questioned the tests as not being related to the diagnosis. The plan representative said the laboratory tests we questioned were commonly given with practically all types of diagnoses. Our medical adviser said the plan's assumption was incorrect.

1/See note on p. 12 for our definitions of questionable and erroneous payments.

--The diagnosis on a hospital claim was "diabetes mellitus with hypertension." The patient was hospitalized for 3 days and received various tests. Charges totaled $699. Our medical adviser said the case appeared to be a diagnostic admission. We believe the plan should have investigated the necessity for the hospitalization before paying the claim. The plan representative said plan policy is that hospital stays for diagnostic tests are medically necessary because the doctor chose to admit the patient.

In commenting on excerpts from our draft report, the plan's director stated that APWU accepts a physician's decision on the need for hospital admissions and lengths of stay. He added that determining whether a hospital confinement was necessary would be after the fact and the patient would not know whether charges would be covered by the plan.

We believe that paying all claims for hospitalizations without ascertaining the medical necessity of the stays does not comply with the contract's medical necessity clause. For example, admitting a patient several days before scheduled surgery or for various diagnostic tests which all could have been safely done without admission to the hospital would probably not be covered because portions of the stays would not be medically necessary even though a physician admitted the patient. Also, hospital stays exceeding the normal length of stay are not always medically appropriate just because a doctor decided to allow the patient to remain longer than usual. If a patient's condition did not justify an admission or the length of a stay, the plan is contractually obligated to pay for only that portion of the hospital stay which is medically necessary.

That all hospital admissions are not, in fact, medically necessary has been officially recognized by passage of legislation to establish a Professional Standards Review Organization program. The program's goals include cost reduction and quality assurance. Simply stated, the Congress and the President have recognized that one cannot routinely assume that all hospitalizations are medically necessary.

Determining whether or not a hospital confinement was medically necessary may be after the fact. In our opinion, however, a plan's members should be familiar with their hospitalization coverage and should be aware that only medically necessary services are covered. Better member education about contract limitations, covered hospitalizations, and lengths of stay could lessen problems associated with

after-the-fact claim processing. In a recent letter, the OPM official responsible for administering the FEHB program said that employees can help hold down the costs of health care by asking their doctors about the need for admission to the hospital when outpatient treatment might be preferable. He said that, with the cost of medical care today, employees "can't afford not" to ask these sorts of questions of their doctors.

Plan officials maintained that they would disallow services and procedures whenever they found them clearly not medically necessary. However, they noted they could not make such determinations in most cases. Additionally, they said that the problem in making such determinations was compounded because one doctor would usually support another on the medical necessity of services.

In further commenting on excerpts from our draft report, the plan's director said that applying medical necessity criteria would not be cost effective because it would (1) increase administrative expenses unnecessarily and significantly, (2) slow down production, (3) require hiring interns or doctors to process claims requiring medical decisions, and (4) require more information than is ordinarily made available to the plan.

We believe that applying medical necessity screening criteria can result in more cost-effective claim processing in accordance with the plan's contract. While it might require more information than the plan now ordinarily obtains, such screening has been implemented by at least one claim processing agent (not associated with the FEHB program) and has been found to be very cost effective. A Rand Corporation consultant reported in a August 1978 letter to the Assistant Secretary for Planning and Evaluation, Department of Health, Education, and Welfare, that the claim processing agent screened for medical necessity on every claim. Additionally, the consultant noted that, because of automation, the agent paid claims very expeditiously and used physicians only to review claims which exhibited potentially bad medical practice. The consultant noted that tight claims adjudication substantially reduced costs.

Considering that over 90 percent of the premium dollars go for paying claims and less than 10 percent for administrative costs, we believe the plan must provide its claim processors with useful medical necessity screening criteria. This would help assure that they consistently and effectively apply the criteria in processing claims to avoid improperly

expending premium dollars to pay claims that may represent medically unnecessary services. The APWU plan should determine to what extent its claim processors should scrutinize claims to assure they represent medically necessary services. For example, expending $50 or more to investigate the medical necessity of a $20 claim would not be desirable. However, APWU plan management should prudently decide which claims must be thoroughly screened for medical necessity.

Effective screening of claims for medical necessity may result in payment delays on some claims. Claims, however, which represented medically necessary services based on useful screening criteria would not be delayed. Claims representing services of questionable medical necessity should be delayed pending receipt of information necessary to determine whether they represented a contractual liability.

The plan does not need to employ interns or doctors as claim processors to adhere better to the contract's medical necessity provision. We believe that the APWU plan has to give its claim processors useful medical necessity screening criteria and assure that they are appropriately applied. Medically trained persons would have to be consulted only in cases where treatment did not appear to be medically necessary or seemed out of the ordinary.

NALC plan

The NALC contract states, "Services and supplies not medically required for treatment of illness or injury, or not required for diagnosis or treatment of the condition for which the patient is hospitalized * * *" are not covered. Further, "The fact that a doctor may prescribe * * * a service or supply does not, of itself, make the charge covered * * *."

NALC is a self-underwritten plan and maintains its own in-house claim processing system. NALC's claim manual contained some guidelines to help processors check hospital lengths of stay, cosmetic surgeries, and medical emergencies, and the plan used a part-time medical adviser. Nevertheless, the plan lacked criteria or guidelines to help determine the necessity of laboratory tests, diagnostic procedures, and hospitalizations, and it rarely referred claims of questionable medical necessity to its medical adviser.

The plan's guidelines on average lengths of hospital stays were incomplete compared to the available Professional Activity Study data on which they were based. The manual

containing the guidelines pointed out the shortcomings of its length-of-stay criteria and advised claim processors as follows:

> "The lists do not cover every surgical procedure or all diagnoses. If the procedure or diagnosis is not listed, compare it with one of comparative severity. In any instance where you feel that the confinement is excessively long, or you cannot relate the diagnosis to one on the list, refer the claim to your supervisor."

Additionally, the instructions said that the research and development department maintained a more comprehensive list available for the supervisors' reviews. The claim processors, who generally lacked any formal medical training, were thus expected to judge the appropriateness of hospital lengths of stay for unlisted diagnoses or surgeries.

Although the length-of-stay data provided in the manual were limited and although application of the data depended on processor judgment, the information could help processors to evaluate length of stay for several surgical and diagnostic categories. The plan, however, has ignored its own criteria. Claim supervisors and processors we interviewed in October 1978 were unaware that length-of-stay criteria had been included in the plan's manual since February 1978. After we told supervisory personnel about these guidelines, they said no policy guidance on how or when to refer to or apply them had ever been provided.

NALC supplemented its manual with in-house "administrative liberalizations," which sometimes appeared to run contrary to the plan's contract. For example, under the contract, cosmetic surgery is covered only if necessary as the result of an accident or to correct a congenital anomaly of a child born to a member while enrolled in the plan for self and family. The manual stated that purely cosmetic and elective procedures were not covered. However, one administrative liberalization stated that excision of nevi (birthmarks) or scars would be paid. Our medical adviser said that the majority of such procedures were likely to be cosmetic. Therefore, this administrative liberalization for excising scars and some nevi may run contrary to the plan's contract and claim processing manual.

The NALC plan also provided a list of emergency conditions. An emergency entitles a patient to special benefits--

benefits that are more liberal than those for visits to a physician for nonemergency treatment. The plan, however, circumvented its own guidelines, as well as the contract, by an administrative liberalization regarding claims for emergencies. It stated that, if a member went to the emergency room and did not meet the accidental injury or medical emergency provisions of the contract and the emergency room physician ordered diagnostic tests, all charges--for the tests, the emergency room, and the emergency room physician--would be paid in full under a special diagnostic benefit.

According to the plan's contract, however, only the cost of the tests should be paid in full, while other charges should be subject to the plan's $50 deductible and the 80-percent coinsurance rate. This administrative liberalization is, thus, contrary to the contract. It could also encourage members to obtain more expensive emergency room treatment and diagnostic studies for nonemergency conditions since the plan would pay more than if the patient went to a doctor's office for the same care. In such a case, the doctor's charge for the office visit would be subject to the plan's deductible and coinsurance provisions. Plan officials said that administrative liberalizations were generally made to clarify the intent of the contract. However, an OPM official, after we advised him of the emergency benefit liberalization, said he thought it went beyond the contract's intent.

Plan officials maintained that it was not their job to police the medical profession in terms of appropriate health care utilization by scrutinizing claims to assure payment for only medically necessary services. NALC's director expressed the plan's position in an April 1977 letter to OPM:

> "In the final analyses, we have come to the conclusion that carriers' attempts to control utilization of health care * * * are ineffective * * * and cannot be made effective * * *.
>
> "* * * if prices and utilization are to be effectively controlled, it will have to be done by the Government through the Department of Health, Education, and Welfare * * * rather than by the Civil Service Commission through carriers in the Federal employee program, which accounts only for a small fraction of health care utilization."

Almost all of NALC's claim processors have been promoted from clerical jobs. They generally lacked outside medical training and were provided training which typically lasted

12 to 16 weeks. During that time, the trainees processed claims under supervision of the training supervisor. The trainees were encouraged to use NALC's claim manual, a medical dictionary, guides to prescription drugs, lists of surgical procedures, and other plan reference materials. Aside from the claim manual and the prescription drug guides, however, the reference material lacked specific usable criteria for determining medical necessity or applying the contract's other medical exclusions.

If processors had a medical necessity question on a claim, they could refer it to the plan's medical adviser. However, all claims referred to the medical adviser were routed through the plan's internal claims audit supervisor. The audit supervisor, who had no formal medical training or education, said he usually determined whether to pay the claimed services as a covered benefit without referring the claim to the medical adviser.

In commenting on excerpts from our draft report, the NALC plan director disagreed with us about the "nonprofessional medical training of analysts." (See app. IV.) We did not criticize the health plan's reliance on in-house and on-the-job training. We do believe, however, that, because of NALC processors' backgrounds, criteria designed (1) to aid in paying only claims representing medically necessary services and (2) to be used by nonmedically-trained persons are desirable.

To find out how claim processors would make medical necessity judgments, we interviewed 3 of 88 experienced medical and surgical claim processors and 1 of 11 claim supervisors. Their responses on plan policy and contract requirements restricting coverage to medically necessary services and supplies were inconsistent. None of the respondents was aware that the NALC claim manual contained length-of-stay guidelines. All respondents said they had no guidelines on length of stay, and answers about screening out apparently lengthy hospital stays varied.

The supervisor, for example, said that stays of 30 days or longer would be questionable. One processor said she would rely on common sense for judging length of stay and refer overly long stays to a supervisor. She also noted on a specific example, however, that, if a stay seemed inappropriately long, she would probably assume the patient had experienced complications and pay the claim. The second processor said she relied on her judgment and her supervisor. The third processor said she did not check claims for length of stay.

We also asked the processors how they would pay illustrative claims for tests, some of which our medical adviser had said were not medically indicated by the diagnoses. Three of the respondents said they would pay for all the tests on two illustrative claims without question. The supervisor said she would question some tests and pay for others. However, her opinion on the medical necessity of tests differed from that of our medical adviser.

We reviewed a sample of 168 members' claim folders to help analyze how the plan determined whether services were covered. The folders contained 522 explanations of the benefits provided. An explanation of benefits could represent one or more claims and one or more checks to the member or providers of health care. Of the 522 explanations, 56 involved questionable payments and 39 involved errors. 1/ The plan made payments on another seven explanations of benefits as a result of administrative liberalizations.

Our review showed that NALC processors did not require a diagnosis on every claim and did not generally relate tests to diagnoses to assure the claim represented medically necessary services. Some claims appeared to represent noncovered routine physical examinations, unnecessary hospitalizations, and excessively long hospitalizations. Additionally, a plan administrative liberalization permitted payment of emergency benefits when such benefits were not contractually warranted. The following are examples of the types of claims we questioned because the services did not appear medically necessary or appeared to be specifically excluded based on information available to the plan when it made payment.

--No diagnosis was provided on a claim for laboratory tests and X-rays totaling $149. Determining whether tests were medically necessary is impossible without knowing what was wrong with a patient. The plan representative said NALC accepted diagnostic tests and paid them without requiring a diagnosis.

--A $160 claim presented several diagnoses: ear problems, hand tremors, and "rule out" bronchitis. Specific billed items included a complete examination, an electrocardiogram, a complete blood count, a chemistry panel, a chest X-ray, a urinalysis, a syphillis test, triglycerides, an occult blood stool,

---

1/See note on p. 12 for our definitions of questionable and erroneous payments.

a thyroid test, and a hearing test. The bill noted that the patient was to return for another examination in 1 year. Our medical adviser said he believed that the claim may have represented a routine physical examination because, if the diagnoses were valid, the patient would need to have been seen much sooner. The plan representative said that none of the tests would be questioned.

--The diagnosis for a hospitalization was "functional upper GI complaint, tension headache, and anxiety." Related charges totaled $726. The patient, who was hospitalized for 3 days, received various laboratory tests and diagnostic services which, according to our medical adviser, could have been done outside the hospital. We questioned the medical need for the hospital admission based on the information available. A plan representative said the plan did not question inpatient stays.

--The diagnosis on a claim for a 41-year-old male was "varicose veins (bilaterally), possible thrombophlebitis." The patient was hospitalized on a Wednesday, but surgery (ligation and stripping of veins) was not performed until the following Monday. A presurgical examination had been made before the patient's admission. The patient was hospitalized for 13 days; hospital charges amounted to $2,617. According to the Professional Activities Study data (the length-of-stay guidelines used by NALC), the average length of stay in 1976 for patients having this type of surgery was 5.2 days. Our medical adviser said that the information available did not indicate the necessity of admitting the patient 5 days before surgery. We believe the plan should have determined the medical necessity for the long presurgical stay before paying the claim in full. The plan representative said she understood why we had questioned the payment, but that the plan would not question this length of stay.

PLANS' ACTIONS AFTER OUR REVIEW

During and after our work at the three Employee Organization Plans, we apprised management at each plan of our findings and our concerns about the way their plan processed claims in relation to their contract's medical necessity requirements. After our discussions and review, all the plans obtained additional information or criteria that could be used to help determine medical necessity of

claimed services. While we have not reviewed these plans' activities to determine how or to what extent they have begun to use the criteria, they may be improving their claim processing systems in line with some of our suggestions. These plans' actions do not fully address our concerns in the area of determining the medical necessity of claimed services, but they should help the plans to process claims more in accord with their contracts.

The claim manual used by AFGE claim processors has been supplemented by a new section. This part of the manual directs processors to check diagnostic procedures to make sure they relate to the diagnosis or symptoms. The manual now provides processors with a list of 43 common diagnoses, many with typical symptoms, and the tests commonly associated with each diagnosis.

In commenting on excerpts from our draft report, the NALC director said the plan was building length-of-stay criteria into its computer system and had begun to require diagnoses on all claims.

Officials at APWU told us that they had tried for years without success to obtain criteria by which to gauge appropriate lengths of hospital stays. We told them of an accepted source of length-of-stay data, which they quickly obtained during our review. Plan officials said they had provided the information to claim supervisors for reference material.

NEED FOR OPM GUIDANCE AND OVERSIGHT

OPM has never given the plans any definitive guidance through policy directives or criteria for applying the contractual medical necessity requirements. Furthermore, neither in its administrative activities nor in its periodic audits of the plans has OPM formally and thoroughly assessed the plans' policies and practices for determining medical necessity. Although a primary function of OPM's Office of Audits is to provide FEHB program administration officers with information on contract compliance, the relationship between the Office of Audits and the Employee Organization Plans Division appeared to be strained and lacking in cooperation.

OPM officials responsible for negotiating and administering the contracts with the Employee Organization Plans said they had not given the plans policy guidance for complying with the contractual medical necessity provisions. OPM guidance to the plans has usually been informal or ad hoc advice on particular claim questions. According to the chief

of the Employee Organization Plans Division, OPM guidance and oversight of the plans had been limited because

- --staff shortages in the division and in OPM's Office of Audits forced the division to accept the plans' statements on what they were doing and to concentrate on other matters, such as disputed claims referred to OPM for review;

- --inadequate medical expertise within OPM precluded the division from being active in this area; and

- --emphasis on strict claim processing, which would probably cause plan members to pay some parts of claims from their own pockets, had to be balanced with service to the members.

One plan official said that, although OPM had admonished the plans to control costs through strict contract compliance, he viewed this as "window dressing" to make it appear that OPM was being more aggressive. He also said that OPM's guidance was usually too general to have any effect on plan practices.

The OPM Employee Organization Plans Division chief said he used several oversight methods to administer the program: information submitted by plans on their activities and problems, accounting reports submitted to OPM, requests for review of claims that plans had not paid, periodic visits to the plans, and reports of plan audits by OPM auditors.

Relying on the plans to inform OPM of their problems or shortcomings does not appear to be an effective oversight method. For example, NALC officials told us they did not notify OPM of their administrative liberalizations unless the change would affect the premium or would broaden coverage in contradiction to the contract. OPM officials were unaware of NALC's practice of not reporting all liberalizations until we told them about it. The periodic accounting reports, while useful for other purposes, do not address questions of compliance with the contract coverages and exclusions.

Likewise, monitoring subscriber correspondence and requests for claim reviews does not seem to be a sound method of overseeing plans' contract compliance. Subscribers are unlikely to complain about the plans' paying for noncovered services or hospitalizations. An OPM official, in testifying before the the Subcommittee on Compensation and Employee Benefits, House Committee on Post Office and Civil Service,

said that one reason FEHB program plans other than the Service Benefit Plan did not receive as many requests for claim reviews 1/ was that the other plans were doing a poorer job of claim control and medical review. During our review, an Employee Organization Plans Division spokesman said he was somewhat concerned that he could not recall ever having received a request to review a denied hospitalization claim.

A final method of oversight is provided by OPM's Office of Audits. A specific group of auditors within that office has exclusive audit responsibility for all the Employee Organization Plans. The Employee Organization Plans Division and the Office of Audits are supposed to cooperate in OPM's administrative and oversight activities to assure that the plans comply with their contracts. The Office of Audits staff periodically audits each Employee Organization Plan. An office representative told us that the plans had been subject to audit on a 3-year cycle, but because of recent staff decreases, the cycle would have to be lengthened to about 6 years.

We reviewed audit reports and supporting documents at the Office of Audits for the three plans in our review. These audits had focused primarily on the allowability and allocation of the plans' administrative expenses, the arithmetic errors in claim calculations and payments, and the manner and speed with which the plans transferred their monthly premium income to generate investment income. There was little evidence of audit work directed at checking whether the plans had paid claims in accordance with the medical necessity provisions of their contracts. The audit documentation relating to the most recent Office of Audits review of 250 paid claims at APWU and 191 paid claims at NALC contained no inquiries or findings relating to medical necessity. In a yet unpublished audit which included a review of 427 AFGE paid claims, the auditors questioned the medical necessity of two claims--a noncovered eye refraction and a routine examination. The plan concurred in the auditors' findings on both claims. The OPM auditors additionally raised the point that the AFGE processors lacked controls to insure that hospital confinements were necessary and that tests and diagnoses were related.

1/In our report "Civil Service Needs To Improve Claims Review Process under the Federal Employees Health Benefits Program" (HRD-78-68, Mar. 14, 1978), we said that the number of requests for OPM claim reviews per 100,000 enrollees was 52 for Aetna, 206 for Blue Cross and Blue Shield, and 49 for the Employee Organization Plans.

The Office of Audits does not use OPM physicians to help audit claims for medical necessity. According to the audit chief, he has chosen not to seek such assistance because the auditors review claims only on the plans' premises. The audit chief said it would not be practical to regularly use the medical chief as a consultant because this would require the medical chief to travel. In an earlier report, 1/ we noted that, without access to medical expertise, OPM auditors would probably have difficulties in sustaining their position on questioned claims. OPM agreed that medical assistance would benefit its audit efforts.

Several members of the audit staff questioned the effectiveness of their audits, regardless of their scope or focus, because they believe FEHB program administrators have not demonstrated much support for their audit findings at the Employee Organization Plans. Audit personnel believed that the Employee Organization Plans Division staff have been reluctant to act on some audit findings.

In contrast, the chief of the Employee Organization Plans Division was critical of the Office of Audits work as being both too hard on the plans' investment practices relating to funds not immediately needed to pay claims and too concerned with administrative expenses, leading to "nitpicking" findings. He also was concerned about what he saw as increasing plan resentment of the auditors where they had been critical of the plans' management practices. Although dissatisfied with the nature and scope of audit activities, the Employee Organization Plans Division has not given the Office of Audits much guidance in seeking necessary and useful audit oversight. One responsibility of the division is:

> "Liaison with the audit staff responsible for Employee Organization Plans * * * including requests for specific areas for audit inquiry and resolution of audit findings."

The point of view of the Office of Audits is that the division has provided little productive liaison, cooperation, or support. The lack of cooperation between the principal OPM groups responsible for overseeing the Employee Organization Plans has, in our opinion, been an important factor in OPM's ineffective oversight of the plans' claim payment policies and practices.

1/"More Civil Service Commission Supervision Needed to Control Health Insurance Costs for Federal Employees" (HRD-76-174, Jan. 14, 1977), pp. 15 and 16.

CHAPTER 3

OPM NEEDS TO ASSURE THAT PLANS PAY ONLY CUSTOMARY AND REASONABLE AMOUNTS

The Employee Organization Plans' contracts generally require them to limit payments to customary and reasonable amounts. These provisions are intended to limit the plans' liability. According to the contracts, a "customary and reasonable charge" is generally one comparable with charges incurred for similar services and supplies in cases of comparable nature and severity in the same geographic area. After determining the allowance for a particular procedure and area, the plan should limit its payment to that amount unless there are unusual circumstances. OPM, however, has not assured that the plans develop and apply sound customary and reasonable allowances to all covered services. Of the three plans we reviewed,

--AFGE and NALC had allowances based on insufficient information,

--APWU and NALC had formally developed allowances for surgery and dentistry only, and

--all had paid amounts exceeding their established allowances without necessary supporting information.

PLANS NEED TO IMPROVE DEVELOPMENT AND EXPAND SCOPE OF ALLOWANCE SYSTEMS

During 1977, none of the three plans based its customary and reasonable allowances on adequate data. APWU, however, recognizing that its allowances might be inadequate because they were based on insufficient information, acquired additional data.

APWU and NALC have formally developed allowances for surgical and dental procedures only. The contracts, however, require that <u>all</u> payments be limited to customary and reasonable amounts. The NALC contract, for example, stated that customary and reasonable allowances were to be used for paying "other hospital benefits," "surgical benefits," and "other medical benefits," including nonsurgical physician services. The contracts for the two other plans were similar. The plans have generally defined the reasonable hospital room and board charge as the hospital's semiprivate room rate.

Although at least one FEHB program plan (as well as Medicare intermediaries) has developed allowances applicable to most physician services, OPM has not required APWU and NALC to expand their formally developed customary and reasonable payment systems to include payments for services other than surgery and dentistry. In its oversight and audits of the plans, OPM has not fully examined the development and application of the plans' payment systems.

AFGE plan

AFGE's 1977 and 1978 customary and reasonable allowance systems did not fully comply with the plan's contracts. The 1977 and 1978 contracts stated that customary and reasonable charges were generally to be comparable to charges for similar services in a particular geographic area. Additionally, the 1978 contract explained that the plan was to develop customary and reasonable allowances for surgery by using relative value studies and statistically developed conversion factors based on actual claims received in "your area" and updated at least annually. AFGE used various editions of the California Relative Value Studies (CRVS) 1/ with dollar conversion factors to compute allowances for medicine, surgery, anesthesia, radiology, and laboratory procedures. However, none of its conversion factors was based on statistical information or actual claim experience. Additionally, plan payment areas were divided into only two groups--high- and low-cost areas. As a result, the plan had only two sets of conversion factors to use nationally. We believe that two areas were not sufficient to meet the requirement that conversion factors be based on claims received in "your area."

1/The CRVS, a compilation of separate studies, lists various health care services in five separate categories by numerical procedure codes. Each procedure is assigned a relative value, not a dollar value. The CRVS can be used as a guide in setting customary and reasonable allowances. Allowances can be computed by applying appropriate dollar conversion factors assigned to a particular service. For example, if a company statistically determined that $6 was an appropriate conversion factor for surgical services, it could compute its allowance for a tonsillectomy by determining the correct procedure code and relative value. A tonsillectomy carries a relative value of 15 units. The relative value would be multiplied by the $6 conversion factor to reach an allowance of $90.

AFGE used the 1964 CRVS edition as its primary basis for reviewing 1977 and 1978 claims. The 1969 or 1974 CRVS edition was used when a charge exceeded the determined allowance as computed by using the 1964 CRVS or when the 1964 CRVS did not list the procedure.

The CRVS instructions explicitly state that a separately developed dollar conversion factor must be used for each service. The conversion factor used for surgery, for example, should be developed separately from the one used for radiology or medicine. AFGE, however, applied the same two factors to all services when it used the 1964 CRVS. According to an AFGE representative, no formal rationale existed for using the same factors for all services--they were used because they seemed to work. This representative added that there was no documentation on how the plan developed the 1964 CRVS factors.

AFGE had available, but did not use, surgery conversion factors for various geographic areas developed by the plan's underwriter, Mutual of Omaha. Mutual officials told us AFGE was supposed to use the factors they had supplied. The factors, which were based on Mutual's surgery claims and other statistical charge information, were presented for use with the 1964 CRVS. An AFGE official said the claim processors did not use these factors because they were too low. Mutual's factors ranged from $8 to $16.50 in the contiguous United States; in 31 States, Mutual's highest factor was lower than the lowest factor AFGE used.

Because the unit values in the 1969 CRVS edition differed from those in the 1964 CRVS edition, AFGE officials determined that different conversion factors had to be used for each edition. AFGE officials told us that the conversion factors they had developed would produce comparable allowances using either the 1964 or the 1969 CRVS. In computing dollar allowances for 18 common procedures, however, we found that for 17 of them the factors produced different allowances. The allowances for 12 of the 18 procedures computed from the 1964 CRVS exceeded allowances obtained using the 1969 CRVS conversion factors by 3 to 50 percent.

APWU plan

APWU officials had recognized that their allowances might have been based on inadequate information and had acquired more comprehensive data. The formal APWU allowance system, however, covered only surgical and dental procedures.

In January 1978, APWU began using reports from the Health Insurance Association of America (HIAA). The HIAA reports provide claim charge data for surgical and dental procedures. The data are provided to HIAA at 6-month intervals by participating health insurance carriers. Recently, HIAA has usually received data on 1.6 to 1.8 million surgical procedure charges and on about 12 million dental procedure charges covering each reporting period. The charge information, which is categorized by about 240 geographical areas, includes the number of charges received for each procedure listed, mean charge, mode charge, and prevailing charge at various percentile levels. APWU has chosen to use charge data reflected in HIAA's reports at the 90th percentile level for its surgery and dental allowances.

The plan seems to have acquired comprehensive statistical data for computing surgical and dental allowances. However, the following table indicates that the plan needs to expand the scope of its formal allowance system to other service categories.

Service category	Calender year 1977 benefits paid by APWU plan	
	Amount	Percent
	(millions)	
Total benefits	$150.3	100
Surgery	22.6	15
Hospital room and board	39.8	27
Benefit payments not subjected to formal allowances	a/87.9	58

a/Includes dental payments subject to customary and reasonable payment screens. According to an OPM official, such payments represent a small percentage of the total; actual percentages were not available from the plan or OPM.

The APWU claim processing manual contained some guidance for paying charges for services other than surgery or dentistry. This guidance, however, was generally based on limited data and relied heavily on claim processors' judgments. The APWU manual said, for example, that when a charge "appears excessive," the claim should be referred to a supervisor for a decision to pay it in full or seek additional information. While this type of management may result in some cost control,

a system which relies so much on judgment could easily result in inconsistent processing and inequitable payment authorizations. A plan official said he did not know where or how the information needed to develop the allowances for additional services could be obtained. Further, the APWU plan director told us the plan cannot engage in meaningful cost control by limiting payments. He said the plan could not control the physicians' and hospitals' charges, and enrollees would have to pay amounts that the plan did not cover.

In commenting on excerpts from our draft report, the plan's director reiterated that "APWU cannot contain medical costs." He added that imposing controls on providers of medical services would penalize plan members because providers would refuse to accept the members for treatment. Further, the director said that the plan's objective was to provide members with the best health benefits available under the contract.

We agree that APWU cannot control medical costs or impose controls on providers. Under its contract, however, the plan has agreed to limit payments to reasonable amounts for medically necessary services. Adherence to these provisions, while not necessarily controlling medical costs, could help control health insurance costs. We recognize that strict adherence to the medical necessity and reasonable payment provisions of the contract could result in some enrollees having to pay for costs that the plan would not pay. However, plans' education of enrollees and providers--an approach OPM has frequently advocated--could help make enrollees and physicians more aware of the contract's limitations and the cost effects of their actions.

NALC plan

Although the formal NALC definition of customary and reasonable allowances seemed to meet contractual requirements, the published allowances were usually based on insufficient information or judgment, rather than experience. Additionally, the plan's formal allowance system was applied only to surgical and dental charges.

NALC defined a "customary and reasonable allowance" as the national average charge for a procedure, with special allowances for locations where the plan's information showed the charges to be different from its average. For example, if the plan's national average for a procedure was $100, that amount

would be the allowance except in areas where the plan's information showed the charges to be different from its national average.

In practice, however, the plan's allowance system was plagued by insufficient information. The September 1978 allowance schedule listed about 1,700 surgical procedures. For almost 300 of those procedures, current information was lacking to compute the published allowances. A comparison of a 10-percent sample of the plan's current charge data with its published allowances showed that the plan relied on its current data to set allowances only about one-third of the time. A plan official explained that the allowances not based on current information were usually based on prior plan allowances or judgment. In one instance the plan had accumulated 134 charges which produced an average lower than the prior allowance. The responsible plan official said he judged that the allowance should remain as it had been. Plan officials told us they would not generally reduce an allowance even when plan information indicated a lower allowance because the reductions would be difficult to justify to members.

While the plan relied somewhat on insufficient information and personal judgment to arrive at its national average allowances, it did so even more in developing the specific geographic area factors. The responsible plan official said that developing these factors was highly judgmental because of inadequate information and insufficient computer capability. For example, although a comparison of the 1978 national average allowances with area charge information showed that 375 areas had charges below the national average and 284 had charges above the national average, the plan adjusted charges only in the 284 areas where its computation showed charges were above its national average. A plan official explained that adjustments were not made for areas with below-average charges because of inadequate computer capability.

Besides being based on inadequate information, NALC's formal allowance system covered only surgery and dentistry. The following table indicates the plan's need to expand the scope of its formal allowance system to other categories.

Service category	Calendar year 1977 benefits paid by NALC plan	
	Amount	Percent
	(millions)	
Total benefits	$136.2	100
Surgery	17.1	13
Hospital room and board	35.8	26
Benefit payments not subjected to formal allowances	a/83.3	61

a/See note a, page 31.

The NALC claim processing manual contained no guidance for determining reasonableness of charges for services other than surgery or dentistry. A plan official explained that processors were expected to rely on their judgment to determine charge reasonableness.

NALC's April 1977 response to OPM's request for cost-containment information said, "We believe we are presently doing all we can to contain costs." The letter noted that the plan could not control what physicians and hospitals charged or the services they provided. The plan concluded that attempts to control utilization and prices could not be effective. Further, the plan believed that reductions from billed amounts frequently would force the members to pay differences from their own pockets. "This," said the plan letter, "contravenes our purpose; which is to pay for our members' covered expenses, as promised in the brochure."

Comparison of allowances among the three plans

If the plans had based their customary and reasonable surgery allowances on valid statistical information as the 1978 contracts required, the allowances would tend to be similar for like procedures in the same area. A comparison of the plans' allowances for 24 selected surgical procedures showed, however, that the allowances varied widely within each of the six areas we sampled. Although we did not have statistical information to determine which allowances, if any, most nearly approached true customary and reasonable amounts, it is probable that, where allowances varied widely,

at least two did not adequately reflect actual charge experience. The table below shows formal allowances used by the plans in late 1978 for three surgical procedures.

Procedure	Area	Plans' allowance AFGE	APWU	NALC
Excision of malignant lesion	New York, N.Y.	$ 99	$ 125	$ 80
	Washington, D.C.	99	125	70
	Greenville, Miss.	79	75	50
	Dayton, Ohio	79	100	55
	Van Nuys, Calif.	99	110	65
	Seattle, Wash.	79	64	55
Cholecsystectomy	New York, N.Y.	990	950	915
	Washington, D.C.	990	770	785
	Greenville, Miss.	812	550	590
	Dayton, Ohio	812	600	625
	Van Nuys, Calif.	990	1,044	740
	Seattle, Wash.	812	680	650
Hysterectomy	New York, N.Y.	1,056	1,200	1,025
	Washington, D.C.	1,056	1,000	880
	Greenville, Miss.	990	600	660
	Dayton, Ohio	990	700	700
	Van Nuys, Calif.	1,056	1,200	825
	Seattle, Wash.	990	712	730

In comparing 21 other surgical allowances effective in these same areas in 1977 and 1978, we found similar variances.

PLANS NEED TO JUSTIFY PAYING MORE THAN CUSTOMARY ALLOWANCES

Each of the three plans made payments over its formally established allowances. Some charges and payments greater than the allowances might be justified by surgical complications or other unusual conditions. However, our interviews with claim processors and our reviews of paid claims showed that the plans' payment systems permitted larger payments than could be justified by available information.

AFGE plan

AFGE's claim processors did not consistently apply the plan's policies for determining customary and reasonable allowances. In some instances, processors used inappropriate

conversion factors to compute allowances, and the plan, without adequate justification, made some payments higher than its allowances. Additionally, plan policy was to allow 10 percent over the computed allowance if this would permit full payment. A plan representative said this policy was to reduce the claimant correspondence that would result from the plan paying less than the provider charged. In commenting on excerpts from our draft report, the plan noted this policy was also to give "the doctor the benefit of the doubt" because of "a certain area of reasonable doubt on any charge submitted."

Our interviews with four claim processors, one of whom was also a supervisor, showed that they generally needed to better understand plan policies and procedures for determining allowances and also to emphasize consistent policy application of allowances. In determining 1978 surgery allowances, for example,

--one processor said she always used the amount that should have been used only for high-cost areas;

--another said she could tell from experience whether the charge was reasonable and generally made payments without computing the allowance;

--a third said she used the high- and low-cost area factors; and

--the supervisor said she used these factors plus 10 percent, plus additional amounts if she thought circumstances warranted.

Responses also varied in relation to computing allowances for: laboratory and radiology charges (one respondent said she used allowances for these services, another said she sometimes used the allowances, and two said they did not use allowances); anesthesia (the four processors' answers showed they used three distinctly different methods to compute allowances for this service); and doctor's office and hospital visit charges.

We reviewed a sample of 52 members' claim folders to help analyze the plan's system for determining the amount to pay for a covered service. The folders contained 125 explanations of the benefits provided. Of this number, 4 involved

questionable payments and 38 involved errors. 1/ The following are examples of the types of claims for which the claim folder did not contain sufficient information to justify paying an amount greater than the plan's allowance.

--One claim included a physician's charge of $1,500 for a posterior cervical fusion. The AFGE allowance was $1,080 or $1,200 using the 1964 and 1969 editions of CRVS, respectively--at least $300 less than the charged amount that the plan had paid. The plan representative agreed that the plan should not have exceeded its allowance without additional information to justify the higher payment.

--One claim for an outpatient hospital bill included a $50 charge for an electrocardiogram. Using the 1964 CRVS, we computed the maximum allowance for this procedure at $36. The AFGE representative disagreed with us, maintaining that the allowances did not apply to hospital billings. The plan's 1977 contract stated, however, that allowances were to be used for hospital outpatient expenses.

APWU plan

The plan's policy for paying surgical and dental procedures seemed to be generally in accord with the plan's contract. We reviewed a sample of 186 members' claim folders to help analyze the plan's system for determining the amount to pay for a covered service. The folders contained 614 explanations of benefits. Of this number, 9 involved questionable payments and 31 involved errors. 1/ The overpayments seemed to result more from human errors than from any system problem.

1/We defined questionable payments as possible miscoding of procedures or services, apparent computation of payment using an incorrect copayment, or possible misapplication of the CRVS. We defined errors as payments above the plan's formally established allowances without information to justify the additional payment, duplicate payments, underpayments, incorrect deductible or coinsurance computations, or general arithmetic errors.

Some claims referred to the plan's medical adviser for review may, however, have been paid in excess of the allowances without justification. Plan officials provided us with 11 cases that their medical adviser had reviewed. The cases concerned surgical procedures performed in 1977 and 1978. In each case the plan's medical adviser had advised the plan to make additional payment, based on the operative report or other information in the case files. Our medical adviser also reviewed the 11 cases. He believed that only one case file contained information indicating a procedure unusual or complex enough to warrant payment above the plan's normal allowance. The surgeons' charges for the 10 cases that our medical adviser felt were not unusual were $16,450. The plan paid $14,778 on the 10 cases--$3,188 more than the plan's normal allowances for the procedures.

In commenting on excerpts from our draft report, the plan's director said its medical consultant had reviewed the 10 cases and concluded that there was no basis for our questioning the plan's procedures and that the payments were proper and complied with the contract. The director added that, after our review, these cases were reviewed by an outside private insurance carrier, which substantially agreed with the plan's medical consultant.

We did not question the plan's procedures for referring surgical claims for review by its medical consultant. We did question the plan's paying in excess of its formally established limits on these 10 claims when, in our medical adviser's opinion, the available information did not warrant additional payment. In reviewing the outside private insurance carrier's findings, we noted that the carrier did not address our concern about whether, based on information contained in the case file, the claims had been paid in excess of APWU's normal allowance. The private carrier said, however, that in 5 of 10 cases, APWU had paid amounts in excess of what it (the private carrier) considered customary and reasonable. We realize that physicians' and others' judgments on reasonable amounts may differ. We continue to believe, however, that the disposition of these surgical cases indicates a need for more conservative treatment of charges in excess of what the plan considers usual.

NALC plan

The NALC plan made payments that exceeded its formally established allowances without obtaining information to show that higher payments were warranted. Some of these payments

resulted from: using incorrect procedure codes, rounding and applying a tolerance factor when a charge exceeded an allowance, supervisors' failing to follow the plan's policies, and applying a non-experience-based payment system when charges exceeded formally established allowances.

The plan paid some surgery claims in excess of its allowances because physicians did not supply procedure codes. In some such cases the claim processors matched the charge to a procedure code which was incorrect but which would permit payment in full. For example, our sample contained one fully paid claim for a physician's charge of $150 for setting a broken arm. The correct procedure code would have permitted payment up to $125, but the processor used a code that allowed payment up to $155. An NALC representative agreed that the claim was overpaid. She added that, when physicians did not supply codes for small surgery claims, the plan commonly matched the charge to a code which would permit full payment of the claimed amount.

NALC also paid above its formally established allowances because of the plan's policies of rounding and applying tolerances. When the factor for a higher-than-average-cost area was used to compute a greater allowance, processors were permitted to round upward to the next $5 if this would permit full claim payment. Additionally, claim supervisors could add an additional amount up to $10 if it would permit full payment. An NALC representative explained that these policies had been adopted to hold down the correspondence costs that could result from members' complaints or from the plan's seeking more information to justify full payment.

Sometimes NALC supervisors authorized payment far beyond what plan policy permitted. Our sample contained two claims for which claim supervisors had permitted payments $40 above the allowance. In another instance, a supervisor authorized a payment $205 over the allowance. A plan representative agreed that this practice did not conform to plan policy.

Many NALC claims were paid in excess of the plan's formal schedule of allowances when they were referred to the supervisor of the plan's internal claims audit unit. Claims that had not yet been paid were referred by plan claim supervisors when charges exceeded allowances, and claims that had been paid in amounts less than charges were referred when a physician or plan member requested additional payment. Some of these referrals did not provide any additional information

to establish why more money should be paid; others, while providing more information, did not, in our medical adviser's opinion, warrant additional payment.

The internal claims audit supervisor used various relative value studies and non-experience-based dollar conversion factors to arrive at amounts to pay. He was unable to provide the source for the factors he used, but suggested they may have been provided by State medical societies. According to the internal claims audit supervisor, he reviewed around 500 surgical claims a month that had previously been paid in amounts less than charged. He estimated that, in 80 to 90 percent of these cases, the conversion factors he used produced allowances higher than the plan's formally established limits. The supervisor explained that, in computing allowances higher than the plan's formal schedule of surgical allowances, he sometimes considered the type of care given, the length of time involved, the patient's age, and the patient's ability--based on family size--to pay the balance.

We reviewed a sample of 168 members' claim folders to help analyze the plan's system for determining the amount to pay for a covered service. The folders contained 522 explanations of benefits. Of these, 4 involved questionable payments and 70 involved errors. 1/ On another eight explanations of benefits, the plan's internal claims audit supervisor had authorized higher payments using a non-experience-based system.

The following are examples of claims on which NALC's internal audit supervisor overrode the plan's formal allowance system.

--NALC had paid its maximum allowance of $210 for a procedure for which the surgeon had billed $250. As is the plan's practice, it sent the member a letter explaining that the charge exceeded the allowance, but that the plan would reconsider its payment if the member or physician could provide additional information. The member returned the plan's letter and the surgeon's bill for the unpaid balance with a note saying that the surgeon was neither average nor expensive. The internal claims audit supervisor said that

1/See note on p. 37 for our definitions of questionable and erroneous payments.

all correspondence concerning payments less than charges was referred to him and that he always applied his system whether or not any relevant additional information had been provided. In this case, despite the lack of relevant additional information, the supervisor determined that the bill should be paid in full.

--NALC originally paid its normal allowance of $840 on a surgeon's charge of $975. In response to the plan's request for additional information, a copy of the surgeon's report on the operation was submitted. Our medical adviser reviewed the report and found that the procedure performed had not been unusually complex or different. Nonetheless, the plan's internal claims audit supervisor applied his system to make additional payment and pay the full $975.

PLANS' ACTIONS AFTER OUR REVIEW

After our review, AFGE and NALC plan officials said they were changing the way they developed or applied their allowances. Although we have not reviewed the changes or proposals to determine how or to what extent they may have been implemented, the plans apparently intend to improve their payment systems in line with some of our suggestions.

The AFGE plan said it was changing the way it developed and applied its allowances. The plan's changes do not fully address our concerns, but altering the allowance system would be a step toward paying claims more nearly in accordance with the FEHB program contract. The plan, for example, has altered its conversion factors and specifically identified the high-cost payment areas where each factor is to be applied. While it retains a single conversion factor for low-cost areas, it now has a range of conversion factors applicable to 36 high-cost areas. A plan official said that the high-cost area conversion factors were developed from Mutual of Omaha's conversion factors for surgery.

At NALC, officials told us that after our review they had changed their position about HIAA charge data reports from one of outright rejection to a decision to buy the information as a supplement to the plan's own claim processing system. In commenting on excerpts from our draft report, NALC said allowances for surgery and dental procedures now include HIAA data and are in its computer system.

NEED FOR OPM GUIDANCE AND OVERSIGHT

OPM has been responsible for overseeing the Employee Organization Plans' activities, but it has not required the plans to develop and apply sound customary and reasonable payment systems. Contract administration and periodic audits of the plans should be improved to address this important contract requirement.

OPM guidance on customary and reasonable payment systems has been limited. The agency has provided general direction in contract language, but has done little else to help the plans develop and apply sound payment systems that conform fully to contract requirements. In most cases of specific guidance on payment policies or practices, OPM has limited its directions or advice to comments on claims that plan members have asked OPM to review.

The responsible OPM official explained that, although he had been concerned about the way plans developed and applied their payment systems and he knew that plans did not apply allowances to all services as required, he has generally relied on providing informal guidance. Additionally, he said that he intended to emphasize the customary and reasonable allowance provisions in negotiating the contracts for 1980. He suggested that, in light of our review, he might have to take a less benevolent approach in dealing with the plans.

As stated on pages 25 and 26, the Employee Organization Plans Division relied partly on subscribers and the plans to inform it about problems. The responsible division official said he knew, for example, from the relative numbers of requests for OPM claim reviews, that some plans applied their allowances more strictly than others. However, information from the plans would not always have alerted the division to problems because plans' descriptions generally indicated that the payment systems were more statistically based and comprehensive than they really were. AFGE, in responding to an OPM call for a cost-containment report, attached a report of Mutual of Omaha's cost-containment efforts. The report said that Mutual was refining its statistical data on customary and reasonable physician fees and could pinpoint physician charge information on a community or even zip code basis. AFGE did not, however, tell OPM that it generally did not use this information. APWU, in its response to OPM's call for a cost-containment report, stated that the plan paid

"Only reasonable and customary charges billed by the out-patient departments of hospitals and by clinics and other out-of-hospital facilities, as well as for medical and dental services and supplies."

The plan, however, did not explain to OPM, as it did to us, that it had no way of defining the term "reasonable and customary" other than for surgical and dental procedures.

OPM's Office of Audits has reviewed the three plans covered by this report. The most recent reports are on NALC in January 1979, APWU in June 1977, and AFGE in July 1976. The auditors completed an audit at AFGE in April 1977 and expect to issue their report in September 1979. Although the auditors' guidelines state that they should review and evaluate the plans' procedures for paying surgical claims, none of the issued reports on the three plans addressed the plans' development of customary and reasonable payment systems. The OPM auditors may, however, be broadening the scope of their audits. During their last audit at the AFGE plan, they issued audit inquiries to the AFGE claim administrator noting that the plan's payment system lacked guidelines and controls and that payments exceeded established allowances.

CHAPTER 4

CONCLUSIONS, RECOMMENDATIONS, AND

OPM COMMENTS AND OUR EVALUATION

CONCLUSIONS

OPM needs to guide and oversee the Employee Organization Plans more effectively to promote (1) better contract compliance, (2) equity in claim payments, and (3) health insurance cost control. More effective guidance from OPM should include being more definitive--either in its contracts or in its other formal activities with the plans--about its requirements for plans' medical necessity determinations and their development and application of customary and reasonable allowances. Better guidance and oversight might affect the Government's contribution to the FEHB program since the NALC and APWU plans' premiums are used in the formula that determines the Government and enrollee shares of the cost.

Both the President and the Congress have expressed concern over rapidly rising health care and health care insurance costs. Although neither OPM nor the plans can directly affect the overall cost of health care, both can demonstrate their concern about insurance costs by taking effective steps to assure that benefit payments are made only for covered services and only for reasonable charges. Under their contracts, the plans are obligated to assure all payments are reasonable and for covered services. As one party to the contracts, OPM is obligated to make sure the Government is getting what it has contracted for.

OPM and plan officials have stated that strict claim adjudication would penalize members who might have to pay part of their medical bills from their own pockets. FEHB program plans, however, should pay only those medical bills that are contractually covered. Educating members and providers, which OPM has suggested to the plans, would be one way to let them know that the plans intend to conform more closely to the contracts. Although liberal claim adjudication practices may benefit certain plan members, payments beyond the scope of the contracts inflate premiums and can produce inequities among plans and members.

OPM has not guided or monitored the plans to assure that payments were for medically necessary services and supplies. Such guidance and oversight are necessary because the plans either lacked comprehensive criteria to enforce the contracts'

medical necessity clauses or often did not use the criteria they had. Moreover, OPM has allowed the plans to use payment systems which have not strictly complied with the contracts and which could produce inequities among the plans' members.

As a result of legislation passed in the 95th Congress, new Employee Organization Plans may enter the FEHB program in 1980. We believe that OPM should require plans applying for entry into the program to demonstrate the potential to adhere to the medical necessity and reasonable allowance provisions of typical FEHB program contracts. Requiring new plans at the outset to process claims in strict accordance with their contracts would undoubtedly be more effective than admitting new plans and later attempting to get better claim processing and payment systems.

Within OPM, effective oversight of the plans has been hampered by a poor relationship between program administrators and program auditors. Better cooperation between these groups and a clearer definition of an effective audit scope would improve OPM oversight.

RECOMMENDATIONS TO THE DIRECTOR, OPM

We recommend that the Director, Office of Personnel Management:

- --Provide definitive guidance to Employee Organization Plans participating, or applying for participation, in the FEHB program on the contractual provisions on (1) medical necessity and (2) customary and reasonable payments.
- --Establish means for increased coordination between OPM's auditors and managers to provide more effective oversight of the plans' operations.
- --Require OPM auditors to evaluate the plans' development and application of medical necessity criteria and customary and reasonable payment systems as part of their periodic audits.
- --Require adherence to the medical necessity and customary and reasonable payment provisions of the contracts as conditions of the plans' continued participation in the program.

--Require plans applying for admission to the program to demonstrate their potential to adhere to the medical necessity and customary and reasonable payment provisions of program contracts as a condition for admission.

OPM COMMENTS AND OUR EVALUATION

In commenting on our recommendations (see app. I), OPM said that

--it had worked with the Employee Organization Plans and provided guidance on customary and reasonable allowance requirements, but was reluctant to provide guidance on medical necessity;

--its FEHB program managers and auditors had sought to cooperate in reviews of the plans;

--the plans already applied customary and reasonable and medical necessity criteria and OPM monitored for such compliance through audits; and

--the plans' error rates and costs compared favorably with the insurance industry and the private sector.

We believe that OPM's comments are not fully responsive to our findings or our recommendations.

OPM said that it had worked with the plans to develop a uniform definition of "customary and reasonable." OPM added that over half of the requests for claim reviews it received involved determinations of customary and reasonable allowances. The agency said that reviews of the plans' actions in these cases reveal patterns of operations and possible problem areas and help it channel guidance to the plans.

Although a uniform definition may provide a basis for developing allowances, our review showed that additional guidance is sorely needed. Despite the uniform definition, the three plans we reviewed used different methods to compute their allowances, and (as shown on p. 35) the resulting allowances varied considerably among the plans for the same procedure in the same geographic area. We continue to believe that enrollee requests for claim reviews--essentially complaints about a plan's action--are most likely to occur when a plan has denied a claim or curtailed a payment. Enrollees are unlikely to complain to OPM about overpaid claims. They are particularly unlikely to complain about

a claim paid in excess of the customary and reasonable allowance because they would have no way of knowing if the plan had paid excessively. Therefore, OPM relies to a great extent on a system of enrollee complaints that can alert managers to a plan's restrictive practices, but that cannot alert managers to a plan failing to use practices to help hold down health insurance costs.

In commenting on the medical necessity aspect of the contracts and our recommendations, OPM said that it had introduced and promoted the concept of concurrent utilization review through Professional Standards Review Organizations and hospital utilization review committees. Additionally, OPM said it had been reluctant to issue medical necessity guidelines to the plans because (1) doctors could not agree on medical necessity, (2) having professional medical personnel ruling on each claim would be expensive, and (3) a rigid set of guidelines would straitjacket benefits and could penalize enrollees.

Although OPM may have introduced and promoted the concept of concurrent utilization review, neither APWU nor NALC uses such reviews. An OPM official told us that Mutual of Omaha (the underwiter for AFGE) has contracted with the National Capital Medical Foundation, Inc.--the Professional Standards Review Organization for the District of Columbia. This is only one of more than 180 such organizations in the United States. An official of the Foundation told us that it does have a contract with Mutual of Omaha and reviews individual cases in a consultive capacity, but that it does not have the authority to deny Mutual coverage for unnecessary hospital admissions or extended stays. The official added that the Foundation reviews documentation for fewer than 100 Mutual-underwritten claims a year.

While physicians may sometimes disagree on the medical necessity of some medical services, we believe that physicians generally can agree on the necessity of most services. To imply that no guidance can be provided because there will be exceptions to the rule will always preclude action. It is true that having professional medical personnel rule on each claim would be expensive, but we did not recommend that. A health insurance plan or administrator may use nonmedical personnel to adjudicate claims, testing for medical necessity with appropriate criteria, and refer to medically trained personnel only claims that fall outside the criteria and require more expert analysis. Finally, OPM reviews claims whenever enrollees indicate that they have not received all

the benefits to which they were contractually entitled. Thus, we do not believe that guidance to the plans would penalize enrollees.

We continue to believe that OPM should provide guidance to the plans on the medical necessity aspects of the contracts. Such guidance need not be so detailed as to provide a manual for claim processing or so rigid as to "straitjacket" the plans. OPM should, however, inform the plans of their specific contractual obligations regarding medical necessity and assure that the plans develop workable systems to monitor claims for compliance. As the Government's representative, OPM is obligated to assure that its contractors are fully meeting their contracts' provisions.

OPM commented that its audit staff and its managers had consistently sought to cooperate and coordinate with each other. According to OPM, the managers requested special reviews of problem areas, and the audit staff responded to these requests. Additionally, an OPM official told us that the audit staff had been responsible for beneficial contract changes, including standardizing definitions of "hospital," "double coverage," and "custodial care" and incorporating statements of the applicability of the Federal Procurement Regulations in the contracts.

Seeking cooperation is commendable, but we believe OPM's auditors and managers need to improve their working relationships to produce reviews and audit reports which can keep management better informed about how the health plans operate. Despite management's request for specific area audit and despite contract changes attributed to the auditors, OPM auditors told us they felt demoralized because they did not believe that management seriously considered many of their findings. On the other hand, as indicated on page 27, OPM management frequently criticized the auditors. This shows a need for a better, more productive association between the two groups.

OPM also said it believed that the plans applied medical necessity and customary and reasonable allowance criteria and that OPM monitored for contract compliance. This statement shows that OPM needs better information about how the plans operate. Our review showed that the plans often lacked necessary criteria to alert claim processors to possibly unnecessary services and that, when guidelines did exist, they often were not followed. Similar conditions existed with respect to customary and reasonable allowance guidelines

and systems. OPM's need for better information is further indicated by the plans' taking several actions to improve claim processing in areas we had pointed out to them during our review.

We believe that OPM auditors should continue to expand their audit scope to review benefit payments and the systems by which they are made in order to more effectively monitor plans' activities for contract compliance. After our review, the chief of the Employee Organization Plans Division agreed that audits similar in scope to ours were desirable.

In conclusion, OPM commented that it believed that the Employee Organization Plans':

--Operations compared favorably with the private sector in that premiums were low and error rates acceptable.

--Low premium rates compared to other FEHB program plans indicated that the plans were doing a good job of providing health insurance.

Statements regarding relative premium rates can be very misleading. If the plans served identical populations that sought identical health care and if the plans provided identical coverage, then rate comparison could be one measure of a plan's performance. Comparing rates does not in itself show how well a plan is providing health insurance. Our review was not made to precisely measure plans' error rates or to compare those rates to the industry's acceptable margin. As stated on pages 6 and 7, we were more concerned with reviewing the plans' systems for determining medical necessity and customary and reasonable allowances. In many cases we could not determine if payment errors had been made because a plan lacked, for example, a payment system which set reasonable allowances for most of its payments.

- - - -

OPM has the responsibility and the opportunity to guide and monitor participating plans to assure that they comply with those FEHB contract provisions which can help hold down FEHB program costs. In general, we believe that OPM's comments on our recommendations indicate a strong commitment to conducting its business as usual and a distinct lack of commitment to implementing our recommendations or taking necessary steps to help control continually rising health insurance costs.

United States of America
Office of Personnel Management Washington, D.C. 20415

In Reply Refer To: JUN 19 1979 Your Reference:

Mr. H. L. Krieger, Director
Federal Pesonnel and Compensation Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Krieger:

Thank you for the opportunity to review your proposed report to the Subcommittee on Compensation and Employee Benefits, "The Office of Personnel Management Has Not Adequately Monitored Employee Organization Health Plans' Payment Practices" (B-164562).

The report concludes that the Office of Personnel Management (OPM) has not done an effective job of guiding and overseeing employee organization plans participating in the Federal Employees Health Benefits Program (FEHBP) and makes five recommendations related thereto. I would like to comment on those recommendations.

The first recommendation is that OPM "provide definitive guidance to Employee Organization Plans participating, or applying for participation, in the Federal Employees Health Benefits program on the contractual provisions on (1) medical necessity and (2) customary and reasonable allowances;" (page 69).

OPM has used a variety of means to provide guidance on these contractual matters. Specifically, we have:

- Worked with the plans during the past 3 years to develop a uniform definition of "reasonable and customary" and to determine the most equitable method of arriving at correct allowances. As a result, some plans have adopted area physician profiles in lieu of unit values and conversion factors.

- Introduced and promoted the concept of concurrent utilizatin review through use of Professional Standard Review Organizations or hospital utilization committees.

CON 114-24-3
January 1979

On a continuing basis, we provide advice on contract interpretaion, both formally through meetings with plan representatives and informally upon telephone or written request, and clarify contract language when warranted. We closely review and analyze utilization reports, incurred claims reports, and rate proposals submitted by the plans to discover any indication of habitual extra-contractual payments.

We also provide policy guidance through determination of claim disputes between plans and enrollees. Although the report states "...monitoring subscriber correspondence and requests for claim review does not seem to be a sound method for overseeing plans' contract compliance." (page 36), we believe the enrollees' letters are a valuable sounding board for plan compliance. For example, well over half of the requests for review of claims handling involve "reasonable and customary" determinatins. Continual review of action taken by the plans in these cases reveals patterns of operation as well as problem areas and help us channel guidance given the plans.

For a variety of reasons, OPM has been reluctant to issue guidelines for the plans on medical necessity. First, the question of medical necessity is one on which doctors themselves cannot agree (for example, note the disagreement between plans' medical advisors and GAO's medical advisor evidenced in the report). Second, if professional medical personnel were asked to rule on the necessity of services submitted on each claim, the cost per claim would increase dramatically and be reflected in later years' premiums. Finally, a rigid set of guidelines setting certain methods of treatment as allowable per diagnosis would straitjacket benefits payment and penalize the enrollee if services and supplies necessary, yet out of the ordinary, were provided.

The report's second recommendation is that OPM "establish means for increased coordination between program auditors and managers to provide effective oversight of the Employee Organization Plans' operations."

In my experience, our audit staff and the managers of the employee organization plan contracts have consistently sought to coordinate and cooperate with each other. For example, the audit staff is responsive to the managers' requests for special reviews of problem areas. The managers routinely brief the auditors prior to their on-site visits to plans and act on audit findings. In fact, some audit findings have led to beneficial contract changes correcting situations of which the managers were otherwise unaware.

There has been discussion among the auditors and managers as to the apropriate scope of audit, but not in the context of the managers being concerned that the auditors are "being too hard on plans" (page 39). I do not believe the fact that the discussion takes place indicates poor relationships; rather, it reflects a healthy exchange of views on the wide variety of potential areas for audit concentration and should result in audits which are responsive to program needs while recognizing the staff constraints under which we operate.

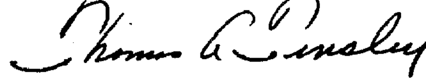
[See GAO note 1, p. 53.]

The remaining three recommendations are integrally related: OPM should evaluate the plans' development and aplication of medical necessity and customary and reasonable payment criteria, and require adherence thereto as a condition for admission to and continued participation in the FEHB Program. I believe that the plans do apply such criteria and that we do monitor for contract compliance, through our audit activity and as explained in the discussion related to the first recommendation.

Overall, I believe the employee organization-sponsored health benefit plan operations compare very favorably with large private sector employees, e.g. one major corporation provides health benefits for approximately one-half of the population served by FEHBP employee organization plans for an annual cost almost twice as great. Additionally, the claims processing error percentage found by your auditors falls well within the insurance industry's acceptable error margin. Further, how good or how bad a job a plan does in providing health insurance is reflected in the rates charged to enrollees. On January 1, 1979, there were 86 plans participating in the FEHB Program. With respect to the High Option Family rate, the rates for the three plans discussed in the report were in the lower two-fifths of all FEHBP rates. I do not believe this would be the case if claims for services and supplies not covered by the contracts were being paid routinely. If you can provide me with the specific identification of each of the erroneous claim payments mentioned in the report, I will see that each is vigorously pursued.

Thank you again for the opportunity to review the proposed report. I trust that these comments will be made part of any final report you may issue.

Sincerely yours,



Thomas A Tinsley
Deputy Director for
Benefits Policy

GAO notes:

1. We have altered the report to say that the OPM manager was concerned that the auditors were being too hard on certain aspects of the plans' operations while emphasizing unimportant findings regarding other facets of plans' operations.

2. Page references in this letter may not correspond to page numbers in the final report.

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES
AFFILIATED WITH THE AFL-CIO
KENNETH T. BLAYLOCK, NATIONAL PRESIDENT · JOSEPH D. GLEASON, EXECUTIVE VICE PRESIDENT · NICHOLAS J. NOLAN, NATIONAL SEC.-TREAS.
1325 MASSACHUSETTS AVE., N.W. · WASHINGTON, D. C. 20005
Telephone: (202) 737-8700

IN REPLY PLEASE REFER TO:
5/GAO/Insurance

June 19, 1979

Mr. Gregory J. Ahart, Director
Human Resources Division
U. S. General Accounting Office
Washington, D.C. 20548

Re: B-164562

Dear Mr. Ahart:

In response to your letter of May 17, 1979, we are herewith providing our comments on the excerpts from the draft of your proposed report to the Subcommittee on Compensation and Employee Benefits, House Committee on Post Office and Civil Service, entitled, "The Office of Personnel Management Has Not Adequately Monitored Employee Organization Plans' Payment Practices".

I. Page 15 of the draft report refers to a recent audit of 427 claims by OPM auditors that did not reflect evidence of any medical referral to the medical consultants located at the underwriter's home office. We take exception to the inclusion of this reference since the latest OPM audit report is not final and we have not had an opportunity to review or respond to such report. [See GAO note 1, p. 57.]

II. In your examples, on page 16, of reference materials made available to claim processors by the Washington, D.C. agent of the plan's underwriter you refer only to medical dictionaries, guides to prescription drug names and the plan's contract. You failed to include "The Merck Manual of Diagnosis and Therapy". In addition, you state that the information was too general to be useful for specific claim adjudication.

TO DO FOR ALL THAT WHICH NONE CAN DO FOR ONESELF

The guide to prescription drugs is more than just a listing of drug names. It provides:

1. Detailed description of drugs.
2. Identifies whether or not it is a prescription item.
3. Indicates the illnesses or injuries for which it would be prescribed.
4. Shows normal dosages given.
5. Shows contraindications.
6. Identifies adverse reactions.
7. Indicates how normally supplied; e.g. tablets, liquid or injectible.
8. Provides a listing of generic and chemical names.

"The Merck Manual" provides the following information relating to illness:

1. Description
2. Symptoms
3. Related diagnostic tests
4. Treatment normally given
5. Prognosis

In addition, "The Merck Manual" lists clinical procedures, laboratory test indications and interpretations, and routine immunization procedures.

We feel that failure to include the indicated details on the reference material available to the claim processors distorts the picture of what is available to them for their use in adjudicating claims. [See GAO note 2, p. 57.]

III. In reviewing your draft proposal with representatives of the Joseph E. Jones Agency, they were unable to identify the guidelines on medical necessity provided by the home office of Mutual of Omaha to them (page 16 of the draft report). We would appreciate receiving further identification of this material. [See GAO note 3, p. 57.]

IV. Regarding the interview with the claim processors, the draft report fails to mention that the four (4) claim processors were relatively new employees. The hire dates on the four persons interviewed were 2/7/77, 3/21/77, 11/21/77 and 1/30/78. We believe that this significantly affects the context in which these interviews should be taken.

V. Representatives of the Joseph E. Jones Agency and Mutual of Omaha advise us that they are unable to determine your source for the formal allowances used by the AFGE Plan in late 1978 for the three surgical procedures shown in the table on page 54.

They state that these allowances are not correct. We would appreciate further clarification and/or discussion on the basis used in determining these allowances. [See GAO note 4, p. 57.]

VI. The reference on page 55 of the draft report to the use of a 10 percent variance over the computed customary and reasonable allowance is not presented in the manner in which it was formally explained by the plan representative. Only one aspect of the plan representative's rationale for this procedure is presented in the draft report.

It is our opinion that in the adjudication of claims, there is a certain area of reasonable doubt on any charge submitted. We have established an area of 10%, thereby giving the doctor the benefit of the doubt up to a maximum of 10% without question. Should the charge exceed the 10% variance, then the entire amount above customary and reasonable is questioned.

We feel that the statement of the plan representative should be revised to include this additional information.

Sincerely,

Harold F. Staub, Director
AFGE Insurance Department

cc: Mutual of Omaha
Mr. Nolan

GAO notes:

1. Our source for the information AFGE has taken exception to was not an OPM draft audit report. The source was an informal, written audit inquiry presented to the AFGE plan. An AFGE representative had responded in writing to the inquiry: "We use the Mutual of Omaha medical consultants on a case basis. We keep no special records * * * on cases reviewed."

2. We have revised our report to address AFGE's concerns.

3. We told the Jones Agency representative that the medical necessity guidelines referred to on page 16 of the draft report were Mutual of Omaha's "Group Claim Briefs."

4. We explained to the Group Claims supervisor at the Jones Agency that she had been the source for the allowances presented on page 54 of the draft report. We further explained that these allowances were computed using the plan's policy of taking the CRVS which would produce the highest allowance and allowing this amount plus 10 percent, when necessary, to pay a claim in full.

5. Page references in this appendix may not correspond to page numbers in the final report.

Hospital Plan

AMERICAN POSTAL WORKERS UNION, AFL-CIO
P. O. Box 967, Silver Spring, Maryland 20910

JOHN R. DUBAY, DIRECTOR
BEN EVANS, EXECUTIVE ASSISTANT
FRANCIS J. KOWALCZUK, ADMINISTRATIVE ASSISTANT

June 5, 1979

Gregory J. Ahart
Director
Human Resources Division
U.S. General Accounting Office
Washington, D.C. 20548

Re: B-164562

Dear Mr. Ahart:

This will acknowledge receipt of your letter of May 17, 1979 enclosing a draft of your proposed report.

After reviewing the draft, I respectfully request and strongly recommend that the report on our plan be an individual one and that we not be included in a general report covering three plans. I note that there are several blank or partially blank pages which obviously dealt with the other plans. Since we have no idea what the deleted material refers to, we obviously do not want to be associated with it. We hope that you will honor this request. [See GAO note, p. 60.]

As we advised at the initial meeting with your staff, APWU cannot contain medical costs. These can only be controlled by legislation and/or governmental efforts to impose controls on the providers of medical services. If we were to attempt to impose controls on hospitals and doctors, they would refuse to accept APWU Hospital Plan members for treatment. Without controls we are experiencing the same problem with hospitals for outpatient services and with Blue Cross participating physicians. Our official objective is to provide American Postal Workers' Union, AFL-CIO, members and other Federal employees with the best health benefits available under our contract with the Office of Personnel Management.

With reference to the comments in the report regarding the criteria to determine medical necessity, it is the opinion of the Plan managers that, in order to comply with the GAO suggestions, the administrative expense would go out of sight and the end results would not be cost effective. It would slow down production greatly as paperwork would become unruly and burdensome and would result in considerable additional administrative cost. To have claims processors available to make the decisions suggested in the report would require the hiring of medical interns and/or doctors to make decisions in most cases. Physicians would be the only people able to make final judgment as to what lab tests or x-rays were necessary in each individual case. Also, to screen the claims, as suggested in your report, would require far more information than ordinarily is made available to this office. The Inter-Office Brochure, referred to as the APWU Manual in your report, is probably more detailed than most health plan carriers provide. Our training procedures are comparable to the insurance industry and, in fact, the brochure has been criticized as being too detailed for ordinary laymen.

In all cases where a claims payment was questioned by your staff, detailed replies were furnished by our staff and we disagree with what are called "errors" in your report.

In reference to the report regarding hospital admissions and length of stays, we accept the physician's decision as to the need for admission to the hospital, as well as the length of stay. We are not in a position to judge each individual case when two physicians disagree. To make a determination as to whether or not a hospital confinement was necessary would be after the fact and the person admitted would have no knowledge as to whether or not the charges would be covered. The length of stay in the hospital is subject to review based on the standard information available prior to your audit.

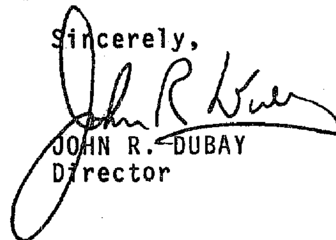
The reasonable and customary procedures of our contract are adhered to and payments are limited, with the exception of individual cases which are reviewed by our technical staff and/or our medical consultant. We have demonstrated, as stated in your report, the use of comprehensive data regarding reasonable and customary charges and we do review payments for medical services with the information available. We also stand on our statement that meaningful cost controls will have to be imposed by the providers of medical services. The members of the APWU Hospital Plan should not be penalized for the absence of such controls.

Payment of the surgical procedures questioned by your staff and your medical adviser was reviewed by our medical consultant, who feels there is no basis for questioning our procedures. He feels the Plan payments were proper as made, and in accordance with our procedures and contract with the OPM. In addition, the cases questioned were reviewed by an outside private insurance carrier (exhibit enclosed) which substantially agrees with our medical consultant's findings.

We certainly would be happy to meet with members of your staff after reviewing our comments in order to clarify any disagreements between the parties. In any event, we hope the matter will be fully discussed with us before a Report is filed with Congress or otherwise published.

In conclusion, the Hospital Plan of the American Postal Workers Union, AFL-CIO, feels that it would be a complete injustice to our members, as federal employees, for them to bear the expense of controlling medical costs when there is no recourse or action they may take. If there are to be controlled medical costs, it is the responsibility of the U.S. Government.

Sincerely,



JOHN R. DUBAY
Director

JRD/gs
enclosure

GAO note: APWU health plan officials were commenting on excerpts from our draft report; the excerpts dealt only with APWU. We explained to these officials that material relating to each plan would be clearly identified in our final report and that, based on the Subcommittee's request, we believed a single report covering our complete review was appropriate.

Officers of the National Association of Letter Carriers
Vincent R. Sombrotto
Tony R. Huerta
Francis J. Conners
Gustave J. Johnson
Ronald L. Hughes
Joseph H. Johnson, Jr.
William M. Dunn, Jr.
Mark Roth

National Association of Letter Carriers
Health Benefit Plan
11111 Sunset Hills Road, Reston, Virginia 22093 (703) 471-1550
Robert J. Buntz Anthony B. Morell

June 19, 1979

Mr. Gregory J. Ahart, Director
Human Resources Division
U.S. General Accounting Office
Washington, DC 20548

Dear Mr. Ahart:

The proposed draft report to the Subcommittee on Compensation and Employee Benefits, House Committee on Post Office and Civil Service, has been reviewed in detail. Before commenting on the report, we would like to thank the GAO auditors for their cooperation while on the Plan's premises and for the fact that they did not interfer with our operation during the audit.

We agree with a few of the audit findings in which we may have been deficient. Steps have been taken, or are in the process of being made, to correct the following:

1) Use of PAS for length of stay is being built into our computer system;

2) Reasonable & customary charges for surgery and dental now include HIAA data and are in the computer system;

3) Diagnosis now required for the payment of all claims;

4) 1978 contract change included diagnostic charges on a performed anywhere basis, removing the reason for a patient to seek outpatient tests at the hospital. [See GAO note 1, p. 63.]

We disagree with the following findings:

1) Nonprofessional medical training of analysts. We know of no academic course offered for the education of claim analysts (processors). On the job training is the standard of the insurance industry.

2) Instructions to analysts regarding length of stay (PAS). Complete instructions to analysts were not quoted from Plan's Claim Manual. Additional instructions were given for referral to supervisors and to the complete PAS records. [See GAO note 2, p. 63.]

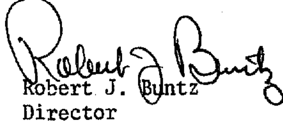
Board of Trustees
George Davis, Jr. Halline Overby James G. Souza, Jr.

3) Accidental injury and medical emergency versus outpatient diagnostic charges. Payment of outpatient diagnostic benefits when the claim does not qualify as an accidental injury or medical emergency is not contrary to the Plan's insuring agreements. [See GAO note 3, p. 63.]

4) Removal of growths, nevi, and neoplasms. Actual diagnosis cannot be determined until removal completed or by advance biopsy. Cost of biopsy and pathological studies would exceed or equal cost of removal in most cases. [See GAO note 4, p. 63.]

In closing, there are two additional items which were not mentioned in the report which we feel are of import. The Administrative Decisions and Liberalizations section of the Claim Manual are not all liberalizations. The majority of the items are interpretations of the contract provisions for use by the analyst in the processing of claims. The other item is the fact that we do use Equifax Services, Inc., to audit hospital bills to ascertain that we have been charged correctly and that the service was actually rendered.

Sincerely,



Robert J. Buntz
Director

RJB:ss

GAO notes:

1. We did not discuss the need for this contract change in our draft report. During our review we had discussed the need for such a change in the contract applicable for charges incurred in 1977, and plan officials had pointed out that the change had been made in 1978.

2. We have recognized and commented on the additional instructions mentioned here.

3. We agree that outpatient diagnostic benefits are covered in full by the contract; however, the plan's policy of covering in full emergency room expenses, besides those for diagnostic testing, when the claimant had not suffered an emergency or injury is contrary to the contract. The chief of OPM's Employee Organization Plans Division agreed the policy was contrary to the contract.

4. According to our medical adviser, the plan is confusing the issue by including growths and neoplasms in their comments. We said that removal of scars and nevi was usually cosmetic.

(101002)

☆U.S. GOVERNMENT PRINTING OFFICE: 1979 620-167/301 1-3

Single copies of GAO reports are available free of charge. Requests (except by Members of Congress) for additional quantities should be accompanied by payment of $1.00 per copy.

Requests for single copies (without charge) should be sent to:

U.S. General Accounting Office
Distribution Section, Room 1518
441 G Street, NW.
Washington, DC 20548

Requests for multiple copies should be sent with checks or money orders to:

U.S. General Accounting Office
Distribution Section
P.O. Box 1020
Washington, DC 20013

Checks or money orders should be made payable to the U.S. General Accounting Office. NOTE: Stamps or Superintendent of Documents coupons will not be accepted.

PLEASE DO NOT SEND CASH

To expedite filling your order, use the report number and date in the lower right corner of the front cover.

GAO reports are now available on microfiche. If such copies will meet your needs, be sure to specify that you want microfiche copies.

AN EQUAL OPPORTUNITY EMPLOYER

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

OFFICIAL BUSINESS
PENALTY FOR PRIVATE USE,$300

POSTAGE AND FEES PAID
U. S. GENERAL ACCOUNTING OFFICE

THIRD CLASS