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Efforts are needed to control health insurance costs for Federal employees. GAO reviewed the operations of 10 Blue Cross and 10 Blue Shield health plans and 2 Aetna Life Insurance paying offices to determine how effectively they were complying with the contracts between the carriers and the Civil Service Commission (CSC) and with the cost control policies developed by the Blue Cross and Blue Shield national offices and by Aetna's home office. GAO also evaluated the effectiveness of the CSC's efforts for assuring that the carriers complied with cost-control policies. GAO projected that 13.5% of all claims paid during 1975 at 19 of the 20 Blue Cross and Blue Shield plans were questionable. A number of variations were disclosed in benefit payments and cost-control systems. Evaluation of Aetna's Indemnity Benefit Plan found 68 questionable claims out of 569 reviewed and some contractual discrepancies in the plan itself. The CSC should deal more aggressively with the carriers of this health insurance both in the negotiation of its contracts and in its reviews of the carriers' benefit payment activities. If not, legislation should be developed which would: require the CSC to include specific cost-control and/or incentive provisions in carrier contracts; give the CSC the specific authority to audit the carriers; and provide the CSC with some flexibility in contracting for the Blue Cross/Blue Shield service benefit plan. (QM)

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STATEMENT OF
GREGORY J. AHART, DIRECTOR
HUMAN RESOURCES DIVISION
BEFORE THE
SUBCOMMITTEE ON
COMPENSATION AND EMPLOYEE BENEFITS
OF THE POST OFFICE AND CIVIL SERVICE COMMITTEE
HOUSE OF REPRESENTATIVES

Madam Chairwoman and Members of the Subcommittee.

We are pleased to be here today to discuss our January 14, 1977, report, "More Civil Service Commission Supervision Needed to Control Health Insurance Costs for Federal Employees."

In December 1975 we presented information to this Subcommittee on the 1976 premium rate increases of the two Government-wide Federal Employees Health Benefits (FEHB) program carriers--Blue Cross/Blue Shield for the Service Benefit Plan and Aetna Life Insurance Company for the Indemnity Benefit Plan. Because of congressional concern over those rate increases, the former chairman of this Subcommittee asked us to determine what the two Government-wide carriers and the Commission were doing to help control costs under the Federal Employees

Health Benefits program. He also asked us to suggest ways to help control the program's costs.

We reviewed the operations of 10 Blue Cross and 10 Blue Shield plans and 2 Aetna paying offices. Our objective was to determine how effectively these plans and paying offices were complying (1) with the contracts between the carriers and the Commission and (2) with cost-control policies developed and disseminated by the Blue Cross and Blue Shield national associations and by Aetna's home office. We also evaluated the effectiveness of the Commission's efforts for assuring that the carriers complied with cost-control policies.

At the local plans and paying offices, we

--reviewed claims processing policies and procedures,

--analyzed a random sample of paid claims, and

--analyzed the systems used for (1) limiting claim payments to reasonable charges and (2) coordinating benefit payments with other insurance companies.

In addition, at the local plans, we evaluated coordination of claim denials between Blue Cross and Blue Shield.

The local Blue Cross and Blue Shield offices we visited made about 33 percent of the total Service Benefit Plan claim payments in 1975. The Aetna paying offices we visited made about 20 percent of the total Indemnity Benefit Plan claim payments in 1975.

Our review showed that the two carriers and the Commission need to improve their efforts to control costs under the program. We found instances where Blue Cross, Blue Shield, and Aetna made benefit payments which did not conform to the contracts or to the carriers' policy requirements, or which were based on information insufficient to determine whether payments were allowable or reasonable.

The Commission is in a difficult position to control the costs of this program because it cannot directly control the costs of health care. So long as health care costs rise, it is reasonable to expect health insurance premiums to increase. We believe, however, that the Commission can help control the costs of this program by assuring that carriers pay benefits in strict accordance with their contracts.

SERVICE BENEFIT PLAN

Blue Cross and Blue Shield provide the Service Benefit Plan which covers about 5.9 million of the FEHB program's 9.3 million participants. In 1975 this plan paid over $1.2 billion in benefits.

The Commission and the Blue Cross Association and the National Association of Blue Shield Plans negotiate the contract for the Service Benefit Plan annually. The Associations in turn enter into contractual plan participation agreements with 139 local Blue Cross and Blue Shield plans to establish uniform contract administration. The Office of the Director, Federal Employee Program, in Washington, D.C., acts for the Associations in overseeing the Service Benefit Plan contract.

Using a stratified random sampling technique developed by the Associations and the Commission, we selected 4,696 basic Blue Cross (hospital) and Blue Shield (physician) claims which had been paid in 1975. We reviewed claims 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. We used the administrative manual because (1) it contains detailed criteria for paying benefits and (2) because 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 Associations * * *." Further, the Commission uses this administrative manual in auditing local plans' benefit payments. Where the local plans we visited had developed additional criteria for processing claims, we also considered them in our audit.

We requested all information available to plan personnel when they paid each claim. According to local plan officials, we were provided all relevant information. After reviewing the claims, we discussed with plan representatives those claims we believed were questionable. In some instances, plan officials were able to demonstrate to us that claims had been paid correctly. In other instances, officials agreed that claims were questionable because they lacked information sufficient to warrant payment; or the officials stated the claims

had clearly been paid in error. Additionally, there were claims which plan officials believed had been paid correctly but which our medical advisors believed were questionable, based on the information available at the time they were paid.

In the final analysis, we questioned 599 claims. Of this number, the plans' representatives said that 49 claims should have been denied and that 280 others should not have been paid based on the information available. Our medical advisors concluded that 270 additional claims should not have been paid based on the information available. Plan representatives disagreed with our medical advisors on these latter 270 claims.

It is important to emphasize that our questions about these 270 claims were based on the Associations' or the local plans' policies. One of the Associations' policies is that plans should develop length-of-stay screening parameters and use them to determine which claims should be removed from the routine claims processing system. It is the Associations' policy that such claims should be subject to investigation before payment is made. To illustrate, a plan's screening parameters could indicate that the expected length of hospitalization for an appendectomy is 7 days. The Associations' policy would require that a longer stay be investigated to evaluate its medical necessity. During our review, we accepted whatever parameters the plans or the Associations established. When we found claims which fell outside these parameters, our medical advisors assessed the adequacy of the information on which the decision to pay the claim was made.

Based on our claims sample, we projected that 13.5 percent of all claims paid during 1975 at 19 of the 20 Blue Cross and Blue Shield plans were questionable. We could not project a percentage of questionable claims at one Blue Shield plan because it maintained paid claim files in a manner which was not comparable to the other plans. Because the charges appearing on a claim are frequently combined rather than listed on a line-item basis, we could not determine the questionable amounts.

We identified several areas where local plans had paid some claims without making adequate determinations of medical necessity as required by the contract and the Associations' criteria. 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 because hospital claims usually did not contain a description of the tests performed. Since this situation 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.

At one plan our medical advisors noted a number of paid claims that contained billings for tests normally associated with routine physical examinations--a contractually excluded benefit. To determine the extent to which benefits connected with routine physical examinations were being provided, we questioned a random sample of GAO employees who were served by this plan. The results showed that during a recent 12-month period this plan paid for 28 routine physical examinations for every 100 enrollee contracts. If GAO employees are representative of all Federal employees in the area, the results of our sample indicate that this plan may have paid for about 77,000 routine physicals during this period. If you assume that tests related to one examination cost about $100, the cost would have been $7.7 million. We found similar claims at 9 of the 10 Blue Shield plans we visited.

In addition to our review of the paid claims, we also evaluated systems used by the plans to assure that payments were not excessive as required by the contract or the administrative manual. We found instances where

--physician claims were not paid in accordance with the usual, customary, and reasonable (UCR) payment scheme of the contracts;

--plans were not screening claims in accordance with the Associations' policies to determine whether 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 noncovered services that had been denied by Blue Cross plans were erroneously paid by the corresponding Blue Shield plans.

These systems weaknesses are not included in the 13.5 percent error rate referred to earlier.

In view of the controversy between the Commission and the Associations over the applicability of the UCR provisions of the contract, we performed a limited test--at two plans--to assess the impact of deviations from the general scheme of the usual, customary, and reasonable physician payment provisions of the contract.

One plan had two payment methods, neither of which fully met the general scheme of the UCR contract provisions. This plan permitted physicians to choose their method of payment. Our analysis showed that if the plan had maintained only one payment system, in 9 months of 1975 it could have saved

either $18,586 or $185,119, depending on which payment plan it selected.

Another plan did not screen physician bills against the physicians' "usual" fee profiles. To obtain some indication of the effect of this practice we developed "usual" profiles for seven common medical procedures. Our analysis showed that for these seven procedures the plan had paid $30,856 more than it would have paid if it had used a "usual" fee screen.

In essence, our review disclosed a number of variations in benefit payments and cost-control systems among the 20 plans we visited. These variations existed in spite of the contractual plan participation agreements which the local plans must sign and which require them to "comply with the policies, practices, and procedures adopted by the Associations * * *."

Associations officials told us they do not always require uniform implementation of the established policies and procedures. The Commission, on the other hand, conducts its audits of local plans based in part on the policies and criteria which are contained in the Associations' administrative manual. Because the Commission audit approach assumed that the Associations' policies in the administrative manual are contractually binding and because the Associations disagreed with this position, the Commission has had difficulties in sustaining its position on several types of audit findings. It seems to us that until this matter is resolved, the Commission will not be able to be fully effective in obtaining corrective action on its findings at the local plans.

INDEMNITY BENEFIT PLAN

The Aetna Life Insurance Company, contractor for the Indemnity Benefit Plan, covers about 1.3 million FEHB program participants. In 1975 this plan paid about $246 million in benefits. Claims processing is the responsibility of 13 Aetna paying offices which are branch offices of the home office.

Aetna's organizational structure is different from that of the Blue Cross and Blue Shield. The Aetna paying offices are branch offices of the Aetna home office, as opposed to the local Blue Cross and Blue Shield plans, which are autonomous.

Our reviews at the two Aetna paying offices were similar to those at the Blue Cross and Blue Shield plans in that we evaluated a sample of paid claims and reviewed the systems designed to control costs. We compared Aetna paying offices' performance to the Indemnity Benefit Plan contract and the relevant policies of the home office. In contrast to the Associations, Aetna considers its policy requirements as an official interpretation of the contract.

On a random basis, we selected 569 claims for review, and we questioned 68 of these claims. Because charges appearing on a claim are often combined and because we did not always question all items on a claim, we were not able to determine the amounts that were questionable. A number of the claims we deemed questionable involved small charges for drugs.

In addition to the specific claims we found questionable, we also found that the Indemnity Benefit Plan

--paid nonitemized hospital charges for laboratory and radiological services without determining medical necessity;

--routinely paid drug charges of up to $50 over a 30-day period, unless the charge was clearly for a nonprescription drug (the former $50 limit was raised to $100 in 1976); and

--did not limit payments to physicians for nonsurgical procedures to prevailing fees as intended by the contract.

CIVIL SERVICE COMMISSION

I would like to turn now from the carriers' performance and comment on the Civil Service Commission's role in controlling costs.

The Commission's responsibilities include negotiating contracts with the carriers, auditing the carriers, and settling claims disputes which occur between carriers and enrollees.

Historically, the Commission's audits of the carriers have been directed toward administrative costs charged to the contracts rather than benefit payments. Since July 1975, however, the Commission's reviews have also emphasized benefit payments.

When we made our review, the Commission had issued two reports on audits made after the July 1975 expansion of scope noted above. Neither report dealt with questionable benefit payments.

The Commission does, however, have a number of audit reports in process which question benefit payments and project dollar amounts. For example, Commission auditors have questioned

--$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).

In the past, the Commission has had some difficulty in questioning the allowability and reasonableness of benefit payments because:

--Commission auditors do not have physicans available to help resolve medical questions;

--even when the Commission and the carriers agreed that a payment was improper, the payment was allowed because payment denied retroactively may cause undue hardship for a patient;

--the Commission and Blue Cross/Blue Shield cannot agree on the extent of the Commission's audit authority; and

--while the Commission reviews plans for compliance with the contracts and with the carriers' policies based on the contracts, one carrier can and does take the position that local plans are not required to follow all of the carrier's policies as contained in its administrative manual.

We believe that unless the Commission and carriers are able to resolve these issues, Commission auditors may continue to have difficulty in sustaining their positions on questionable benefit payments.

The contracts negotiated by the Commission with the two carriers included in our review lack incentives for the carriers to control costs, and they do not set forth specific requirements for implementing cost control provisions.

As a result of our review, we recommended that the Commission

--revise FEHB program health insurance contracts to provide incentives to control costs;

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

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

The Commission agreed with our recommendation concerning the clarification of is audit authority, expansion of its audits, and actions on its audit findings and stated that it would continue its improvement efforts in this area. The Commission also told us that our findings regarding the carriers' benefit payments are representative of the practices employed by the carriers and that Commission audits are also identifying such deficiencies.

The Commission, however, disagreed with our recommendations regarding the need for contract incentives and the need for incorporating specific cost control provisions into the contracts. Basically, the Commission believes that it is doing the best job

it can given the fact that (1) it is dealing with a sole source contractor for the Service Benefit Plan and (2) the guidance it perceives it has received from the Congress suggests all claims should be paid.

We believe that our recommendations to the Commission continue to be appropriate. However, as its comments indicate, the Commission is in a difficult position with regard to influencing the control of carriers' health benefit payment activities. On the one hand, the Commission 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, it currently relies heavily on the carriers to exercise control over benefit payment costs. In this regard, the Commission 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 plans.

We believe that the Commission should 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 the Commission's stated concerns regarding these matters, we believe that the Subcommittee should clarify the Commission's relationship with the Federal Employees Health Benefit program carriers by considering legislation designed to assist the Commission in strengthening its position in dealing with the carriers regarding health benefit payment activities.

RECOMMENDATIONS TO THE SUBCOMMITTEE

If the Commission does not adopt our recommendations, the Subcommittee should consider developing legislation which would

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

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

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

Madam Chairwoman, this concludes my statement. We shall be happy to answer ny questions that you or other members of the Subcommittee may have.