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Report to Rep. Richard C. White, Chairman, House Committee on Post Office and Civil Service: Retirement and Employee Benefits Subcommittee; by Elmer B. Staats, Comptroller General.

Issue Area: Health Programs: Reimbursement Policies and Utilization Controls (1208).
Contact: Human Resources Div.
Budget Function: Health: Health Care Services (551).
Organization Concerned: Civil Service Commission: Bureau of Executive Manpower; National Association of Blue Shield Plans; Aetna Life Insurance Co.; Civil Service Commission.
Congressional Relevance: House Committee on Post Office and Civil Service: Retirement and Employee Benefits Subcommittee.
Authority: Federal Employees Health Benefits Act of 1959 (5 U.S.C. 8901).

Representative Richard C. White requested a review to determine what the two Government-wide carriers (Blue Cross and Blue Shield and the Aetna Life Insurance Company) and the Civil Service Commission are doing to control health care costs under the Federal Employees Health Benefits program.
Findings/Conclusions: Benefit payments have been made without conforming to contract or policy requirements and without enough information to determine whether payments were allowable. The contracts negotiated by the Civil Service Commission provide no incentives for the carriers to control benefit payments, and contain no provisions under which the Commission, either through audit or other means, can exercise sufficient control over the allowability of benefits paid by the carriers. Recommendations: The Civil Service Commission should revise its health insurance contracts to provide incentives for compliance with the Commission's contract requirements; it should include in its contracts specific cost-control programs that the carriers must follow; and should clarify its audit authority, expand its audits, and act more effectively on its audit findings. If the Commission does not adopt these recommendations, the Subcommittee on Retirement and Employee Benefits should consider developing legislation to this end. (Author/SW)

REPORT OF THE
COMPTROLLER GENERAL
OF THE UNITED STATES

More Civil Service Commission Supervision Needed To Control Health Insurance Costs For Federal Employees

Under the Federal Employees Health Benefits program, Blue Cross/Blue Shield and Aetna have made benefit payments

--without conforming to contract or policy requirements or

--without enough information to determine whether payments were allowable.

Their contracts with the Civil Service Commission do not contain incentives for them to control payments. To achieve better controls, the Commission should

--include incentives in the contracts;

--include specific cost-control procedures the carriers must follow; and

--clarify its audit authority, expand its audits, and act more effectively on audit findings.

If the Commission does not adopt these recommendations, the Subcommittee should consider developing legislation to this end.

HRD-76-174

JAN. 14, 1977

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20...

B-164562

The Honorable Richard C. White
Chairman, Subcommittee on Retirement
and Employee Benefits
Committee on Post Office and
Civil Service
House of Representatives

Dear Mr. Chairman:

This is in response to your request that we determine what the two Government-wide carriers (Blue Cross and Blue Shield and the Aetna Life Insurance Company) and the Civil Service Commission are doing to control health care costs under the Federal Employees Health Benefits program.

Our review showed a need for the two carriers and the Commission to improve their efforts in controlling health care costs under the Federal Employees Health Benefits program. We are making recommendations to the Commission. (See p. 20.) If the Commission does not adopt these recommendations, we believe the Subcommittee should consider developing legislation to this end. (See p. 25.) We have not included legislative language in this report; however, we would be available to assist the Subcommittee in drafting any legislation it believes is warranted.

As requested by your office, we plan to provide copies of this report to a number of Senators who are interested in the Federal Employees Health Benefits program. We are also sending copies to the Chairmen, House and Senate Committees on Appropriations, Government Operations, and Post Office and Civil Service; Chairman, Civil Service Commission; and the Director, Office of Management and Budget.

Sincerely yours,

Comptroller General
of the United States

Contents

ABBREVIATIONS

CSC	Civil Service Commission
FEHB	Federal Employees Health Benefits
GAO	General Accounting Office
UCR	usual, customary, and reasonable

REPORT OF THE COMPTROLLER GENERAL OF THE UNITED STATES

MORE CIVIL SERVICE COMMISSION SUPERVISION NEEDED TO CONTROL HEALTH INSURANCE COSTS FOR FEDERAL EMPLOYEES

D I G E S T

Rates of two Government health insurers--Blue Cross/Blue Shield and Aetna--increased 35 percent in 1976. (See p. 3.) Prices may continue skyward if the Civil Service Commission and the insurance carriers do not strictly control insurance costs. Blue Cross/Blue Shield and Aetna paid about $1.4 billion for insurance claims in 1975.

Local Blue Cross and Blue Shield plans paid claims in some cases

--without making sure that medical treatments or procedures were related to the diagnoses, as required by contract and by the policies of the Blue Cross Association and the National Association of Blue Shield Plans (see p. 26);

--for assistants-at-surgery without requiring certification that an assistant surgeon was needed or that adequate staff assistance was unavailable at the hospital, as required by contract (see p. 29);

--for dental work not covered under the contract (see p. 30);

--for nervous and mental conditions without determining whether patients actually needed treatment (see p. 32); and

--without screening claims for unnecessary hospital stays, as required by the contract and the Associations' policies (see p. 33).

These types of claims accounted for about 13.5 percent of the claims sampled at 19 Blue Cross and Blue Shield plans. In addition, the local plans did not always make sure that they paid the correct amount of money for claims. In some cases:

--Physician claims were not paid according to the usual, customary and reasonable payment provisions of the contract. (See p. 36.)

--Administrators were not screening claims, in accordance with the Associations' policies, to see whether the patients were covered by other insurance. (See p. 40.)

--Because of a lack of coordination, claims for unauthorized services that had been denied by Blue Cross were paid by Blue Shield. (See p. 42.)

Further, the Associations are not effectively requiring local Blue Cross and Blue Shield plans to follow contract provisions and cost-control requirements. (See p. 5.)

The two Aetna branch offices were not, as required by contract

--limiting payments for nonsurgical physician services on the basis of prevailing fees and

--making sure that claims were always paid only for necessary medical services. (See p. 44.)

About 12 percent of the claims sampled at the two Aetna branch offices should not have been paid based on the information available. A number of these claims were for small drug charges.

CIVIL SERVICE COMMISSION ROLE

The contracts negotiated by the Commission with the Associations and Aetna do not contain incentives for the carriers to control costs. Nor do they set forth specific requirements for implementing properly cost-controlling provisions. Without these provisions, the Commission cannot verify that payments carriers make are allowable. (See p. 11.)

The Commission's audit reports on the health insurance carriers in the past emphasized

administrative costs charged to the contracts rather than proper benefit payments, in accordance with the contracts. Since July 1975 the Commission's audits have emphasized a review of benefit payments, but the Commission has been largely ineffective in making sure that benefits are paid properly. For example:

--Although the auditors are reviewing benefit payments, they do not have doctors available to help them resolve medical questions.

--Even when the Commission and the carriers agree that payments have been made improperly, these are allowed because payments denied retroactively may cause undue hardship for the patients.

--The Associations and the Commission cannot agree on the extent of the Commission's audit authority.

If the Commission imposes strict cost-controls, patients may become disgruntled, since they may have to pay bills paid up to now by the carriers. Nevertheless, without strict cost-control programs, the carriers may continue to provide benefits not covered under the contracts, causing higher premium costs for the Federal employees and the Government.

RECOMMENDATIONS TO THE COMMISSION

The Chairman of the Commission should

--revise Commission health insurance contracts to provide incentives to control costs;

--include in the contracts specific cost-control provisions which carriers must follow; and

--clarify Commission audit authority, expand its audits, and act more effectively on audit findings.

CARRIER AND COMMISSION COMMENTS

The Commission and the two carriers disagreed with GAO's suggestions to include in their contracts (1) incentives to control costs and (2) specific cost-control provisions.

The carriers said that competition for insurance policies provides enough incentive for carriers to furnish the most benefits for the least cost.

Commission officials stated that they had considered incentives but had been unable to develop a workable plan. The Commission does not want to see specific cost-control provisions included in the contracts. It favors the use of contract and policy requirements developed by the carriers as guidelines in their audits.

While competition may exist for employee insurance subscriptions, the Commission's contracts with the carriers are essentially noncompetitive. GAO believes the Commission should include in its contracts specific incentives to control costs and specific cost-control provisions to permit the Commission to review and sustain its position on the carriers' benefit payments. (See p. 20.)

RECOMMENDATIONS TO THE SUBCOMMITTEE

If the Commission does not adopt these recommendations, the subcommittee should consider developing legislation to

--require the Commission to include specific cost-control and/or incentive provisions in contracts with the Federal Employees Health Benefits program carriers;

--authorize the Commission to audit the carriers for economy, efficiency, and achievement of results, as well as for financial soundness and compliance with the contracts; and

--provide the Commission with some flexibility in contracting with the Associations for the Service Benefit Plan. (See p. 25.)

CHAPTER 1

INTRODUCTION

We reviewed the effectiveness of the programs used by the Civil Service Commission (CSC) and the two Government-wide Federal Employees Health Benefits (FEHB) plan carriers--Blue Cross/Blue Shield and Aetna--to make certain that benefits are paid in accordance with the contracts between CSC and the carriers. We made our review in response to a request from the Chairman, Subcommittee on Retirement and Employee Benefits, House Committee on Post Office and Civil Service. (See app. I.)

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 3.1 million Government employees and annuitants and 6.2 million dependents. For fiscal year 1974, the program's cost, which is shared by participating employees and the Government, was $1.6 billion, of which the Government's share was about $960 million. For fiscal year 1975, the cost had increased to $1.8 billion and the Government's share to $1 billion. The program's cost for fiscal year 1976 was about $2.2 billion, and the estimated cost for fiscal year 1977 is $2.9 billion.

The FEHB program is administered by CSC, which contracts for coverage through the following four types of health plans.

--Service Benefit Plan: A Government-wide plan under which the carrier, Blue Cross/Blue Shield, generally provides benefits through direct payments to physicians and hospitals. About 5.9 million of the total 9.3 million program participants are covered by this plan, which paid about $1.2 billion in benefits in 1975.

--Indemnity Benefit Plan: A Government-wide plan under which the carrier, Aetna Life Insurance Company, provides benefits by either reimbursements to the employees or, at their request, direct payments to physicians and hospitals. About 1.3 million program participants are covered by this plan, which paid about $246 million in benefits in 1975.

--Employee Organization Plans: These plans, available only to employees and individuals in their families who are members of the sponsoring organizations, provide benefits either by reimbursing employees or, at their request, by paying physicians and hospitals. In 1975 the 12 Employee Organization Plans provided coverage to about 1.5 million program participants and paid about $285 million in benefits.

--Comprehensive Medical Plans: These plans, available only in certain localities, provide (1) comprehensive medical services by teams of physicians and technicians practicing in common medical centers or (2) benefits in the form of direct payments to physicians with whom the plans have agreements. Thirty-two such plans provide benefits to about 680,000 program participants. Benefits in 1975 amounted to about $147 million.

The two Government-wide plans make about 77 percent of the total benefit payments and provide coverage to about the same percentage of program participants.

ADMINISTRATION OF GOVERNMENT-WIDE PLANS

Since 1960 CSC has contracted annually with the Blue Cross Association and the National Association of Blue Shield Plans (hereinafter referred to as the Associations) to provide Federal employees health insurance coverage under the Service Benefit Plan. The Associations' Office of the Director, Federal Employees Program, Washington, D.C., is responsible for contracting with CSC and for seeing that the Associations follow the contract provisions in providing health care benefits.

Benefit payments for Service Benefit Plan members are made by 139 local Blue Cross and Blue Shield plans. The local plans have formally delegated authority to the Associations to represent them in contractual and other dealings with CSC. Plan participation agreements--contracts between plans and the Associations--spell out the duties and responsibilities of each. (See p. 5.)

The Aetna Life Insurance Company, the contractor for the Indemnity Benefit Plan, maintains general management responsibility for the plan at its home office in Hartford, Connecticut. Routine claims processing and benefit payments are the responsibility of 13 nationwide Aetna paying offices, which are branch offices of the home office, as opposed to the local Blue Cross and Blue Shield plans, which are autonomous.

As the Government's representative, CSC, through its Bureau of Retirement, Insurance, and Occupational Health, is responsible for overseeing the contracts with Blue Cross/Blue Shield and Aetna. Specific CSC functions include

--auditing the Associations and the local Blue Cross and Blue Shield plans and Aetna and its paying offices,

--annually negotiating contracts with the Associations and Aetna, and

--adjudicating claims disputes between subscribers and the carriers.

RISING COSTS AND RELATED CONTRACT PROVISIONS FOR GOVERNMENT-WIDE PLANS

The Congress has expressed concern about the increasing costs of health insurance for Federal employees, particularly the 35-percent increase in 1976 rates of the two Government-wide plan carriers--the Associations and Aetna.

From 1967 to 1976, the Associations' monthly premium rates for the family high option increased more than 230 percent--from $28.30 to $93.47. The rates for the family low option increased about 44 percent--from $17.76 to $25.59. For the same period, Aetna family high option premium rates increased about 222 percent--from $25.91 to $83.33--and family low option rates increased about 241 percent--from $13.52 to $46.04.

The proper implementation of a number of provisions in the contracts between CSC and the Government-wide carriers should control costs. For example, some services--generally those not considered medically necessary--are excluded as covered benefits; reimbursements to health care providers are to be limited to amounts established by specified payments systems; and payments are to be limited to benefits not payable by other group insurance or workmen's compensation.

To comply with the contract provisions, the Associations and Aetna have developed cost-control procedures for local Blue Cross and Blue Shield plans and Aetna paying offices to follow. The Associations' procedures are contained in an administrative manual and a 16-point claims cost-control program provided to local plans. Aetna provides its paying offices with directives intended to assure uniform claims processing and cost control.

CHAPTER 2

CSC NEEDS TO MAKE CERTAIN THAT CARRIERS PAY BENEFITS ACCORDING TO CONTRACTS AND COST-CONTROL POLICIES

We reviewed the practices followed by 10 Blue Cross plans, 10 Blue Shield plans, and 2 Aetna paying offices in making benefit payments under the Service Benefit Plan and the Indemnity Benefit Plan. The Civil Service Commission needs to strengthen its program for ensuring that benefit payments are made in accordance with the contracts and with the cost-control provisions (policy requirements) established by the carriers for implementing the contracts.

The local Blue Cross/Blue Shield plans and Aetna paying offices made many benefit payments

--not in accordance with contract or policy requirements or

--without sufficient information upon which to determine the allowability or reasonableness of the claim.

The contracts negotiated by CSC with the two Government-wide carriers lacked incentives for the carriers to control health benefit costs.

The Associations have entered into formal contracts with the local Blue Cross/Blue Shield plans which require the local plans to comply with the provisions of the contract as well as the Associations' cost-control policy requirements. In practice, however, the Associations do not require the local plans to comply with the Associations' cost-control policy requirements, which results in differences in the payments of benefits by the local plans.

CSC's reports on its pre-July 1975 audits of the health insurance carriers emphasized administrative costs rather than the carriers' proper payments of benefits under the contracts. Since July 1975 CSC's audits have begun to emphasize reviews of benefit payments; however, only two final reports have been issued on these audits. CSC has, to some extent, been ineffective in ensuring that benefits are paid properly because:

--Although the auditors are now reviewing benefit payments, they do not have access to medical expertise to help resolve medical questions.

--When CSC and the carriers agree that individual benefit payments have been made improperly, CSC has not required the carriers to make adjustments in allowable costs under the contracts.

--The Associations and CSC cannot agree on the extent of CSC's audit authority.

The lack of CSC's assurance that the carriers have effective benefit cost-control programs has resulted in excessive payments and payments for noncovered benefits.

CSC needs to improve its cost-control program by ensuring that benefit payments are made in accordance with contracts. CSC should revise the contracts to include incentives for reducing costs. The contract should set forth the specific cost-control programs the carriers must follow to properly implement the contracts. Further, CSC should improve the effectiveness of its audits to better identify improper payments and to ensure that the carriers take corrective action.

CARRIERS NOT FULFILLING CONTRACT AND POLICY REQUIREMENTS

The Associations and Aetna have developed cost-control procedures to be followed by the local Blue Cross and Blue Shield plans and Aetna paying offices. The Associations' procedures are contained in an administrative manual and a 16-point claims cost-control program provided to local plans. Aetna provides its paying offices with a claims guide and directives intended to ensure uniform claims processing and cost control.

The 139 local Blue Cross/Blue Shield plans and the Associations enter into contracts, which are called participation agreements. These agreements, among other things, bind the local plans and the Associations to a uniform pattern of contract administration.

The plan participation agreements require the Associations to

--contract with CSC;

--establish policies, practices, and procedures for the administration of the Service Benefit Plan; and

--interpret the contract.

The agreements require the local plans to

--comply with the policies, practices, and procedures adopted by the Associations for administering and providing benefits under the Service Benefit Plan;

--comply with the terms, provisions, and conditions of the contract and the Federal Employees Health Benefits Act; and

--conform to all reasonable requests of the Associations regarding the administration of the Service Benefit Plan.

Aetna's home office establishes overall policy for administering the Indemnity Benefit Plan. The home office has developed policies for the 13 Aetna paying offices to use in implementing its contract. These policies are contained in the Indemnity Benefit Plan Claim Guide and home office directives. Unlike the Blue Cross and Blue Shield plans, paying offices are not independent.

Blue Cross and Blue Shield

We reviewed a random sample of claims paid in 1975 at each of the 10 Blue Cross and 10 Blue Shield plans we visited. Our review was to determine whether benefit payments had been made in accordance with the 1975 Service Benefit Plan contract and the Associations' policies, as contained in their administrative manual. The administrative manual was used because it contains detailed criteria regarding the proper payment of benefits and the agreements between the Associations and the local plans state that the local plans "shall comply with the policies, practices and procedures adopted by the Association * * *." Also, CSC uses this administrative manual in its audits of the local plans in assessing the proper payment of benefits.

As will be discussed later (see p. 18), there is significant disagreement between CSC and the Associations as to whether the local plans must comply with this manual.

Our sample contained 4,696 basic benefit claims 1/ at the 20 Blue Cross and Blue Shield plans involving benefit payments amounting to $5.7 million. We questioned 599 claims amounting to more than $1.2 million either because the claims were paid improperly or there was not sufficient information to determine that the payments were proper. Because the charges appearing on a claim are frequently combined rather than broken out on a line-item basis, we could not precisely determine the questionable amounts.

All claims we questioned were discussed with plan officials. They said that 49 claims should have been denied and that 280 should not have been paid based on the information available. When plan officials disagreed with us or did not comment, our medical advisors, using the Associations' and local plans' criteria, reviewed the information on which the plan had based its decision to pay the claim. Based on these criteria, our advisors concluded that another 270 claims lacked sufficient information to substantiate payment.

Claims that plan officials said should have been denied or not paid and claims questioned by our medical advisors amounted to 13.5 percent of the Blue Cross claims sample and 13.5 percent for 9 of the 10 Blue Shield plans' claims sample. 2/ These percentages indicate, with a 95-percent confidence level, that at these 19 plans between 283,456 and 469,852 claims were not paid in accordance with contract provisions or policy requirements.

In commenting on our report (see apps. II and III), CSC and the Associations said it was not appropriate to lump together all elements of questioned claims and suggest that 13.5 percent of the claims were paid in error. The Associations also questioned our percentage of questioned claims, stating that we did not have access to information which claims processors used and that our statistical projections were exaggerated.

1/Basic benefits accounted for about 85 percent of total high option benefits paid by Blue Cross and Blue Shield.

2/The claims for one Blue Shield plan were not comparable with those of the other plans for projection purposes because it did not stratify its paid claims in the same manner.

Each questioned claim was discussed with local plan officials who provided us with the information available at the plan upon which the plan had based its decision. Furthermore, our projections were made using CSC's and the Associations' claims sampling method, which is a valid statistical method. We recognize that some of the 599 claims we questioned because of a lack of sufficient supporting information may have been valid claims; however, the documentation the plans had at the time they paid the claim did not support the payment. For example, one Blue Cross plan questioned only those claims which exceeded $10,000, regardless of the supporting documentation. It seems to us that the local plans should obtain the necessary supporting information, required by the Associations' instructions, prior to the payment of such claims. Also, it should be recognized that we identified other deficiencies that were not included in the 13.5-percent error rate, such as the various usual, customary, and reasonable (UCR) payment methods used by the plans, various methods used for investigating for other insurance coverage, and problems in coordination of denied claims between Blue Cross and Blue Shield plans.

In our analyses of the paid claims and the claims payment systems, we found instances where:

--Claims, both inpatient and outpatient, were paid without ensuring that treatments or procedures were related to the diagnoses as required by the contract and the Associations' policies. (It was not possible for us to determine whether treatments or tests related to the diagnosis on inpatient claims since hospital claims usually did not contain a description of the tests performed. Since this existed at all plans we did not include these in our error projections.)

--Claims for assistants-at-surgery were paid without requiring certification that an assistant surgeon was needed or that adequate staff assistance was not available at the hospital as required by the contract.

--Claims were paid for dental admissions that were not covered benefits under the contract.

--Nervous and mental benefit claims were paid without screening for medical necessity.

--Plans were not adequately screening claims for unnecessary hospital stays as required by the contract and the Associations' policies.

We also tested systems used by the plans to assure that payments were not excessive as required by the contract or the administrative manual. Although we found deficiencies in these areas, they were not included in our error projections. We found instances where

--physician claims were not paid in accordance with UCR payment scheme of the contract;

--plans were not screening claims in accordance with the Associations' policies to determine if other insurance coverage existed (referred to as coordination of benefits),

--claims were paid that should have been investigated for work-related accidents (workmen's compensation) as required by the contract and Associations' policies, and

--because of lack of coordination, claims for non-covered services that had been denied by Blue Cross plans were erroneously paid by the corresponding Blue Shield plans.

These weaknesses are discussed in more detail in chapter 3.

Aetna

We reviewed a random sample of claims paid from April 1975 through March 1976 at two Aetna paying offices to determine if benefit payments were made in accordance with the Indemnity Benefit Plan contract and procedures established by Aetna in its claim guide for implementing the contract.

Our sample included 569 claims involving benefit payments of $79,689. We questioned 68 claims valued at $5,901. It should be recognized that we usually questioned only certain items on a claim; however, because the charges appearing on a claim are frequently combined, we were unable to determine the precise amounts that were questionable.

Our medical advisor and officials from the Aetna home office reviewed the same information that the plan used to support its decisions to pay the claim. Officials from the Aetna home office said that 65 of the 68 claims we questioned should not have been paid. A number of the questioned claims involved small drug charges.

Claims that we questioned amounted to 12 percent of the claims sample. We could not project the total number of claims paid in error because Aetna was unable to provide us with the total universe from which our sample was drawn.

In addition to the 68 claims mentioned above, we identified other deficiencies in Aetna's claims payment system which were not included in the 12-percent error rate. In our claims analysis we found instances where we could not determine if claims were medically necessary because Aetna's claims payment system permitted the paying offices to

--routinely pay lump-sum hospital charges (X-rays, laboratory tests, and drugs) without question since these charges were not broken out or described on hospital claims; and

--pay for small drug charges without an investigation if the drug charges were less than $50 over a 30-day period, unless a charge was clearly for a nonprescription drug.

In addition, Aetna paying offices were not limiting payments for nonsurgical physician services on the basis of prevailing fees as intended by the contract.

In commenting on our report (see apps. IV and V), Aetna stated that although some changes in claims payments procedures are desirable, they did not believe that payments were being made in violation of their policy requirements. However, it should be noted that most of the claims we questioned during the review were questioned because the policy requirements followed by the claims processors do not appear to satisfy the intent of the contract. Aetna is, however, considering changes for some of these matters.

The paying offices' performance in these areas is discussed in chapter 3.

PROBLEMS IN ACHIEVING CARRIER COMPLIANCE

The following factors contributed to CSC's problems in achieving compliance with contract provisions of the Federal Employees Health Benefits program.

--The contracts lack incentives for the carriers to comply with cost-control provisions.

--The contracts lack specific criteria on the type of cost-control programs the carriers must employ.

--CSC has not effectively ensured that benefit payments are made in accordance with contract provisions.

Contracts do not contain incentives

The contracts between CSC and the two Government-wide carriers lack incentives for the carriers to control health benefit costs. The contracts enable the carriers to recoup any losses incurred as a result of benefit payments in 1 year by increasing premium rates for the following year. For example, a significant portion of the 1976 premium rate increase for these two carriers was to recoup projected 1975 losses. Losses incurred as a result of administrative expenditures, however, may not be recovered because administrative costs are limited to actual expenses up to a specified percentage of subscription income. In 1975 these contract limitations were 5 percent for the Associations and 4 percent for Aetna.

Strict application of benefits and exclusions would reduce total benefit payments while possibly increasing administrative expenses. Therefore, tight administration of contractual provisions, which could save the FEHB program money, could also result in losses to the carriers. Further, reducing benefit payments in 1 year would reduce subscription income in the following year since benefit payments are the primary factor in determining premium rates and subscription income. This reduction would cause even more losses on administrative expenses since the base (subscription income) on which the administrative allowance is computed would have decreased.

However, the carriers can negotiate with CSC to increase their administrative expense allowances. The following schedule details the two carriers' administrative expenses for 1973-75.

Year	Subscription income	Administrative expense allowance	Actual administrative expenses	Loss
	(millions)			
		Associations		
1973	$ 831	$37.4	$42.6	$5.2
1974	1,038	46.7	52.6	5.9
1975	1,233	61.6	a/58.1	-
		Aetna		
1973	186	7.4	6.4	-
1974	212	8.5	7.7	-
1975	240	9.6	9.0	-

a/Does not include the $3.2 million administrative expense of the Office of the Director.

In 1973 and 1974, when the Associations' allowance was 4.5 percent, the Associations lost $5.2 million in 1973 and $5.9 million in 1974. In 1975 the Associations' administrative expense allowance was increased from 4.5 percent to 5 percent of subscription income; in addition, the administrative expenses of the National Associations were removed from the administrative expense allowance and set up as a separate expense account. Aetna's administrative allowance was 4 percent for 1973-75.

Contracts do not contain criteria for implementing cost-control provisions

The contracts between CSC and the two Government-wide carriers specify benefits and exclusions and include other cost-controlling provisions, but they do not contain specific criteria for implementing these provisions. As a result, both carriers have established their own criteria--the Associations in their administrative manual and Aetna in its indemnity benefit claim guide. Although these manuals represent the carriers' interpretations of the contract and are the carriers' instructions to the local plans and paying office, CSC has not made reference to these manuals in its contracts, nor has it determined whether the carriers' manuals are valid interpretations of the contract. Therefore, when questions are raised by CSC auditors regarding compliance with a manual, the carriers can and do take the position that the auditors cannot legally hold them to provisions in their manuals.

For example, the contract with the Associations provides that benefits shall not be paid if they are payable by other group health insurance coverage determined to be primary to the Service Benefit Plan, such as Medicare or coverage by an employer of a subscriber's spouse. The contract requires that a reasonable effort be made to avoid liability as the primary carrier. The contract does not specify what constitutes a reasonable effort and contains no specific criteria for identifying other primary coverage. The Associations' administrative manual, however, instructs plans to investigate for other coverage in specific circumstances, such as when the patient is a subscriber's spouse.

CSC audit findings on local plans' failure to investigate for other coverage have been disputed by the plans because the administrative manual criteria are not included in the contract.

Another example relates to the enforcement of UCR payment provision (see p. 36) of the contract. The contract with the Associations requires that physician payments in general be in accordance with the UCR payment system. The contract defines the terms usual, customary, and reasonable but contains no criteria for implementing the system. For example, no requirements are given on how frequently data on physicians' usual charges are to be updated or at what level customary fees are to be set. Consequently, CSC auditors lack contractual requirements to use as criteria for measuring the effectiveness of the systems.

The Associations have used the lack of specific criteria in the contract to justify deviation from the general scheme of UCR contract provisions. To illustrate, in response to a CSC audit finding concerning a local plan's lack of a UCR system, the Associations stated that (1) the auditors' interpretation of the contract was not sustained by the language of the UCR provision and (2) it was unnecessary and undesirable for CSC auditors to continue to raise issues regarding payment of benefits on a UCR basis because of the generality and flexibility of the contract language regarding such payments.

Another problem under the Service Benefit Plan contract is that the Associations have exercised only limited control over local plans, and therefore, differences existed in the payment of benefits at the local plans we visited. The participation agreements between the Associations and the local plans are intended to establish uniform contract administration for the Service Benefit Plan.

Associations officials said that, notwithstanding the existence of participation agreements, the Associations do not require plans to comply with all of the Associations' policies for implementing the contract. CSC agreed that its experience in dealing with local plans has shown that the Associations do not require full compliance with the Associations' policies. Despite this lack of strict compliance over local plans' payment of benefits of over $1 billion a year, CSC has not made an attempt to change the contract to rectify this situation.

According to Associations officials, variances among plans in administering the Service Benefit Plan may be a result of varying relations between plans and area health care providers; differences between the benefits authorized under the Service Benefit Plan and benefits authorized by the plan's other contracts; and the relative unimportance of the Service Benefit Plan to a local plan's total business.

CSC audits

CSC says that its audits at the local Blue Cross and Blue Shield plans and Aetna paying offices are to "determine that the claims processing and related systems are operating in an efficient, economical and effective manner." The audits are mostly compliance audits, and the criteria used are the contract provisions and the respective policy requirements issued by the Associations and the Aetna home office.

Problems in questioning benefit payments

Before July 1975 CSC placed little emphasis on ensuring that local plans and paying offices were complying with the contracts' benefit payment provisions or with the carriers' policy requirements. Audits were directed at the proper allocation of administrative expenses to the contract by the local plans.

We reviewed CSC's final audit reports issued from January 1975 to June 1976--on 43 audits made before July 1975--and found that, although the auditors had reviewed about 5,100 claims, only 3 claims were questioned in the final audit reports because the benefit payments were not in accordance with the provisions of the contract. In the 43 audits referred to above, CSC auditors had questioned 29 additional benefit payments as follows:

Benefit area	Number of claims questioned
Diagnostic admissions	7
Workmen's compensation	6
Custodial care	2
Medical emergency	7
Assistant-at-surgery	2
Termination of benefits	2
Recertification	1
Occupational therapy	1
Diagnostic X-ray	1
	29

After discussing these questioned claims with representatives of the various plans, CSC dropped all 29 cases. According to CSC officials, they were not successful in questioning the allowability and reasonableness of benefit payments during their visits to the plans because they did not have a medical advisor to assist in claims review. Thus, the CSC auditors had to accept the opinions of the plans' medical personnel.

For example, marital counseling is specifically excluded as a benefit under the contract for the Indemnity Benefit Plan. The CSC auditors questioned a claim for possible "marital counseling." When the CSC auditors brought this claim to the attention of plan representatives, the auditors were told that the medical department had decided the counseling was for a mental condition. The auditors dropped the finding.

Since July 1975, CSC audits of local plans have emphasized a review of benefit payments. As of December 1976 CSC had issued only two reports on audits made after July 1975. Although the number of reports is too small to assess the impact of CSC's expanded audit scope, neither report contained findings on questionable benefit payments.

CSC does have a number of draft reports in process in which CSC questions the mispayment of benefits. For example, in one or more of these draft reports, CSC has projected that the local plans have mispaid

--$4 million for diagnostic admissions and custodial care (3 reports),

--$1.17 million overpayments of UCR (2 reports), and

--$1.5 million in coding and pricing payment errors (1 report).

However, CSC auditors still do not have access to medical expertise, and unless CSC obtains the assistance of such medical advice, in all probability it will encounter considerable difficulties in sustaining its position on questioned claims.

In commenting on our report (see app. II), the Commission stated that medical expertise would be beneficial to its audit effort. CSC stated that medical expertise in reviewing claims would not be used as a vehicle to recover costs of questionable claims, but rather that such expertise would be beneficial in identifying specific claims processing problems. CSC said it did not want to become bogged down in reviewing individual erroneous payments that may result in recovering a few hundred dollars.

CSC also pointed out that its auditors cannot review medical records, other than the claim form itself, without written authorization from the patients and offered the opinion that if the patients know the purpose of the auditors' need for the authorization, they would be unlikely to give them approval.

We believe that the identification and resolution of claims processing systems problems requires that CSC be able to support the validity of its judgments about specific erroneous payments. In the absence of medical expertise to support its judgment, it is doubtful that CSC can make strong enough cases regarding individual claims payments to either reach agreements with the carriers about such system problems or support its own judgments regarding these problems.

Also, CSC's audit responsibility should not require that the CSC auditors request patients' authorizations for them to review individual medical records. Rather, CSC's responsibility should be limited to ensuring that benefit claims paid by the carriers are proper and are supported by sufficient documentation. In instances where CSC finds, during its reviews of carriers' payment systems, that paid claims are not sufficiently supported, it should disallow the inclusion of such payments for the purposes of the next year's premium adjustment unless and until the carrier obtains and provides adequate supporting documentation for the payment of the questioned claims.

Another problem CSC has encountered relates to its audit authority. According to CSC, its audits are based on "Standards for Audit of Governmental Organizations, Programs, Activities, and Functions," issued by the Comptroller General of the United States. These standards provide for an audit scope that includes not only financial and compliance auditing, but also auditing for economy, efficiency, and achievement of desired results. 1/

On several occasions, the Associations have questioned CSC's audit authority. They have maintained that CSC's audits should be limited to financial matters and that CSC should not attempt to evaluate management. For example, CSC has questioned the lack of UCR payment systems at the local plans.

In an April 2, 1976, report on a local plan, the CSC auditors stated:

> "A Usual, Customary, and Reasonable (UCR) Program is not in effect to determine appropriate fees charged by providers. The Federal Employees Program (FEP) Contract requires charges to be usual, customary and reasonable."

In commenting on this report in June 1976, the Associations stated:

> "The position of Blue Cross and Blue Shield, simply stated, is that financial audit reports should not attempt to dispose of management issues. The principal purpose of financial audits is to examine charges to FEP. Management audits are important, but conclusions reached with respect to such audits should not be confused with financial audits which can lead to final decisions on specific charges to FEP."

Also, the Associations have denied CSC auditors access to pertinent information involving charges to the contract. To illustrate, on August 13, 1976, a CSC audit report questioned an administrative charge of $721. The charge represented the Service Benefit Plan portion of the cost incurred

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1/This matter was previously discussed in a GAO report "Information On Unresolved Audit Exceptions With Federal Employees Health Benefit Carriers," B-164562, November 7, 1974.

by the local plan as the result of an evaluation by the Associations of the local plan's total business. The auditors questioned the charge because they were denied access to the Associations' report. The Associations said:

> "We do not concur with this finding in that it is predicated on the Plans' refusal to allow the CSC auditors to examine the Total Plan Review Report. This review is an internal one and the report candidly calls to the attention of Plan officials those management policies, if any, that need to be corrected or could be improved. The reports are confidential in nature and are not available for public review. In our judgment, as long as the Plan makes available to the auditors the related invoice, the total amount paid and the method of allocation for the charges to FEP, the cost can be audited and is chargeable to the Program."

In commenting on our report (see app. III), the Associations stated that they did not object to an evaluation of management systems, but rather to the enforcement of such observations through the power of audit disallowances, which they believed would inject CSC into management decisions. The Associations stated that they believe CSC's audits should be limited to financial matters and pertain only to the contract. The Associations stated that CSC agreed to this in October 1974, but that CSC's current audit activity exceeds the agreed upon scope. The Commission, in its comments, said that its audit scope would continue to include economy, efficiency, and achievement of desired results as well as financial and compliance auditing. CSC also said that it expects this issue to ultimately be resolved in court.

CSC auditors have occasionally requested assistance from the Commission's contracting office (Legislative and Policy Division) regarding payments of benefits not covered by the contract. Between January 1975 and June 1976, the auditors requested assistance from this division seven times on apparently erroneously paid claims which they had found during audits. In all cases the division determined that the claims had been for noncovered benefits. However, the charges to the contract were allowed to stand. It is CSC's policy that disallowing such claims would penalize the patient and therefore such retroactive denials are not made.

We recognize that denial of claims at any point in the adjudication process will entail a hardship on the patient.

It should be noted, however, that if the plans and paying offices had adjudicated these claims properly in the first place, the patient would have been subject to financial hardship. We do not believe it is equitable for CSC to allow some enrollees to receive noncovered benefits when other enrollees in areas where claims processing is more in accord with the contracts must themselves pay for noncovered benefits.

CONCLUSIONS

CSC needs to improve its efforts to ensure that health insurance carriers control benefit costs which for the two carriers included in our review amounted to more than $1.4 billion in 1975.

The local Blue Cross and Blue Shield plans and the Aetna paying offices have frequently made payments that do not appear to be in accordance with contract and/or carriers' policy requirements, and certain systems designed by the carriers to eliminate excessive payments were not always functioning properly.

The contracts negotiated by CSC provide no incentives for the carriers to control benefit payments and contain no provisions under which CSC, either through audit or other means, can exercise sufficient control over the allowability of benefits paid by the carriers. In this regard, CSC has experienced difficulties in conducting audits of certain carriers' activities under the FEHB contracts. These difficulties appear to stem from the lack of contractual basis for questioning, and perhaps disallowing carriers' payments of benefits under the contracts, disagreements between CSC and at least one carrier, the Associations, regarding the extent of CSC's audit authority, and an apparent lack of medical expertise needed to challenge and sustain CSC's audit findings concerning questionable benefit payments.

We recognize that, if CSC develops and applies strict cost-control provisions and enforces such provisions, enrollees could react adversely since they may incur liabilities for charges not paid by the carriers. However, without cost-control programs, the carriers will continue to provide benefits not covered under the contracts, which will result in higher premium costs for both the enrollees and the Government.

RECOMMENDATIONS TO THE COMMISSION

We recommend that the Chairman of CSC

--revise its health insurance contracts to provide incentives for compliance with CSC's contract requirements;

--include in its contracts specific cost-control programs which the carriers must follow; and

--clarify its audit authority, expand its audits, and act more effectively on its audit findings.

EVALUATION OF CARRIER AND CSC COMMENTS

In their comments on our report (see apps. III, IV, and V), the carriers said that our review did not give adequate credence to their efforts to control benefit costs under the FEHB contracts. The carriers cited the guidance they provide to the local plans or paying offices as evidence of their good-faith attempts to control benefit costs in an environment where health provider costs have been increasing continuously and rapidly. For example, the Associations stated that they had instituted their 16-point cost-control program without resorting to contract incentives.

Both carriers objected to our suggestion that CSC make their internal cost-control mechanisms a part of their contracts with CSC. The carriers also pointed out that the competition between and among the numerous FEHB carriers for enrollees subscriptions provides significant incentives for each carrier to provide maximum benefits at minimum premium costs.

We conducted our review of the carriers' claims payment systems and processes in a manner which would enable us to assess (1) CSC's efforts to control carriers' benefit payment costs under the contracts and (2) the effectiveness of the carriers' internal cost-control systems and procedures. We noted, for example, that while the Associations did, independently, develop their 16-point cost-control program, they have not required the local plans to implement it. As a result of our review, we have concluded that the combined efforts of all parties to the FEHB contracts--and particularly those of CSC as the Federal contracting authority--need to be improved if adequate control is to be exercised over the benefit payments under the contracts.

We recognize that the competition among FEHB carriers for enrollees constitutes an incentive for each carrier to control its benefit payment costs since premium rates are largely determined by the carriers' benefit payment experiences. It should be pointed out, however, that while competition may exist for enrollee subscriptions, CSC's relationship with the two carriers included in our review is based on an essentially noncompetitive, negotiated contract. We believe that in view of this circumstance, CSC should include in its negotiated contracts with each of the two carriers specific contractual incentives to control their costs and specific cost-control provisions which will permit CSC to review and, if appropriate, sustain its position regarding the allowability of the carriers' benefit payments under the contracts.

In commenting on our report (see app. II), CSC agreed with our recommendation concerning the clarification of its audit authority, expansion of its audits, and actions on its audit findings and stated that it would continue its improvement efforts in those areas. In addition, CSC stated that our findings regarding the carriers' benefit payments are representative of the practices employed by the carriers and that CSC audits of the carriers' activities are also identifying such deficiencies. However, CSC stated that:

--Our report suggests that CSC has significantly more influence over health insurance costs than is actually the case. CSC stated that health providers, insurance carriers and other third-party payers, and finally users of health services are in the primary positions to control health costs.

--Although our report recognizes that CSC's application of strict cost control measures could result in adverse enrollee reaction, it suggests that CSC implement measures that would, in CSC's opinion, merely shift additional benefit payment responsibility to the enrollees themselves.

--It views its responsibility to Federal employees in the FEHB program as a significant one and continues in its negotiations of FEHB contracts to provide a health benefits plan design that is more conducive to reducing costs and providing quality medical care. CSC cited examples of its efforts in this area and indicated that the redirection of its audit efforts toward review of benefit payments should result in more cost control.

--Our report did not make specific suggestions regarding the types of incentives appropriate for use in CSC's negotiated contracts with the carriers. In this regard, CSC noted that under the FEHB Act, CSC must contract with the Associations for the Service Benefit Plan and negotiations with a sole source contractor seldom result in the unilateral addition of contract clauses and features. The Associations have been very careful in negotiations so as not to restrict their alternatives on management prerogatives in any way. CSC also stated that the inclusion of incentives in the contracts would put the carrriers in a position to manipulate costs in order to stay below incentive targets.

--Our report failed to recognize that (1) the administrative cost ceilings in the current FEHB contracts act as incentives and (2) the FEHB Act requires the premiums under the two Government-wide plans to be based on past experience and this means that the carriers' gains and losses are carried forward whenever a new premium is established.

--It does not agree that specific cost-containment measures should be imposed contractually. In this regard, CSC said that the state of the art of health benefits cost control is an everchanging area which should not be limited by specific contractual requirements.

CSC recognizes its responsibility to ensure that carriers have effective health benefits cost-control programs under the individual contracts it awards.

However, in our opinion, CSC's comments indicate that it believes that it is in a relatively weak position both (1) as an influence over health insurance costs and (2) insofar as its contractual relationships with the two Government-wide FEHB carriers are concerned.

Our review addressed the extent to which CSC carries out its responsibilities and the efforts of carriers to control benefit costs. In our opinion, current efforts to control such costs have not been adequate for a number of reasons--one of which is CSC's reluctance or inability to question and sustain its position regarding the carriers' payments of benefits.

CSC's statements concerning (1) the application of strict cost-control measures and (2) the inclusion of incentive provisions in the contracts with the two Government-wide carriers seem to be indicative of CSC's reluctance to negotiate and deal aggressively with the carriers in this regard. We believe that if CSC were to question benefit payments and sustain its positions, responsibility for erroneous payments would have to be accepted by parties who should have been responsible for them in the first place. We recognize that under the current contractual conditions (where CSC negotiates with each carrier on a noncompetitive basis), the carriers might not be amenable to CSC's suggestions regarding the inclusion of incentives and cost-control provisions in the contracts. We believe, however, that it is incumbent upon CSC to attempt to negotiate such provisions into the contracts if it is to have an impact on the propriety of benefit payments.

We did not make specific suggestions concerning the type of incentives appropriate for inclusion in CSC's contracts with the carriers since we believe that such incentives should be tailored to the individual contracts negotiated between CSC and the carriers and is a matter for CSC, as part of its contractual responsibility, to consider in preparing for its negotiations with each individual carrier. For example, it would seem that as a minimum CSC should be able to have some control over the local Blue Cross and Blue Shield plans participating under the Service Benefit Plan, since these local plans are responsible for the carriers' day-to-day performance under the contract. If CSC could decide whether or not a local plan participates in the FEHB program, it might give the plans an incentive to comply with the Service Benefit Plan contract and would constitute an incentive for the Associations to influence the local plans to comply with the contract.

We recognize that administrative cost ceilings provide incentives for the carriers to control their administrative costs. However, these same ceilings could act as disincentives for the carriers to control benefit costs, since allowable administrative costs are currently calculated as percentages of carriers' benefit payments. In our opinion, administrative cost ceilings should be agreed upon using some basis other than historical benefit payments.

While we agree that the FEHB Act requires that premiums are to be based on past experience, the act does not require that benefit losses be recouped the following year. We feel

that if the carriers were required to spread their losses over a period of years, it would give them more incentive to control co.

With regard to CSC's position on the imposition of cost-control provisions in its contracts, it should be recognized that these contracts are negotiated annually with the carriers and that changes in the state of the art of health benefit's cost control could be incorporated into CSC's program at least that often.

Also, although CSC states that its auditors will continue to review the carriers' benefit payment activities using the carriers internal guidelines, it also states that the carriers have objected to CSC's audit scope (which includes the use of their internal guidelines) and that the matter will eventually have to be settled in the courts. In our opinion, an attempt by CSC to incorporate benefit cost-control provisions in its contracts might preclude possible litigation of the matter and would decrease CSC's current reliance on the carriers' activities to control benefit payment costs.

More importantly, if CSC were successful in its attempt to include cost-control provisions in its contracts, its auditors would have a basis for conducting their reviews of carriers' activit[illegible]d CSC would be in a stronger position to deal with th[illegible]s in the area of benefit cost control.

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We believe that the recommendations made to CSC continue to be appropriate. However, as its comments indicate, CSC is in a difficult position with regard to influencing the control of carriers' health benefit payment activities. On the one hand, CSC is responsible for overseeing these activities in an attempt to ensure that the carriers' premium rates accurately reflect the benefits they are to provide. On the other hand, CSC currently relies heavily on the carriers to exercise control over benefit payment costs. In this regard, CSC stated that the legislative and policy guidance it has received in recent years from the Congress has been in the direction of a "pay claim syndrome"--that is, a mandate to direct its efforts toward ensuring that maximum practicable benefits are paid to enrollees under the various FEHB plans.

We believe there are additional opportunities for CSC to initiate actions to deal more aggressively with the carriers both in the negotiation of its contracts and in its reviews of the carriers' benefit payment activities. However, in

view of CSC's stated concerns regarding those matters, we believe that the Subcommittee should clarify CSC's relationship with FEHB carriers by considering legislation designed to assist CSC in strengthening its position in dealing with the carriers regarding health benefit payment activities under the FEHB program.

RECOMMENDATIONS TO THE SUBCOMMITTEE

If the Commission does not adopt these recommendations (see p. 20), the Subcommittee should consider developing legislation which would

--require CSC to include specific cost control and/or incentive provisions in contracts with the FEHB carriers;

--give CSC the specific authority to audit the carriers for economy, efficiency, and achievement of desired results, as well as for financial and compliance with the contracts; and

--provide CSC with some flexibility in contracting with the Associations for the Service Benefit Plan.

Currently, when CSC contracts with the Associations for the Service Benefit Plan, the Associations, in turn, contract with all local Blue Cross and Blue Shield plans. To provide CSC with some flexibility, the Subcommittee may want to amend the act specifically to allow CSC to exclude a local plan from the contract if that local plan does not adhere to the contract.

We believe that these matters should be of importance to the Subcommittee, especially since the Government's relationship with health benefit insurance carriers may take on added significance if any one of several national health insurance proposals is ultimately enacted by the Congress. Legislation which helps CSC to more effectively control benefit payments under the FEHB program could constitute an important step toward making carriers--who may be an integral part of a national health insurance program--more accountable for their benefit payment actions.

CHAPTER 3

LACK OF COMPLIANCE WITH COST-CONTROL REQUIREMENTS

Local Blue Cross and Blue Shield plans and Aetna paying offices have not fully complied with provisions of the Civil Service Commission contracts and the policy requirements developed by the Associations and the Aetna home office.

BLUE CROSS AND BLUE SHIELD PLANS

At the local plans we visited (1) benefit payments were not always made in accordance with contract and policy requirements and (2) the systems to ensure that benefit payments were not excessive were not always functioning properly.

Claims adjudication

Relating treatments and procedures to diagnoses

The contract between CSC and the Associations states that "Routine examinations or periodic physical examinations" and diagnostic tests "not related to a specific illness * * * or a definitive set of symptoms" are not covered by the Service Benefit Plan.

In 1971 the Associations directed the local plans to (1) obtain diagnostic information on all outpatient X-ray and lab claims for $10 or more, (2) obtain diagnoses on all Pap smear claims regardless of the claims amount, and (3) screen all lab and X-ray claims to determine whether the tests might be related to a routine physical examination rather than to an illness or a definite set of symptoms.

As part of this direction, the Associations pointed out to the local plans:

> "A major area of abuse concerns diagnostic procedures done in connection with routine physical examinations."
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> "In many instances unrelated procedures are ordered in conjunction with others entirely relevant and appropriate to the diagnosis or treatment (e.g., gall bladder series when treatment is for an upper

respiratory condition). Such unrelated procedures are not covered services (under either Basic or Supplemental) and should be denied as unnecessary to diagnosis or treatment of an illness or injury."

The Associations' administrative manual provides a list of laboratory tests related to specific diagnoses and points out that claims not conforming to these relationships should be referred to a plan's medical advisor. Regarding routine physical examinations, the manual states:

"When the pattern of laboratory tests performed indicates the possibility of a routine physical examination, investigation is necessary before providing benefits." (Underscoring supplied.)

The administrative manual further states that Pap smears should always be considered routine unless the procedure is associated with one of nine specific diagnoses.

Of our random sample of claims, 51 had been paid even though some laboratory services on the claims were unrelated to the diagnosis. These problems existed at 9 of the 10 local Blue Shield plans visited. The administrative manual requires that, before diagnostic X-rays and laboratory tests are approved, the plans must determine that these tests are medically necessary. However, it was not possible to make this determination at Blue Cross plans because Blue Cross claims usually contain only an item charge for laboratory tests or X-rays without a breakdown of what they were or why they were performed.

The plans agreed that 21 of the claims were questionable, but disagreed that the other 30 were questionable. For many of the claims on which the plans disagreed, however, the plans assumed that extenuating circumstances existed which justified paying the claims; other claims they justified as conservative medical practice. Our medical advisors believed that there was not sufficient information to justify paying these claims.

As the Associations have stated, a major problem involved diagnostic procedures performed in connection with routine physical examinations. The following are examples of Blue Shield claims we questioned as possible routine physicals and the plans' comments.

--Diagnosis on the claim was chronic fatigue and exhaustion. The plan paid $60 for seven lab tests.

The plan said that the claim should have been denied as a routine physical examination.

--Diagnosis on the claim was miscellaneous female disease and miscellaneous diseases of muscular skeletal system. It included four laboratory tests, an electrocardiogram, and a chest X-ray. The total charges were $83.26. The plan said that the claim should have been denied as a routine physical examination.

--Diagnosis on the claim was hepatitis. The patient had been treated for this disease 2 months before he received the services on the claim in question. Tests involved 15 laboratory tests, an electrocardiogram, and a chest X-ray. The total charges were $132. We questioned the claim as a possible routine physical since, according to the Associations' criteria, only 3 of the 17 tests were related to the hepatitis diagnosis. The plan disagreed, stating that this treatment suggests that the patient was not responding to treatment and that further studies were needed to establish the cause of the condition. Since no information on the claim indicated that the patient was not responding to treatment or that further tests were needed, our medical advisors did not believe that this claim should have been paid without further information.

While our medical advisors were reviewing claims at one plan, they noted a number of claims which contained laboratory tests normally associated with routine physicals. To obtain an indication of the extent to which routine physicals were being paid by this plan, we sent questionnaires to a random sample of GAO enrollees whose claims are processed by this plan.

We sent out 438 questionnaires and received 387 usable replies, 74 of which indicated that the subscriber and/or a family member had received one or more routine physicals in the past 12 months and Blue Shield had paid for the related laboratory and X-ray charges. According to the responses, the 74 subscribers and/or their family members received a total of 111 routine physicals paid for by the Blue Shield plan.

Of the 373 usable responses regarding Pap smears, 92 indicated that the subscriber and/or a member of the family had received one or more routine Pap smears. These replies indicated that for every 100 enrollee contracts, the plans had paid for 28 routine physical examinations and 24 routine Pap smears over a 12-month period.

If the GAO employees are representative of all Federal employees served, this plan may have paid for about 77,000 routine physical examinations and at least 65,000 routine Pap smears during a 12-month period in 1975-76. Assuming that tests relating to a routine physical would be valued at $100 and Pap smears at $10, this plan could have paid $7.7 million for routine physicals and $650,000 for routine Pap smears.

In commenting on our report (see app. III), the Associations stated they did not believe that valid conclusions could be reached from the information provided from the questionnaire. They believed it was unreasonable to expect a subscriber to recognize what constitutes a routine physical examination within the definition of covered benefits used by a claims adjudicator. The Associations also stated that the sample was biased because the questionnaire implied that routine physicals were a covered benefit.

We agree that the subscribers do not have access to the claims submitted by the physicians and that some of the claims could have included symptoms and diagnoses which would have justified the claims payment by Blue Cross/Blue Shield. If the claims had included valid symptoms and diagnoses, however, it would seem reasonable to assume that the subscribers should have been made aware of such symptoms and diagnoses, and would not have indicated to us that they had received a routine physical. Furthermore, it seems reasonable to assume that the employees responding to this questionnaire knew whether they had gone to a physician for a routine checkup or for diagnosis or treatment of an illness. In regard to Associations' comments regarding our questionnaire, it should be noted that the questionnaire was developed with the express purpose of avoiding the introduction of bias in its results.

Necessity for assistants-at-surgery

The CSC contract covers payments to assistant surgeons if the claim contains a certification that such assistance was required because of the patient's condition and that a qualified intern, resident, or other hospital staff physician was not available. The Associations require certification from the attending physician on both of these points. When the hospital has a residency program, surgery is performed by a team of surgeons, there is more than one assistant, or the assistant is in practice with the surgeon, claims should be reviewed by the plan's medical advisor to determine the assistant's necessity.

Three of the 10 Blue Shield plans did not require the physicians to certify that the patient's condition required an assistant surgeon. One also did not require physicians to certify that qualified interns, residents, or other staff were not available.

Officials of the latter plan said these requirements were not workable because such requirements attempted to dictate how physicians should practice. The officials believed this would create serious administrative, provider, and subscriber problems. From October 1975 through April 1976, this plan had paid fees for assistant surgeons in 3,347 cases at a cost of $458,418.

The following are examples of claims questioned for not having adequate certification on the need for an assistant-at-surgery:

--A claim for a Caesarean section included a charge of $100 for an assistant surgeon.

--A claim for a "right salpingo oophorectomy" (removal of uterine tube and ovaries) also included an assistant surgeon fee of $100.

In neither case was there a certification that an assistant surgeon was necessary or that interns, residents, or other hospital staff physicians were unavailable.

Dental admissions

The Service Benefit Plan contract limits dental benefits to medically necessary hospital services for oral surgery or for extraction of impacted teeth. Hospital services for extraction of other than impacted teeth or other dental processes are excluded except when admission to a hospital is necessary to safeguard the life or health of the patient from the effect of dentistry because of the existence of a specified, nondental, organic impairment, and when the dentistry was performed by a physician.

The Associations' policy is that certification of need for dental-related hospitalization must always be obtained. The Associations' administrative manual includes examples of acceptable and unacceptable nondental organic impairments. Impairments which could qualify a dental patient for hospital benefits include hemophilia, essential hypertension, and endocarditis. Nonqualifying conditions include anxiety, retardation, controlled diabetes, and nonacute organic

conditions. Admissions for removal of impacted teeth and for other covered dental procedures must be of such complexity as to require inpatient care.

Five of the 10 Blue Cross plans we reviewed used the Associations' criteria for providing dental benefits. However, the other five plans had developed their own criteria for dental hospitalization which resulted in some payments for noncovered dental hospital care.

--Three plans paid inpatient dental claims if the patient had been under general anesthesia for at least 30 minutes. One of these plans paid over $51,000 in dental benefits during 1975 under the Service Benefit Plan. In addition, plan officials said that during that year only one dental admission claim had been denied. Our medical advisor, commenting on the 30 minutes of anesthesia criterion, said that it does not indicate in any way the seriousness or complexity of the dental procedure and that further information was required to justify payment in compliance with the contract.

--One plan permitted payment for 1-day hospital stays for removal of impacted teeth.

--One plan, which screened claims by computer, routinely paid dental hospitalization claims because it had not programed the computer to screen for such claims.

The following are examples of claims we questioned.

--One claim of $662 was paid for a hospital stay with an admitting diagnosis of dental restorations and a final diagnosis of dental caries. Although the corresponding Blue Shield charges were disallowed, the Blue Cross benefits were paid because the patient was under anesthesia for more than 30 minutes.

--One claim of $142 was paid for a hospital stay for infected and impacted teeth. The plan's justification was that the patient was under anesthesia for more than 30 minutes.

--One claim for $110 was paid for a hospital stay for impacted teeth. The plan's justification was again the 30-minute criterion.

Nervous and mental benefits

The contract provides that services rendered by a member of a mental health team--psychologist, psychiatric nurse, or psychiatric social worker--must be performed under the supervision and direction of an attending physician. Claims for services of a mental health team are to be denied if the patient has not seen the attending physician within 1 year, and the attending physicians are required to periodically report to the plans about their supervision of the team. Also, each claim for the services of a psychiatrist or clinical psychologist must be accompanied by a mental health report that includes information on type of therapy and the patient's prognosis. In addition, if hospital confinement or medical care (including private nursing or physical therapy) extends for more than 30 days, a claim must be filed by the last day of the month following the month in which the hospital confinement or medical care occurred.

Three of the plans we visited deferred all mental and nervous claims for further review by medical staff or claims examiners. One Blue Cross plan reviewed nervous and mental claims which involved hospitalization of 60 days or more; two others reviewed those which involved hospitalization of 30 days or more. Officials at one plan said that, because of a lack of screening criteria, they had no basis for questioning mental and nervous claims. Consequently, the plan paid all basic mental and nervous claims.

In commenting on our report (see app. III), the Associations said that treatment modalities vary in different geographic areas, as well as basic professional education of providers and personal patterns of practice. Thus, claims adjudication for nervous and mental benefits is difficult and presents a good example of how plan variations from the Associations' criteria may be necessary.

The Administrative Manual does not provide specific guidance in this area. In February 1975, the Associations distributed nervous and mental guidelines for the local plans. The guidelines directed the plans to give all nervous and mental claims special consideration to ensure proper substantiation of these claims and provided general screening parameters for certain nervous and mental diagnoses.

If local plans had implemented these guidelines, we believe there would have been less variation in benefit payments than currently exists.

In 1974 nervous and mental claims accounted for 7.2 percent ($70 million) of the Associations' benefit payments. In our claims review, we found that many nervous and mental claims had been paid by the plans without requiring any supporting information from either the hospitals or the attending physicians.

The following are examples of claims we questioned.

--One plan paid a claim for $22,385 involving 301 days of inpatient hospitalization. The room and board charges totaled $18,275; the balance was mainly for group and occupational therapy and pharmacy charges. The admitting diagnosis was not given and the final diagnosis was presenile dementia, cause unknown; obsessive compulsive personality; and depressing adjustment reaction to the above. The plan said this diagnosis requires screening if the hospital stay exceeds 7 days and it should have investigated this claim for the additional 294 days.

--Another plan paid a $7,863 claim with an admitting diagnosis of schizophrenic hebephrenia, a final diagnosis was not given. The patient remained hospitalized 164 days, but the plan's criteria provided a 13-day stay was indicated for such a diagnosis. Although the claim went to utilization review before payment, the plan agreed that the stay was excessive and should have been investigated further.

--A third plan paid $2,625 for a claim involving 75 physician hospital visits. The diagnosis was schizophrenia, schizo-affective type. The plan agreed it should have investigated further to determine the justification for the number of visits.

Medically unnecessary admissions

The contracts require that hospitalization be medically necessary and specifically list custodial care, domiciliary care, milieu therapy, and diagnostic admissions as noncovered services.

--Custodial care is room and board and supervisory physician care for a person who is mentally or physically disabled and who is not being treated to reduce a disability in order to allow the patient to live outside an institution providing medical care.

--Domiciliary care is institutional care provided because care in the home is not available or is unsuitable.

--Milieu therapy is confinement in an institution primarily to change or control environment.

--Diagnostic admission is hospital service and in-hospital physician care (other than surgery) when the hospital admission or continued confinement is primarily to perform X-rays, laboratory, and pathological services, and machine diagnostic tests, if the tests could have been performed on an outpatient basis without adversely affecting the patient's physical condition or the quality of medical care rendered.

The Associations' administrative manual states that hospitalization becomes medically unnecessary when the patient's status as an inpatient is no longer necessary to render the services being performed, even though for socioeconomic reasons continued hospitalization might be desirable or even necessary for the patient's well-being.

The administrative manual instructs plans to use criteria for normal length of stay for various diagnoses to identify claims involving possible excessive hospital stays. Claims which exceed the criteria should be investigated to determine whether the stay represented a medically necessary hospitalization.

Seven of the 10 Blue Cross plans reviewed apply some type of length-of-stay criteria in reviewing claims to determine whether hospital stays are medically necessary. Most plans had either developed their own length-of-stay guidelines or used guidelines presented in the Professional Activities Study which was developed by the Commission on Professional and Hospital Admissions. Professional Activities Study data contains average (and other) lengths of stay for various diagnoses, surgeries, and age groups. This data is available for the Nation and by regions. Some plans consider age in determining length-of-stay criteria; others do not.

The plans having length-of-stay criteria used them to flag a claim for more than routine review. For example, a claim representing an apparent excessive stay could be subject to a more thorough review by nonmedical personnel or referred to a nurse or physician for review. If further review of the claim failed to substantiate the need for the excessive stay, hospital records might be obtained and reviewed.

During our review at the 10 Blue Cross plans, we questioned a number of claims at all plans for exceeding the plans' length-of-stay criteria. Four Blue Cross plans appeared to have problems primarily with diagnostic admissions. At these plans we questioned 44 claims as representing possible diagnostic admissions.

Of the three plans that did not use length-of-stay criteria, one plan questioned only claims exceeding $10,000; one sent only claims for stays over 30 days to medical review; and one did not attempt to determine excessive stays because claims examiners were not familiar with length-of-stay criteria. The following are examples of claims we questioned:

--The final diagnosis on the claim was "abdominal pain." There was no admitting diagnosis, and the patient was hospitalized for 35 days with total charges of $6,107. The only procedure listed was a sigmoidoscopy. The plan said that this diagnosis and procedure requires screening if hospital stay exceeds 7 days and agreed that it should have investigated this claim to determine if the stay was medically necessary.

--The final diagnosis on the claim was "Bakers cyst left knee." There were no procedures or admitting diagnoses listed on the claim. The patient was hospitalized for 84 days with charges of $10,058. The plan said that this diagnosis requires screening if the hospital stay exceeds 5 days and agreed that this claim should have been investigated.

Recertification

The Associations have instructed Blue Cross plans to develop recertification procedures for the Service Benefit Plan. Recertification requires local plans to review patient's medical status after a specified number of days of hospitalization to determine how many, if any, additional days of hospitalization are necessary. The Associations' policy is that in-house medical advice is necessary for an adequate recertification program. Also, initial approval of care must not exceed 20 days in a general hospital, and hospitals must be required to report on a patient's condition after 16 days of care. The plan then is to decide whether the patient's condition warrants more days of care than initially authorized.

An effective recertification procedure may have two cost-control advantages. First, the procedure can help reduce

excessive hospital stays. 1/ Second, it can increase the possibility of avoiding retroactive denial of claims. If the plan informs a patient or a provider that it no longer considers hospitalization medically necessary before the patient incurs additional liability, the patient, the physician, and the plan can act accordingly. This is especially important in light of CSC's position that paying an invalid claim (for example, one for an excessive stay) is often preferable to subjecting a subscriber to the financial hardship that a retroactive denial normally entails.

None of the 10 Blue Cross plans reviewed had adopted the Associations' policy for recertification. Four plans had alternative procedures which they believed met the intent of the recertification requirement. The other six plans had no recertification procedures.

Other systems

Usual, customary, and reasonable payment to physicians

The contract between CSC and the Associations states that physician reimbursements under the high option portion of the Service Benefit Plan 2/ will, in general, be in accordance with the UCR payment method. Payments for participating physicians' 3/ services are made directly to a doctor in amounts "which in general are equal to his usual charges for the same services, but which do not exceed amounts customarily charged by other physicians for the same service."

1/In "Study of Health Facilities Construction Costs" (B-164031(3), Nov. 20, 1972), we found that recertification procedures produced shortened stays for patients covered by two group insurance companies.

2/Physician reimbursements under the low option are based on an allowable fee schedule included in the Service Benefit Plan contract.

3/In many areas, local Blue Shield plans have contractual participation agreements with physicians who agree to accept the plan's payment for a service or procedure as payment in full and not to bill the patient for any unpaid amounts.

The contract defines usual, customary, and reasonable as follows:

--A charge is "usual" if it is the fee most frequently imposed by a provider for the particular service or supply.

--A charge is "customary" if it is within the range of fees usually charged for the particular service or supply by providers of similar training and experience in the same locality.

--A charge is "reasonable" when it is usual and customary or, in the opinion of the Associations, is justified because of unusual circumstances, such as the complexity of a surgical procedure.

Using the contractual definition of UCR and applying the concept to physician payments, Blue Shield plans must maintain individual physician charge profiles (a particular doctor's usual charge for a service) and procedure charge profiles (the customary charge for a service by practitioners in an area).

Under the UCR system, a doctor is generally paid the least of his actual charge, his usual fee, or the customary fee. The following table illustrates how the system should work.

Physician's bill	Physician's usual fee	Area/specialty customary allowance	Blue Shield payment
$25	$30	$40	$25
30	30	40	30
40	30	40	30
50	40	35	35

In 1971 the Associations noted that many plans' administration of UCR was weak because

--claims were being screened only for a customary fee allowance,

--individual physician usual charge profiles were not maintained or used, and

--tolerance levels were being applied to make payments above the UCR limit (plans would set usual and customary limits and pay a certain amount above these limits).

The Associations (1) told the local plans that the presence of such conditions raised a serious question of conformance with the intent of the contract with CSC, (2) directed the plans to cease using UCR tolerances, and (3) required plans having physician profiles to apply them to claims submitted under the Service Benefit Plan.

The Associations' administrative manual states that plans must develop physician usual charge profiles, use these profiles in developing the customary charge levels, and use both profiles to determine the amount of benefits.

The 10 Blue Shield plans we visited developed and applied the UCR reimbursement concept differently. Most plans did not comply with the general scheme of the UCR contract provision.

--Physician bills were not screened against usual charges (four plans). Thus, physicians could charge at the customary level, and the plans have no assurance that the customary fee does not exceed a physician's usual fee.

--The usual charge was defined as the charge which appeared on the claim or whatever the physician stated was his usual fee (three plans). This practice amounts to not having a usual fee screen because the plan has no basis on which to determine whether a fee is actually the fee most frequently imposed by the physician.

--Customary fee levels were not developed from usual charge data (four plans) and were updated by periodically applying across-the-board percentage increases to each payment (two plans). Consequently, the customary fee levels may have little, if any, relation to what physicians usually charge.

--Additional amounts (tolerance levels) of $1 to $15 were applied to UCR payments (one plan). Payments, therefore, exceeded the UCR limitation.

--Physicians were allowed to choose either of two payment methods, neither of which conformed to the UCR requirements (one plan). Physicians usually chose the method that resulted in the higher payment.

Assessing the impact of plans' deviations from the general scheme of the provisions is difficult. However, for some areas, we could determine that such deviations resulted in excessive payments.

At one plan, to obtain an indication of the effect of not screening against a doctor's usual fee profile, we developed these profiles for seven common medical procedures and compared what the plan had paid over a 12-month period with what it would have paid had it screened against the usual profiles. For these seven procedures, the plan had paid $30,856 more than it would have paid under the usual fee screen.

One plan mentioned above had two payment methods and permitted physicians to select either method. The one method allowed physicians to merely state their usual charge for a procedure, while the other method based payment on a relative value assigned to procedures. To determine the effect of permitting a choice, we analyzed a random sample of 249 claims. For these claims the plan had incurred additional costs of $3,575 by allowing physicians to choose the most advantageous payment system. Based on this sample, we estimated for April to December 1975 that, had this plan implemented only one system, it could have saved either $185,119 or $18,586, depending on the system selected.

In commenting on our report (see app. III), the Associations stated that the use of the words "in general" was a considered and deliberate recognition by both parties that payments for the same services were not expected to be "usual" and "customary" in all cases and that the methods employed in determining that payments are usual or customary were not expected to be either precise or uniform in all cases or in all areas. The Associations agreed that variations "have occurred in some areas as described in the GAO report." The Associations also stated that the results of the plans' UCR payment systems "have been entirely in keeping with the intent of the Contract." The Associations said they believed the impact was minor and that an overwhelming majority of benefit payments meet the contractual tests of "the fee most frequently imposed" and "within the range of fees usually charged by providers."

The Associations went on to say that benefit payments that do not meet these tests are fully authorized by the "in general" wording of the contract. The Associations stated that they are prepared to conduct a study to determine the

extent to which benefit payments are meeting the contract requirements and they expect this study to demonstrate that their UCR programs have created a level of uniformity and equity in benefit payments beyond what was anticipated by the parties to the contract.

CSC, the other party to the contract, does not agree with the Associations' contention that payments for the same services were not expected to be usual and customary in all cases and that this is in keeping with the intent of the contract. Since the Associations are apparently planning a study on these UCR variations it would seem desirable for CSC, being the other party to the contract, to participate in the study with the Associations.

Coordination of benefits

The contract requires the carrier to make a reasonable effort to avoid liability as the primary carrier. Under this provision, benefit payments are limited whenever a subscriber has other group health insurance coverage or no-fault automobile insurance that is determined to be primary to Service Benefit Plan coverage. For example:

--Medicare coverage is always primary to FEHB program coverage.

--If the spouse of a subscriber with family coverage has other coverage provided by an employer, that coverage would be primary for the spouse.

--If children are covered under policies of both spouses, the husband's insurance is deemed primary for the children.

Effective coordination of benefits can reduce the costs of a nonprimary carrier since that carrier is obligated to pay only the balance of charges not paid by the primary carrier up to 100 percent of UCR charges.

The Associations' policy is that plans should investigate for other insurance coverage (1) for Blue Cross outpatient and inpatient claims exceeding $50 and $100, respectively, or (2) for patients for whom there is a history of other coverage on file. Plans are not to rely on negative responses from providers on whether a patient has other insurance coverage. The plans must investigate for other coverage when the patient is a spouse, child of a female employee, or a dependent over

18. Associations officials maintain that, of all claims costs-control procedures, tight administration of the coordination of benefits provision has the greatest measurable potential payoff.

Seven of the 20 Blue Cross and Blue Shield plans included in our review investigated for other coverage in accordance with the Associations' directives. Two plans followed the directives to some extent but often failed to obtain complete information on other insurance. The other 11 plans investigated for other insurance coverage only if the claim form or the plans' files indicated that the patient had other insurance.

In commenting on our report (see app. III), the Associations stated that its monetary recovery from coordinating with other insurance has increased each year since 1971 and that in 1975 its recovery from coordination with other insurance companies was $120 million. The Associations also stated that investigating claims for other insurance coverage is subject to the law of diminishing returns, that investigation and followup are costly and delay disposition of the claim, and they believed selective screening was important from both a cost benefit and a service point of view.

The $120 million cited by the Associations includes $104 million recovered from Medicare. Also, while the Associations' recovery from coordinating with other insurance increased by about $32 million from 1974 to 1975, over $28 million of this was recovered from Medicare. Under the Medicare program, Medicare carriers pay their benefits first and thus little, if any, investigation is required by the FEHB carriers. Investigating claims may be costly and time-consuming and perhaps should be screened from a cost-benefit standpoint. As indicated above, however, there was no consistency among the 20 plans we reviewed as to the degree to which they coordinate their benefits with those of other insurance carriers, even though the Associations' own criteria for administering the FEHB contract requires local plans to carry out such coordination activities.

Workmen's compensation

The contract excludes payment for services and supplies for any condition, ailment, or injury for which benefits are payable to the subscriber under any workmen's compensation law. The Associations' policy is that information on a patient's occupation should be provided on claim forms. However,

questionnaires must be sent to all subscribers submitting claims for injuries of a Federal employee or a spouse or child over 18 years of age if there is reason to believe the injury might be work related. Blue Cross and Blue Shield plans are required to work together so that the exclusion will be administered consistently.

Fifteen of the 20 local Blue Cross and Blue Shield plans we visited had criteria for investigating claims for workmen's compensation. The other five plans did not screen in accordance with the administrative manual to determine whether claims for accidental injuries were work related.

One plan had a computer deferral system for claims to be investigated for workmen's compensation. However, the system appears to be ineffective since we identified five claims in our sample at this plan which met the Associations' criteria regarding workmen's compensation but which were not investigated.

Coordination between local Blue Cross and Blue Shield plans

The Associations' policy is that local Blue Cross and Blue Shield plans must work together to ensure consistency in the payment and denial of claims for hospital stays involving both local plans. According to the Associations' administrative manual, the Blue Cross plan is responsible for deciding when the benefits are to be terminated or denied and for notifying the Blue Shield plan of its decision. Blue Shield must accept Blue Cross' determination.

Five of the 10 Blue Cross plans appear to have adequate coordination on payment and denial of claims. The other five plans had coordination procedures but did not always follow them. One plan notified the Blue Shield plan of only 9 of 46 claims it had rejected. The Blue Shield plan did not attempt to adjust its payments for the nine claims. Our review of a sample of 91 claims denied by the other 4 Blue Cross plans showed that the Blue Shield plans had incorrectly paid 29 of these claims. The payments resulted from (1) the local Blue Cross plans not properly notifying the Blue Shield plans, (2) the Blue Shield plans paying before a notice had been received from the Blue Cross plans, or (3) the Blue Shield plans not properly acting upon Blue Cross notices of denied claims.

ASSOCIATIONS' COMMENTS

In commenting on our report (see app. III), Associations officials said "Neither the Participating Agreements nor the Administrative Manual require that every Plan administer benefits mechanically in the same way." They also said

> "The GAO report concludes that any departure by a local Blue Cross or Blue Shield Plan from the National Associations' policies and procedures contained in the Administrative Manual represents a violation of the Contract with the Civil Service Commission."

The Associations further stated that the intent of the plan participating agreements is to assure uniform results, not to require uniform administrative procedures.

We have not intended to imply that a plan's failure to follow a specific policy is a contract violation. We have noted throughout the report which plan practices entailed deviations from administrative requirements and which deviated from the contract. Although the Associations have taken the position that departures from Associations policies and procedures do not represent violations of the contract, these policies and procedures were initiated for contract compliance. Also, the plan participation agreements require the plans to comply with the Associations' policies for implementing the contract. For example, when the Associations initiated the 16-point cost-control program and instructed the local plans to comply with these 16 points, they stated that:

> "* * * immediate steps must be initiated by all Plans to assure more precise benefit administration to the letter of the FEP contract with the U.S. Civil Service Commission."

Another example concerned the Associations' instructions to the local plans on the administration of mental and nervous benefits. The Associations stated:

> "In order to ensure that benefits are provided in accordance with the provisions of the Government-wide Service Benefit Plan, the guidelines presented herein should be implemented in the claims processing departments without delay."

We have not questioned claims merely because they did not conform to administrative requirements. For example,

some of the plans' procedures for determining the necessity of an assistant-at-surgery or for implementing recertification did not meet the procedural requirements of the administrative manual. In such cases we evaluated the procedures in terms of results. Further, we do not believe the plan participation agreements have produced uniform results since the Associations have not exercised the authority provided for in the agreements and because our review showed that the results of the plans' procedures varied.

In our view the fact that CSC continues to audit against the Associations' policy requirements, even though the Associations have taken the position that departures from these requirements are allowable, exemplifies the need for specific cost-control provisions to be included as part of the FEHB contracts.

AETNA PAYING OFFICES

The following information pertains to the paying offices' performance in meeting selected contract and policy requirements for benefit payments and limiting charges to reasonable amounts.

Medically necessary services

The contract for the Indemnity Benefit Plan excludes charges for services and supplies not medically necessary for diagnosis or treatment of illness or injury. The contract also excludes charges for physical checkups and diagnostic tests that are made in the absence of definite symptoms of disease or injury or that do not reveal a need for treatment. The Aetna's claim guide includes criteria for determining medical necessity for only the more common diagnoses.

At both paying offices we visited, claims processors, who lack formal medical training, relied on their experience and judgment (except for the common diagnoses set forth in the claims guide) in determining whether claims for hospital confinements, physician services, diagnostic procedures, and drugs and medicines were medically necessary. In many cases, determinations were made based on limited information because the paying offices did not always require that the diagnosis or a description of the treatment be provided on the claim. For example, a claim of $81 which was paid included office calls, tests, and drugs, but no diagnosis.

In most cases, however, when a claim does not have a diagnosis, Aetna is able to justify the claim based on information contained in the patient's complete medical file, which is available to the claims processors. The 68 claims we questioned were payments that Aetna was unable to support from the patients' medical history. A number of these questioned claims were for small drug charges.

In addition to these claims, we also identified other deficiencies which we did not include in our error rates. We believe these are system problems since Aetna's claim guide allows paying offices to pay these charges without an investigation of the claim. One of these deficiencies relates to claims involving prescription drugs. Aetna permits payments of drug charges if

--a prescription number is shown or the claim indicates that the drug or medicine was prescribed by the attending physician or

--the total expenses for prescribed drugs and medicines submitted currently and during the 30 days preceding the present submission is less than $50.

The home office permits the paying offices to use these criteria liberally since Aetna allowed these charges as long as less than $50 of drugs ($100 beginning in 1976) are purchased during a 30-day period regardless of the amount submitted. For example, Aetna could receive a $300 drug claim; but if purchases of the drugs did not exceed $50 over any 30-day period, it would not have to investigate.

In addition, we also identified deficiencies in the payment of certain hospital charges where it was not possible to determine if drug, laboratory, X-ray, or other charges related to the diagnoses. The paying office routinely paid these charges without investigating. The home office and the paying offices considered investigation as economically impractical; however, noncovered hospital charges are difficult to detect when hospital charges are not itemized.

If a paying office cannot decide whether a claim is allowable, the claim may be referred to the home office for disposition. Aetna estimates that claims referred to the home office represent less than 1 percent of all claims, although they are usually of high value. These claims are reviewed by senior claims examiners who have access to physician and dental consultants.

Home office auditors review a sample of paid claims from each paying office three or four times a year to check for erroneous payments and statistical errors. They do not, however, attempt to relate the diagnosis to the treatment, the length of hospital stay, or the drugs provided. Nor do they have the benefit of nurses' notes, hospital histories, or other medical records pertinent to a claim.

The following are examples of claims we questioned because the services appeared not to be medically necessary.

--A claim showed a diagnosis of "post myocardial infarction" (heart attack) and included a physical examination and numerous laboratory tests amounting to $149. The patient was no longer under physician care for the heart attack, which had occurred 2 years before. Paying office officials agreed that the claim was for a routine physical examination.

--A claim showed diagnosis of "osteoarthritus, left hip remission" and involved an office visit and laboratory tests totaling $109. Paying office officials agreed that some of these tests did not relate to the diagnosis and that the claim should have been denied as a routine physical.

--A claim showed a diagnosis of "atopic dermatitus disseminated" (skin disease) and included office visits, laboratory tests, and drugs totaling $150, which were paid by the paying office. We questioned whether some of the prescription drugs were related to the diagnosis and whether some of the drug charges were for nonprescription drugs, and therefore not payable. The plan agreed that more than $20 of the charges were for drugs not related to the diagnosis or for nonprescription drugs.

Reasonableness of charges

Under the Indemnity Benefit Plan, payments are based on prevailing fees, which are defined as the fees normally charged by other providers in an area for similar services or supplies.

Both paying offices we visited used prevailing fee schedules developed by Aetna for paying charges for surgical procedures. However, Aetna has not developed prevailing fee schedules for nonsurgical procedures. Aetna's claim guide instructs the paying offices to establish prevailing fees for

such procedures. When sufficient charge data is not available, the paying offices are to attempt to establish its own prevailing fees.

The paying offices we visited established neither prevailing fees nor tentative prevailing fees for nonsurgical procedures. Also, these offices had not compiled data on nonsurgical charges that could be used to establish prevailing fees. According to officials at one local office, such fees had not been established because of the high administrative cost involved.

At one paying office, 271 of the 285 claims in our sample contained nonsurgical procedures. None of the charges for covered nonsurgical services had been reduced by the paying office. At the other paying office, we did not attempt to determine the number of claims in our sample that were for nonsurgical services.

AETNA COMMENTS

In commenting on our report (see apps. IV and V), Aetna stated it had not skimped on claim settlement expenditures; however, the company had tried to be prudent. Aetna officials noted that their claims payment system was predicated on the assumption that, in the absence of any indication of fraud or abuse, small items of expense should be paid rather than elaborately investigated. They also stated that health is highly subjective and in the absence of symptoms of disease or injury documented by several unrelated and disinterested third parties, no claim can be unquestionably substantiated. Aetna said that it is a carrier's job

> "to effect a reasonable balance between the risk that a benefit payment based on limited data but good judgment might not be proper and the risk that fuller documentation before payment of the claim might be expensive, irritating, time-consuming, and non-productive."

We agree that at times good judgment can be used in lieu of more expensive, time-consuming documentation. Aetna's policies of routinely paying all hospital charges for tests, drugs, and X-rays without these charges being itemized or other wise supported, and of paying drug charges under $50 routinely ($100 for 1976), and not requiring diagnoses on all claims or for all items on a claim, may be a practical solution for processing claims economically. However, we do

not believe it is possible for a claims processor to determine the medical necessity of claims without supporting documentation.

As a result of our review, Aetna is considering

--requiring certification from claimants that they do not have other insurance coverage if more than 90 days have elapsed since Aetna has received such a certification;

--having the home office furnish prevailing fees for covered services and supplies for use at the paying offices and requiring charges exceeding the fees to be reviewed by claims analysis units of the paying offices;

--requiring enrollees to provide a diagnosis for drug bills and, generally, the name of the drug as well; and

--not treating diagnostic tests as allowable expenses if there is no indication in a claim file of a condition within the past 12 months that would warrant the tests.

CHAPTER 4

SCOPE OF REVIEW

We reviewed the operations of 10 Blue Cross and 10 Blue Shield plans and 2 Aetna paying offices to assess how effectively they were complying with (1) Civil Service Commission contracts and (2) cost-control policies developed and disseminated by the Associations and the Aetna home office. We also reviewed CSC's efforts in ensuring that the carriers complied with cost-control provisions. The local Blue Cross and Blue Shield offices we visited made about 33 percent of the total benefit payments of the Service Benefit Plan in 1975, and the Aetna paying offices we visited made about 20 percent of the total benefit payments of the Indemnity Benefit Plan. In addition to reviewing claims processing policies and procedures, we analyzed a random sample of paid claims at each local plan and paying office. Our medical advisors reviewed all claims requiring medical judgment.

We also reviewed the carriers' systems for (1) limiting claims payments to reasonable charges and (2) coordinating benefits with other insurance. In addition, at local Blue Cross/Blue Shield plans, we evaluated the coordination of benefits between the plans.

We made our review from February to August 1976 at (1) the Civil Service Commission is Washington, D.C., (2) the Blue Cross/Blue Shield Federal Employee Program headquarters in Washington, D.C., (3) local Blue Cross and Blue Shield plans in Washington, D.C.; Harrisburg and Camp Hill, Pennsylvania; Richmond, Virginia; Atlanta and Columbus, Georgia; Birmingham, Alabama; Denver, Colorado; Salt Lake City, Utah; Albuquerque, New Mexico; and San Francisco and Oakland, California, (4) the Aetna home office in Hartford, Connecticut, and (5) Aetna paying offices in Richmond, Virginia, and Denver, Colorado.

APPENDIX I

U.S. House of Representatives
SUBCOMMITTEE ON RETIREMENT AND EMPLOYEE BENEFITS
OF THE
COMMITTEE ON POST OFFICE AND CIVIL SERVICE
B-345-D RAYBURN HOUSE OFFICE BUILDING
Washington, D.C. 20515

January 22, 1976

Honorable Elmer B. Staats
Comptroller General of the United States
General Accounting Office
Washington, D. C. 20548

Dear Mr. Comptroller General:

During the past few months there has been a great deal of Congressional interest in the 1976 premium rate increases for two Government-wide plans of the Federal Employees Health Benefits (FEHB) program. During November and December 1975, your Office provided this Subcommittee with both a staff paper and testimony regarding premium rate increases for these two plans. At that time we discussed with your staff the desirability of doing further work in this area to determine how the Civil Service Commission and the carriers for these plans -- Blue Cross/Blue Shield and Aetna -- can better control health insurance costs.

In view of this, we would like for your Office to determine what these two carriers and the Commission are now doing to control health costs under the FEHB program. Specifically, we would like your Office to determine, to the extent possible:

--the procedures employed by these two carriers to ensure that health insurance benefits are limited to only medically necessary procedures and that payments for benefits are not excessive, as provided for in the contracts between the Commission and the carriers;

--what the Commission does, such as audits and otherwise, to assure that the carriers' payments for benefits are in accordance with the contract provisions;

--the extent of compliance by local plans and paying offices with cost control procedures established for the Government-wide plans at the headquarters level of the two carriers and how effective these cost controls have been; and

APPENDIX I

--what actions the Commission and the carriers can take to improve their procedures for controlling costs.

In addition to the above, the Subcommittee would appreciate any suggestions you may have which could help reduce costs to the FEHB program. Because of the constraints of time limitations now placed on us by the Congressional Budget and Impoundment Control Act of 1974, it would be greatly appreciated if we could have this report not later than September 1, 1976.

With best wishes, I am

Sincerely yours,

Richard C. White
Chairman

RCW:rml

APPENDIX II

UNITED STATES CIVIL SERVICE COMMISSION
BUREAU OF RETIREMENT, INSURANCE, AND OCCUPATIONAL HEALTH
WASHINGTON, D.C. 20415

IN REPLY PLEASE REFER TO

YOUR REFERENCE

NOV 12 1976

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

Dear Mr. Ahart:

This is a response to your September 21, 1976 letter which enclosed a draft of your proposed report to the Subcommittee on Retirement and Employee Benefits, House Committee on Post Office and Civil Service on the Federal Employee Health Benefits Program. Since receiving your draft, your staff and my own have had meetings during which it was agreed to change portions of the draft. Our comments, which follow, are based on your original draft except where it has been agreed to change it.

Our comments are directed primarily to the overall theme of the report, the Digest and Chapter 2 (CSC Should Ensure That Carriers Pay Benefits According To Contracts and Cost Control Policies). We have commented only briefly on Chapter 3 (Lack of Compliance with Cost Control Requirements). We did not comment on Chapter 1 (Introduction) or Chapter 4 (Scope of Audit). We also have not commented on those portions of the report which deal specifically with the carriers.

Comments on Overall Theme of the Report

The overall theme of this report implies that the Commission has the power to significantly control health insurance costs by means of specific detailed contract requirements and audit actions relating to cost control activities and procedures followed by the insurance carriers. While effective claims administration review and control procedures are essential in administration of an insurance program, the extent to which they will, in themselves, significantly control health insurance costs or reduce premiums, is not as substantial as implied by the report or as the report would lead one to believe.

We agree completely with the statement contained in the report that benefit payments are the major factor in determining premium rates. The cost of health insurance in the Federal Employees Health Benefits Program reflects and is determined by the cost of the health services covered by the insurance. Therefore, unless we are able to reduce or control the cost and/or utilization of health services there will be no significant or substantial reduction, leveling off or control of insurance premiums.

APPENDIX II

Given today's health care delivery system and third party payer arrangements, the control of health insurance costs lies primarily with the providers of health services (doctors and hospitals), secondly with insurance carriers and other third party payers, and finally with the users of medical services. During the course of hearings held on October 20, 1975, before the House Subcommittee on Retirement and Employee Benefits, I discussed in some detail the factors that went into the health insurance premiums and costs in the Federal Program, as well as the components that make up that cost and the effect various actions might have in connection with each one of them. During the course of that hearing, I also discussed various actions either legislative, regulatory or administrative that might be taken that would have some impact on either leveling or controlling, to some extent, any further increases in health insurance premiums. At that time I also stated my view that:

> "I think, in my rather limited view, that the only real solution, other than some of the artificially imposed ones that I may have mentioned to this problem, if one is ever to exist, lies in the hands of the individuals who really control health care costs.
> That is the individual physician and the physicians as a group. The physician, in fact, is in a unique position. He controls everything, really, in this field, except the first contact by the patient. From that point on, that patient is in the hands of that physician. The type and length of treatment the individual receives is in the hands of that physician. The number of consultations and who he will consult with, when he is hospitalized, the length of time he will stay in the hospital, the type of drugs he will take, just about everything else is in the hands of that physician."

The influence over health care costs exercised by the Commission is relatively insignificant by comparison.

The providers of health services must be held accountable and primarily responsible for the current high cost of health care as they make up the community having the authority for establishing the cost of health care services.

Health insurance carriers must next be held responsible for the control of rising health care costs. Carriers can exert a significant influence on the medical community by implementing and enforcing cost control programs. The Carriers can also be effective by informing users of health services of what they can do to help hold down health care costs.

The Commission represents only a small portion of the users of health care services. In fact, FEP comprises only about 6 percent of the total Blue Cross/Blue Shield enrollment. In some

individual local plans FEP may comprise only 1 percent (or less) of the enrollment. Where such local plans do not have effective cost control programs and/or adequate management systems for their other lines of business, the Commission is in a position to exercise only limited influence for requiring changes to existing practices.

In summary, we believe that the control of health care costs to a considerable extent is dependent upon at least the following external forces:

a. Providers of Health Care Services
b. Carriers of Health Care Insurance, and
c. Users of Health Services.

The report recognizes that the application of strict cost control could result in adverse enrollee reaction since the employees may incur liabilities for charges not paid by the carriers. Actually, the cost controls implied by the report are tighter claims control and strict claims adjudication. Such cost control actions would not really control health care costs, but would merely shift a greater portion of the cost to the employee who felt such charges were covered by this insurance only to find out afterwards that they were not. Here again, I might also call your attention to my testimony of October 20, 1975, wherein at one point I referred to "the tendency and the direction taken in most legislation and in most policy guidance that we have been receiving from the Congress in recent years has been in the direction of what I have begun to call a pay claim syndrome. It seems that we have been building in all kinds of mechanisms to either review or go after a carrier when he turns down a claim under the contract so the emphasis seems to be on making it as difficult as possible for carriers to either turn down, reduce or take adverse action on the claim of any Federal employee". The increase in litigation against carriers and their experience as a result of such litigation has not helped matters any. At the present time, members of one of the medical professional organizations is objecting quite strenuously, with some support from some members of Congress, to efforts on the part of carriers to obtain additional information which they believe is needed to properly evaluate and adjudicate claims under the Federal Employees Health Benefits contract and which would be of assistance to them in reviewing claims from the standpoint of cost and utilization control.

The Commission does, however, view its responsibility to Federal employees enrolled in FEP as a significant one. We believe that, to the extent possible, we should exert our maximum influence on carriers to do their part to help control rising health care costs. In this regard, the Commission has in the past, and at present, been

attempting in its contract negotiations with the carriers to provide a health benefits plan design that is more conducive to reducing costs, yet at the same time, providing quality medical care. Some of these effective cost control benefit provisions involve such things as the use of free-standing facilities; surgi-centers; dialysis centers which can provide quality care at less cost than in-hospital patient care; in and out same day surgery where appropriate; the use of second surgical opinions where elective surgery is involved; the use of PRSOs and peer review committees; home nursing services; and pre-admission testing. In addition, we have been encouraging and providing benefits for the use of utilization and review committees, the monitoring of hospital stays and patient and employee education designed to eliminate unnecessary utilization of benefits. We have also required in all our contracts for the coordination of benefits to prevent double coverage and double payments. We have also encouraged the use of alternative delivery systems and more effective provider rate setting. These activities are designed to attack the real high cost of medical services which are reflected in the health insurance premiums. The ultimate result of these types of activities is reduced cost and more cost control. They appear to be very effective tools in this area and are meeting with continued success. We have significantly redirected our audit effort toward review of benefit payments and an analysis of management techniques employed by each plan for developing and implementing cost containment programs. We have increased our efforts during contract negotiations for additional controlling features such as the disputes clause and, currently, an advance agreements clause. We have interpreted other contract clauses very strictly and we continually evaluate the cost impact of health benefits offered under the contract. We cannot, however, exercise a significant influence over the cost of health care (the health care industry in total) and we recognize that the cost of health care for Federal employees will continue to rise is some relation to the rise of health care costs in the economy.

Comments on Digest of Report

In the digest of the report you state that as a result of your review of benefit payments made by carriers, you found numerous payments which were made either (1) in violation of contract or policy requirements or (2) in the absence of sufficient information upon which to determine the allowability or reasonableness of the payments. We believe that such findings by GAO are representative of the practices employed by the carriers. Audits of carriers performed by the Commission on a regular basis are also identifying such deficiencies.

While your findings imply that 13.5 percent of Blue Cross/Blue Shield claims and 23 percent of Aetna claims were paid in error, we note that a high percentage of these "errors" represent claims paid without "sufficient information". We do not believe that it is equitable to include payments of this type in error projections. Only 1 percent

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of the Blue Cross/Blue Shield claims reviewed should have been denied, all others reflect a judgmental factor as to whether or not sufficient information was available on which to base payment of the claim. A similar situation exists relative to the GAO review of Aetna.

The question of whether "sufficient information" was available, as stated above, is a matter of medical judgment and we believe that such controversies cannot be settled on a basis satisfactory to all parties involved. We are also confident that the subscriber involved and his physician would consider services that are rendered as being covered benefits and medically necessary. We find this to be true today more than ever before in light of the current trend of malpractice suits being lodged against physicians. This type of an atmosphere causes physicians to take additional precautions against an incorrect diagnosis or treatment program.

Many situations in this area involve medical judgement and certainly there is some question raised as to who is in the better position to render medical judgement, the attending physician, the Plan's consultant, a GAO or our medical advisor or whether the ultimate in resolving such issues would be the costly device of peer review.

Weaknesses found by GAO in the benefit payment area and in the systems used by the local plans to ensure that benefits were not in excess of contract requirements are similar to findings found by the Commission in its audits of local plans. The Commission is consistently calling such deficiencies to the attention of the local plans and the Associations through the issuance of audit reports. The Associations do recognize that in many instances our findings represent valid deficiencies in local plan management systems and have, in some cases, taken steps to encourage local plans to take appropriate corrective action.

The report states that the contracts negotiated by the Commission with the carriers contain neither incentives for the carriers to control health benefit costs nor penalties if the carriers do not pay benefits in accordance with contract provisions. Incentives in Government contracts normally take form according to the type of contract negotiated, such as Fixed Price Incentive (FPI) contracts or Cost Plus Incentive Fee (CPIF) contracts. We do not believe that health benefit contracts lend themselves to either the FPI or the CPIF format. Either of these formats would have to be based on contractor performance and consequently the contractor would be in a position to control (manipulate) the contract costs in order to stay below targets. Accordingly, this could result in the awarding of incentives that may not be justified.

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Therefore, incentives in the contract would have to take some unique form. We have, of course, considered the idea of incentives and penalties in order to stimulate more efficient contract administration by the carriers. Unfortunately, no workable plan has been developed to date which would result in the desired objective.

Your report did not offer any suggestions on what incentives or penalities were appropriate or how best to achieve such results in negotiations with the intermediaries. Also, your report did not consider that the Commission can only contract with Blue Cross and Blue Shield for the Service Benefit Plan and negotiations with a sole source contractor seldom result in the unilateral addition of contract clauses and features. The Associations have, in the past, been most careful during contract negotiations and generally are not receptive to any contract changes which would serve to restrict their alternatives or management prerogatives in any way.

The imposition of penalties appears to be impracticable. Only two penalties could be imposed because of a carrier's failure to pay claims properly:

1. Terminate the contract;
2. Make the carrier bear the loss of claims paid in error or without adequate justification.

Considering that only the Blues can provide the Service Benefit contract and the number of employees enrolled in the Plan, you should agree that the former is not feasible. The Commission has considered the practicality of the latter alternative. We recognized in our considerations that with the small service charge our carriers now receive, they would be unwilling to agree contractually to absorb erroneous payments out of that service charge. I am sure the only way they would agree to this kind of penalty is in exchange for a much larger service charge.

If we could agree contractually that carriers must pay for any erroneous payments out of their own funds, we should not be naive enough to believe that the matter would rest there. The carriers would not stand such losses, but would recoup these erroneous payments from the Federal patients.

Your report views the following two features of the Blue Cross/Blue Shield and Aetna contracts as disincentives for the control of health benefit costs:

1. all losses on benefit costs in one year can be recouped the following year and
2. the administrative cost allowance of the carriers bears a direct relationship to benefit costs.

You have overlooked the fact, however, that the Health Insurance law (Chapter 89, Title 5) provides that the rates charged under health benefits plans shall reasonably reflect the costs of benefits provided. Further, Sec. 8902 (i) states that the rates for the Service Benefit and the Indemnity Benefit Plan determined for the first contract term shall be continued for later contract terms, except that they may be readjusted for any later term, based on past experience and benefit adjustments under the later contract.

Accordingly, we believe that the law provides for an "experience rated" rate structure which by its very nature takes prior year costs into account when formulating rates for subsequent years.

The report states that there are no contractual incentives for carriers to implement tight cost-control procedures and implies that the administrative cost ceiling is a disincentive to tight control over benefit payments. The report suggests that by eliminating the cost ceiling, the carriers would implement tighter benefit payment controls. The purpose of the administrative cost ceiling is to provide the carriers with an incentive for efficient operation of its administrative processes. We believe that the carriers could implement tight cost controls within a cost ceiling if they operate efficiently. Generally the benefit payment controls applied to the Federal Employee Program by local Blue Cross/Blue Shield Plans are the same controls applied by the local plan for all its lines of business. This is especially true in the area of Coordination of Benefits, Utilization Review, and Usual, Customary and Reasonable (UCR) physician payments. Yet the Plans do not have cost ceilings on their other lines of business and similar problems exist. We believe that the cost ceiling acts as an incentive towards reordering the spending priorities at the local plan levels. Elimination of the ceiling would promote inefficiency and would not provide any positive incentive for tighter benefit payment controls. We believe that elimination of the cost ceiling would provide carriers with an incentive to shift administrative costs from their local business to FEP's fully reimbursable contract.

In addition, we believe that some consideration should be given to the fact that an incentive is built into our contracts to control cost in the form of competition. Widespread payment of claims in violation of the contract provisions would result in substantial premium increases and would place the carrier at a competitive disadvantage. The fact that the two Governmentwide Plans compete against each other benefit and premium wise is good incentive for them to attempt to strictly follow contract provisions and cost control techniques.

We concur with your statement that the National Associations are ineffective in requiring local Blue Cross and Blue Shield plans to adhere to the provisions of the contract and cost control provision

requirements established by the Associations. It is their very structure that causes this condition. Each local plan is an autonomous entity established and incorporated within the various States in accordance with State laws and regulations. Further, each local plan has its own management team, policies, procedures, and internal systems. The Associations are not in a position to effectively dictate to local plans on any matters. Only a cooperative atmosphere between the Associations and the local plans can be used as a tool for achieving contract compliance and enforcement of cost control efforts.

Your report is correct in its statement that prior audit effort by the Commission was directed primarily toward the review of administrative charges to the contract. Several years ago, however, the Commission recognized that its audit effort would be more effective in the review of benefit payments. To that end, therefore, the Commission has completely revised its audit programs and techniques and has been emphasizing the proper application of benefit payments and the review of cost control practices employed by each local plan audited. Consequently, our audits have resulted in the identification of inappropriate benefit payment practices and inadequate implementation of cost control features required by the contract.

The audit function does not have the benefit of medical expertise to help resolve questions of medical judgment. We believe that such expertise would, indeed, be beneficial to our audit effort. Medical expertise on the Commission staff would have a balancing effect and would have the tendency to help us reach more equitable conclusions. Our main objective, however, would be to determine whether or not the specific claim is an isolated erroneous payment or whether it was caused by a defective procedure. We cannot review medical records, other than the claim form itself, without a written authorization by the patient. If the patient knows the purpose of our need for the authorization, he is unlikely to give us authorization to look at his records. Medical expertise in our review of claims would not be used as a vehicle to recover costs of questionable claims. We believe that such expertise would be beneficial in identifying specific claims processing problems that may save hundreds of thousands of dollars rather than becoming bogged down in individual erroneous payments that may result in recovering a few hundred dollars.

Concerning the question of the Commission's audit authority, the Commission has established audit practices which are based on "Standards for Audit of Governmental Organizations, Programs, Activities and Functions" issued by the Comptroller General of the United States. Accordingly, our scope of audit includes auditing for economy, efficiency and achievement of desired results as well as financial and compliance auditing. The Associations have long

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taken exception to this scope of audit and contend that, based on the type of contract involved, only a financial scope of audit is appropriate. Other carriers have also taken this position. We expect that this issue will ultimately be resolved in court. In the meantime, we intend to continue our audits in accordance with our position.

Comments on Chapter 2 of Report

Chapter 2 contains detailed information on many of the items reported in the Digest. Our comments on this chapter, therefore, will not be repetitive of previous comments, but will be directed only to items not mentioned in the Digest.

The report Digest points out that the Associations are ineffective in requiring local plans to adhere to cost control requirements established by the Associations. In Chapter 2, however, it is recommended that the contracts with carriers should set forth specific cost control programs to which carriers must adhere. We do not believe that specific cost control programs should be addressed contractually. We believe that the carriers should be encouraged in the area of cost control and that FEP should have benefit of all such measures taken by the Associations and local plans. The state-of-the-art (health benefits cost control) is an ever changing area and to limit our participation in cost containment efforts by contractual requirements may prove to be self-defeating.

[See GAO note, p. 63.]

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[See GAO note, p. 63.]

Comments on Chapter 3 of Report

Chapter 3 of the report details the findings of your review of claims at the two major FEP carriers. While we find no basis to take exception to your reported findings, we would like to point out that such findings are also routinely reported in Commission audit reports on the carriers. We have placed high priority on such items in our audit effort and have made many recommendations relative to usual,

customary and reasonable (UCR) physician payments, coordination of benefits (COB) and other claims processing system deficiencies at the local plan level. We also place emphasis on medical necessity of benefit payments including the relating of treatments and procedures to diagnosis and the review of length of stay in hospitals. We have long been interested in the mental and nervous benefit area and have called many claims to the local plans attention which appeared to be non-medically necessary confinements. We have, however, attempted to relate such findings to system deficiencies and have not directed the carriers to credit FEP with such erroneous payments.

Comments on Report Recommendations

The report resulted in three recommendations, namely:

1. The Commission should revise its health insurance contracts to provide incentives for compliance and penalties for non-compliance with contract and Commission requirements;

2. The Commission should include in its contracts specific cost control programs which the carriers must follow; and

3. The Commission should clarify its audit authority, expand its audits, and take more effective action on its audit findings.

Our preceding comments have presented our position on the first two of your recommendations. In summary:

1. We do not believe that health insurance contracts lend themselves to incentive and/or penalty provisions. Further, such provisions must be developed bilaterially and a sole source contractor such as Blue Cross/Blue Shield would be reluctant to agree to such provisions.

2. We do not believe that cost containment programs of the type discussed should be addressed contractually. Rather, FEP should benefit from all state-of-the-art endeavors initiated by the health insurance industry. We do agree, however, that contract and policy requirements (internal guidelines and contract interpretations) developed by the Associations and Aetna should be used by our auditors in their audit efforts.

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We consider the third recommendation to be appropriate and we will continue our efforts in those areas.

Thank you for giving us an opportunity to comment on the draft report.

Sincerely,

Thomas A. Tinsley,
Director

GAO note: Deleted material concerns matters in the draft report which have been revised in the final report.

Blue Cross
Blue Shield
Federal Employee Program

1800 M Street, N.W.
Washington, D.C. 20036
202/785-7950

October 6, 1976

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

Dear Mr. Ahart:

Our response to the draft GAO report on cost containment activities of the Blue Cross and Blue Shield organizations in the Federal Employee Program consists of page-by-page, line-by-line comments on statements made in the report.

However, before presenting that much detail, we feel that a more general introduction is needed.

The bulk of the findings described in the GAO report fall into four categories:

1. Health care cost in general.
2. National Associations' policy versus the actual Contract.
3. Claims handling by the Blue Cross and Blue Shield Plans.
4. Overall cost containment activities.

We want to present our point of view regarding each of those.

Health Care Cost

The cost of health care—and the challenge of containing it—is a complex issue. Such a major "industry" cannot be isolated from the effects of inflation which afflicts the entire nation.

Blue Cross and Blue Shield Plans have had no choice but to recognize and accommodate the higher cost of care brought about by advances in medical technology, the increased intensity and complexity of health care services, as well as the inevitable cost of inflation.

[See GAO note 1, p. 76.]

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[See GAO note 1, p. 76.]

Policy Versus Contract

The GAO report concludes that any departure by a local Blue Cross or Blue Shield Plan from the National Associations' policies and procedures contained in the Administrative Manual represents a violation of the Contract with the Civil Service Commission.

This is not true at all.

The Contract with the CSC is "result" rather than "procedure" oriented. The intent of the Participating Agreements between Plans and the Associations is not to require uniform administrative procedures; it is to assure uniform results as measured against the Contract.

Neither the Participating Agreements nor the Administrative Manual require that every Plan administer benefits mechanically in the same way.

There have been numerous instances in which the Associations have insisted that Plans comply with the Contract to achieve required results or achieve a given level of performance; the Plans have complied.

We continually review the performance of Plans in handling the Federal Employee Program in order to identify weaknesses and correct them.

Claims Handling

Handling claims is extremely complex, in many respects, an art. While more than 80 percent of the claims submitted to Blue Cross and Blue Shield Plans under the Federal Employee Program are easily recognized as covered benefits and are paid promptly, the remainder require mature judgment and a knowledge of the diagnostic and treatment considerations which affect services provided by hospitals, physicians and other providers.

In some cases, in its report, the GAO—on the basis of a sample of claims reviewed by its own medical consultants—has made erroneous assumptions that have resulted in exaggerated and misleading extrapolations.

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Claims adjudication personnel at the Plans often have access to information other than the specific claim, bearing on whether or not that claim should have been paid. For example, a history of prior claims for the same patient might provide valuable insights as to the nature of an illness and the appropriateness of the claim.

Plan personnel are also familiar with providers in their area. They are able to judge which claims can be accepted at face value and which might require further investigation.

Plan claims personnel are also able to decode the procedure and service codes on the claims form and discern more from a given claim than could a medical advisor to GAO who is unfamiliar with the codes.

[See GAO note 1, p. 76.]

It would be ideal to investigate thoroughly every claim submitted. However, there is a huge volume of claims (11,017,239 in 1975) and in view of what has already been said about claims handling, the cost of exhaustive investigation must be balanced against the need and desire to restrict administrative cost for the Program. Put bluntly, it is scarcely worthwhile to spend six dollars in order to save three.

As a final thought on the subject of claims handling, we would like to emphasize that the purpose of the Federal Employees Health Benefits Program is to provide benefits—to pay claims. In this context, we think it is sound administrative practice, and we encourage Blue Cross and Blue Shield Plans to resolve borderline claims decisions in favor of the Federal enrollee.

Cost Control

Blue Cross and Blue Shield Plans and the National Associations are committed to cost containment.

The Service Benefit Plan returns approximately 95 cents of every subscription dollar to subscribers in the form of benefit payments to providers, and to subscribers themselves for out-of-pocket expenses. And that in spite of the fact that we can expect about one out of every two of our subscribers to use their health care benefits during the coming year.

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It is important to note that the Service Benefit Plan instituted a cost containment program long before such moves were broadly called for and supported. Our 16-point cost control program was developed and implemented in 1971, without the pressures of Contract incentives or penalties, and it has yet to be utilized in full by any other carrier. The program emphasizes areas of the Contract where more intensive and sophisticated administration can result in the payment of fewer unnecessary benefit dollars.

A major incentive for cost containment (although not recognized in the GAO report) is the competition in the overall Federal Employees Health Benefits Program. Sixty health plans are offered by a variety of carriers with a variety of benefits at various price levels. The individual choice of program by each employee strengthens competition and results in better benefits at minimum cost. Most carriers are anxious to increase their Federal Program enrollment, and since price is one of the key determinants in the choice of Plan, there is a built in incentive for careful claims administration to make the price attractive to the enrollees.

A program of comprehensive benefits naturally costs more than one with limited benefits, deductibles and co-insurance. Our price is directly related to health care cost. A health care package covering every possible health care cost would be ideal; it also would be at a price that few are willing to pay. To keep this discussion within reasonable bounds, let's look at just three elements of cost containment.

Coordination of Benefits (Duplicate Coverage)

Our recovery from COB has increased each year since the effort began in 1971. The 1975 recovery was $120,399,000. However, investigating claims for duplicate coverage is like all other forms of cost containment; it is subject to the law of diminishing returns. But we believe, and we have proved, that selective screening of claims for COB is important from both a cost and a service point of view.

Workmen's Compensation

The same potential inefficiency would result from trying to screen every claim for workmen's compensation conflict. Since records of injury or illness cases among Federal employees are maintained by the Occupational Safety and Health Administration of the Department of Labor, it would help carriers a great deal if cases approved for compensation by the Department of Labor were identified for all carriers.

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Usual, Customary and Reasonable Payments

The GAO has misinterpreted both the letter and the intent of the Contract regarding "usual, customary and reasonable" benefit payments for physicians' services. The Contract wording is unusual in stating that such payments will be made in amounts "which in general are equal to his usual charges for the same services, but which do not exceed amounts customarily charged by other physicians for the same service."

The words "in general" are a considered and deliberate recognition by both parties to the contract that: (a) payments for the same services were not expected to be "usual" and "customary" in all cases, and (b) that the method of determining that a payment is "the fee most frequently imposed by a provider for a particular service or supply" or that the payment "is within the range of fees usually charged...by providers of similar training and experience in the same locality" was not expected to be either precise or uniform in all cases and in all areas.

This unique Contract wording permitted Plans to implement benefit payment procedures that would accommodate variations necessitated by local circumstances but would substantially conform to the "usual, customary and reasonable" fee concept and objectives. At the same time, it preserves the "paid-in-full" principle that is the hallmark of Blue Cross and Blue Shield coverage.

Detailed Comments

Following are our detailed comments on the GAO report. Each comment is keyed to the appropriate page and line number in the draft report.

Page Line

[See GAO notes 1 and 2, p. 76.]

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6-7 The statements on pages 6 and 7 are misleading. They give the impression that any departure by a local Blue Cross or Blue Shield Plan from the National Associations' policies and procedures contained in the FEP Administrative Manual is a violation of the Contract provisions with CSC. The Administrative Manual and Participating Agreements are internal management documents. The Manual provides guidelines and alternative administrative mechanisms intended to help Plans perform at an optimum, but not mandatory, level. However, the Associations do require strict adherence to those parts of the Manual and Agreements that touch on matters essential to the discharge of our Contract responsibilities.

The Associations realize that due to State regulations, local provider situations, or the prevailing practices of Plans related to their local business, deviations by Plans from the Manual guidelines may often be necessary. If, in the judgment of the FEP Director's Office, these alternative practices will produce results equivalent to those obtained by following the Manual, such deviations are permitted. Therefore, it is important to recognize the fact that because a Plan uses procedures other than those contained in the Administrative Manual, it is not sufficient reason to conclude that it is paying claims improperly. Many of the findings cited by GAO in this report are based on such improper assumptions.

8 In discussing the sampling of claims and in extrapolating the dollar amounts involved in so-called "questionable" claims, the report gives an inaccurate picture of the total monies involved. The GAO sample was less than 4,700 of the 11 million claims paid by the Blue Cross and Blue Shield FEP Program in 1975 and of this group, 599 were questioned. Moreover, discussions of the claims resulted in agreement by Plan personnel that only 49, or approximately one percent, of the claims should not have been paid. There was agreement that 280 of the claims questioned required additional investigation.

We also point out that claims adjudication personnel at the Plans often have access to other information, bearing on whether or not the claims should have been paid, beyond information contained on the claim form itself. For example, the history of prior claims for that same patient may provide valuable insights as to the nature of an illness and the appropriateness of the claim. Plan personnel also frequently are familiar with the providers in their area; they are able to judge which claims can be accepted at face value and which may require further investigation. Claims personnel also are able to

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decode the procedure and service codes entered on the claim forms and, consequently, may be able to discern more from a given claim than could a GAO medical advisor who is unfamiliar with these codes.

Under any circumstances, it is inappropriate to lump all elements of claims cited—those questioned, denied, and to be investigated further—into a single percentage figure which implies to the reader of the report that 13.5 percent of all claims are paid in error. One percent of those claims which were questioned should have been denied. All the others were only questioned by the GAO medical advisor as needing further investigation. Notwithstanding this distinction, the GAO implies that all 599 claims would have been denied had further investigation been carried out. This is patently incorrect.

9 The extrapolation of the broadest possibilities of claims problems from a small sample is misleading because it results in a gross exaggeration, and your own data indicate that the vast majority of the questioned claims would ultimately be found to be properly paid.

In projecting dollar amounts, the report lumps together claims allegedly paid in violation of Contract provisions, of policy requirements, or in the absence of sufficient information. The appropriateness of payment of claims can only be measured against the Contract with the CSC since—as noted previously—other documents utilized are management tools to achieve the results expected and required by the Contract between CSC and the Associations.

10 The Associations' policy is an internal matter between the Associations and the participating Plans. The benefit payment should be measured only against the Contract.

[See GAO note 1, p. 76.]

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[See GAO note 1, p. 76.]

12 The report's allegation of a lack of incentives to control costs fails to consider the basic nature of the Federal Employees Health Benefits Program (FEHBP), especially its competitive environment. Sixty health plans are offered by a variety of carriers with a variety of benefits at various price levels. The individual choice of program and carrier by the employee strengthens the competition, resulting in improved benefits at minimum cost. A comprehensive benefit package (Blue Cross and Blue Shield Service Benefit Plan) will cost more than a limited benefit package with deductibles and co-insurance. Our price is directly proportional to health care benefit costs. For instance, a health care package covering every facet of health care costs would be considerably more costly than is presently available. The reason it is not available is because few are willing to pay the price.

[See GAO note 1, p. 76.]

15 It is important to note that the 16-point cost control program was developed and implemented by the Blue Cross and Blue Shield Federal Employee Program in 1971. It is yet to be utilized by any other carrier. Also, it was effectively implemented without resort to Contract incentives or penalties. Our cost control program emphasizes those areas of the Contract where intensification of administration will result in the greatest cost benefit to the Program.

16 The intent of the Participating Agreements between local Plans and the Associations is not to mandate uniform Contract Administration, but to assure uniform results required by the Contract. Neither the Participating Agreements nor the Administrative Manual require that

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every Plan administer the benefits mechanically in the same way. It is not the intent of the Associations to insist upon operating uniformity among the Plans as long as the results required by the Contract are obtained or greater efficiencies are achieved. The Plans exhibit significantly high levels of uniformity in Contract compliance.

17 There is an obvious misunderstanding of the comments made by Association officials regarding their authority over local Plans in regard to the FEP Contract. Clearly the Contract and the Participating Agreements invest significant authority in the National Associations. There have been numerous instances where the Associations have insisted that Plans comply with the Contract to achieve certain results or to achieve a given level of performance, and the Plans have complied. We have legal authority as provided in the Participating Agreements, and use that authority in a reasonable manner. The ultimate penalty to any Plan would be for the Associations to remove that Plan from FEP participation.

18 - 20 We wish to clarify that we do not object to the evaluation of management systems, but rather to the enforcement of such observations through the power of audit disallowances. Such a practice would, in effect, inject CSC into the management decisions that we must make on a daily basis. We do believe that CSC's audits should be limited to financial matters and should pertain only to the Contract. In October 1974, we reached agreement with CSC on the scope of audit. The current audit activity exceeds that scope.

21 Again, we seriously object to the consistent combining of Contract and policy requirements relative to claims processing, benefit payments, and cost containment efforts. We again point out that the Contract is the appropriate document by which to measure our performance. The policy requirements, Administrative Manual, and the 16-point program are internal management tools designed to provide strengthened administration. Their existence results in a stronger administration.

25 This is another situation based on a set of assumptions from strongly questionable data, which is then extrapolated into a broad universe.

We obtained a copy of the questionnaire, have examined it, and do not believe that valid conclusions could be reached from the information it provided. It is unreasonable to expect a subscriber to recognize what constitutes a routine physical examination within the definition of covered benefits used by a claims adjudicator. It is our understanding that this sample is biased as a result of communications which implied that routine physical examinations were a covered benefit.

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[See GAO note 1, p. 76.]

Conflicting professional opinion on treatment occurs throughout the field of medicine, but it is most prevalent in the area of nervous and mental disorders. Treatmer modalities vary in different geographic areas relative to the services and facilities available, as well as the basic professional education of the providers and personal p erns of practice. Thus, claims adjudication for nervous and mental benefits is difficult and presents a good example of how Plan variations from National Associations' criteria may be necessary.

38 The document misinterprets both the letter and intent of the Contract as it relates to "usual," "customary," and "reasonable" benefit payments for physicians' services. The Contract wording is unusual in stating that such payments be made in amounts "which in general are equal to his usual charges for the same services, but which do not exceed amounts customarily charged by other physicians for the same service". The words "in general" are rarely, if ever, used in contracts of health insurance which intend to provide precise

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and uniform payments. Their use in the Contract between CSC and the Associations was a considered and deliberate recognition by both parties that: payments for the same services were not expected to be "usual" and "customary" in all cases, and that the methods employed in determining that a payment is: (a) "the fee most frequently imposed by a provider for a particular service or supply", or (b) "within the range of fees usually charged . . . by providers of similar training and experience in the same locality", were not expected to be either precise or uniform in all cases or in all areas.

This unique contract wording thus permitted Blue Shield Plans to implement benefit payment procedures that, although accommodating variations necessitated by local circumstances, substantially conformed to the "usual, customary and reasonable" fee concepts and objectives, while maximizing the "paid-in-full" principle that is the hallmark of Blue Cross and Blue Shield coverages.

Having established by contract the practical environment within which Plans could administer benefit payment programs that "in general" conformed to the fee "most frequently imposed" and "within the range usually charged by providers" objectives, the Associations prescribed in the FEP Administrative Manual, optimum procedures for making UCR benefit payments, which included the maintenance and use of both individual physicians' and procedures profiles. Blue Cross and Blue Shield Plans are encouraged and assisted by the Associations to use these prescribed methods, to the extent not precluded by local conditions. The objective has been, and continues to be, to steadily move toward uniformity in UCR methodology.

Under these conditions, variations from procedures prescribed in the Administrative Manual have occurred in some areas as described in the GAO report.

Importantly, the results have been entirely in keeping with the intent of the Contract. The GAO report admits it cannot assess the impact of local variations from recommended UCR methodology. We submit that it is minor, that an overwhelming majority of benefit payments by the Service Benefit Plan meet the contractual tests of "the fee most frequently imposed" and "within the range of fees usually charged by providers"; and benefit payments that do not meet these tests are fully authorized by the "in general" wording of the Contract. In support of this contention, the Associations are prepared to conduct a study to determine the extent to which benefit payments are meeting the Contract requirements. It is expected that this study

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Blue Cross
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will demonstrate that our UCR programs have created a level of uniformity and equity in benefit payments that is beyond what was anticipated by the parties to the Contract.

42 The Blue Cross and Blue Shield Federal Employee Program's monetary recovery from COB has increased each year since the effort began in 1971. The 1975 recovery from COB was $120,399,000. However, investigating claims for duplicative coverage (COB) is —like all other forms of cost containment—subject to the law of diminishing returns. In a sample of 64 claims of the type which GAO indicates should have had further investigation, only one case of duplicate coverage was found after 49 claims were disposed of following an initial follow-up. The remaining 15 required a second follow-up, which disposed of 10 of the remainder. These follow-up attempts, as well as the original investigation, are costly and result in delayed disposition of the claims. We believe that selective screening of the claims for COB is important from both a cost benefit and a service point of view.

Similar inefficiencies would result from an attempt to screen all possible Workmen's Compensation claims. However, an alternative exists which the Federal government may wish to explore: since records of injury or illness cases among Federal employees are maintained by the Occupational Safety and Health Administration of the Department of Labor, it would significantly assist carriers if cases approved as compensible by the Department of Labor were identified to all carriers.

It is important to note that the Blue Cross and Blue Shield Federal Employee Program, in administering the Government-wide Service Benefit Plan instituted a cost containment program in 1971 before such moves were broadly called for and supported. Blue Cross and Blue Shield Plans and the National Associations are committed to cost containment. The Service Benefit Plan returns approximately 95 per cent of subscription income to subscribers in the form of benefit payments to doctors and hospitals, and to subscribers themselves for out-of-pocket expenses. We expect that about one out of every two of our subscribers will use their health care benefits during the coming year.

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We have demonstrated our commitment to cost containment through our endeavors to strengthen and intensify the administration of the Blue Cross and Blue Shield Government-wide Service Benefit Plan.

If you have additional questions or wish to confer with us at any time regarding this effort, please advise me.

Sincerely yours,

James N. Gillman
Vice President

JNG:jg

GAO notes 1: Deleted material concerns matters in the draft report which have been revised in the final report.

2: Page and line numbers in the final report differ from those in the draft.

APPENDIX IV

Ætna
LIFE & CASUALTY

151 Farmington Avenue
Hartford, Connecticut 06156

D. W. Pettengill
Vice President
Group Division

September 28, 1976

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

Dear Mr. Ahart:

Thank you for giving Ætna Life Insurance Company an opportunity to comment on the draft report by the Comptroller General on cost control efforts under the Government-Wide Indemnity Benefit Plan. We would appreciate your incorporating the following comments into the final report.

[See GAO note, p. 78.]

The section of Chapter 2 entitled "Contract Incentives" is so worded that some readers might gain the erroneous impression that Ætna had been skimping on its proper claim settlement expenditures and hence had materially failed to limit its claim payments to the benefits of the contract.

We have not skimped. However, we have tried to be prudent. Our claim payment system is predicated on the assumption that, in the absence of any indication of fraud or abuse, small items of expense should be paid rather than elaborately investigated. It must be constantly borne in mind that health is highly subjective. Hence, in the absence of symptoms of disease or injury documented by several unrelated and disinterested third parties, no claim can be unquestionably substantiated. The carrier's job is to effect a reasonable balance between the risk that a benefit payment based on limited data but good judgment might not be proper and the risk that fuller documentation before payment of the claim might be expensive, irritating, time-consuming, and non-productive.

This does not mean that we believe we have the perfect balance. We periodically test new techniques and have already agreed to make some changes in 1977 which should reduce claim costs but which will increase claim settlement expenses.

Sincerely,

Daniel W. Pettengill

Daniel W. Pettengill
Vice President, Group Division

DWP*mp

GAO note: Deleted material concerns matters in the draft report which have been revised in the final report.

LIFE & CASUALTY

151 Farmington Avenue
Hartford, Connecticut 06156

D. W. Pettengill
Vice President
Group Division

October 25, 1976

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

Dear Mr. Ahart:

I am most grateful that, in response to my letter of September 28, your associates reviewed with my associates the Indemnity Benefit Plan claims thought to be questionable. We now have a much better understanding as to which of our claim settlement practices were deemed inadequate by GAO.

We concur that some changes in these practices are desirable and, subject to concurrence by the United States Civil Service Commission, we shall make some. We do not believe, however, that we are making payments which are in violation of policy requirements, and we trust that you agree with us on this point.

Among the changes we contemplate making are the following:

(1) Whenever we receive a new submission of bills from a claimant and more than ninety days have elapsed since the date of incurral of the latest expense for which we do have a certification by the claimant that he and his family have no other coverage that constitutes a "plan" for purposes of the coordination of benefits provision, we will require that an updated certification re other coverage be submitted. While this will not be an airtight control on double coverage, we believe it will be a very adequate control without incurring too much additional expense.

(2) The development of equitable prevailing fees for services other than surgery is a very difficult and expensive task. We believe the most appropriate approach for Aetna to take at this time is for the Home Office to furnish each of its paying offices with prevailing screens for covered services and supplies and to require that charges exceeding the applicable screen must be reviewed by the claim analysis

unit of the paying office. This unit will continue to exercise its best judgment as to what, if any, additional information needs to be obtained in order to be satisfied that the charge is necessary, usual, and customary, and hence covered under the plan. We are presently studying several alternatives in order to determine an effective, but not unduly expensive, method of developing the necessary prevailing screens.

(3) With respect to drug bills for which a prescription number but no name of the drug is given, we expect to continue our practice of not going back for the name of the drug so long as the condition being treated normally would involve the use of prescription drugs and the amount of charges for such drugs is less than $50 within a 30-day period of time, or $240 in a calendar year. Where no diagnosis is given, we will ask the enrollee to secure this for us and, generally, the name of the drug as well.

(4) With respect to bills for diagnostic tests where there is no indication in the claim file of a condition within the past twelve months that would warrant diagnostic tests, we will write to the enrollee advising that, based on the medical information we have, these services cannot be considered allowable expenses. However, if the attending physician can and does provide us with additional information indicating that there were symptoms, illnesses, or injuries which caused these tests to be made, we will reconsider the claim.

It should be appreciated that we have furnished and will continue to furnish our FEHBA paying offices with detailed claim settlement guides in order that they may properly carry out the benefit provisions of the Indemnity Benefit Plan. However, we do not believe that these guides should be made part of the contract. This is so both because of the need for flexibility in the administration of the plan and because much of the information contained therein is proprietary information that we do not want made available to competitors. If the Claim Guide were part of the contract, it would be a public document that would be available, for the asking, to any person or insurance carrier.

In our opinion, competition to secure federal employee participation on the basis of sound benefits at low cost is sufficient incentive for us to comply with the contract provisions as well as the administration of specific, effective cost-control procedures. Therefore, financial penalties for clerical errors should not be imposed.

APPENDIX V

Thank you again for the opportunity to comment on the report before it is released.

Sincerely,

DWPettengill/mp

Daniel W. Pettengill
Vice President, Group Division

DWP*mp