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Information on the Appeals Process for Disputed Claims under the Federal Employees Health Benefits Program. HRD-78-16; B-164562. November 22, 1977. 2 pp. + 2 appendices (11 pp.).

Report to Rep. John E. Moss; by Elmer B. Staats, Comptroller General.

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Organization Concerned: Civil Service Commission.
Congressional Relevance: Rep. John E. Moss.
Authority: Federal Employees Health Benefits Act of 1959 (5 U.S.C. 8901). P.L. 93-246. 5 C.F.R. 890.105.

The Federal Employees Health Benefits program provides health insurance coverage for about 3.3 million enrollees (Government employees and annuitants) and over 6.4 million dependents. The health insurance plans review health benefits claims to determine if they are payable under their contracts with the Civil Service Commission (CSC). Federal regulations require the CSC to notify the enrollee and the health insurance plan of its finding within 30 days after it receives all information it requested to aid in reviewing the case. Findings/Conclusions: A review of a random sample of disputed claims under the Government-wide plans found that CSC met the Federal timeliness criterion in less than 30% of the cases. Of the claims reviewed under the Employee Organization Plans and Comprehensive Medical Plans, 80% and 85%, respectively, of the claims to CSC were resolved within the established time frames. For the first 3 quarters of 1977, the disputed claims rate (the number of claims appealed to CSC per 100,000 enrollees) was: 128 for the Government-wide plans (41 for Aetna and 151 for Blue Cross and Blue Shield), 30 for the Employee Organization Plans, and 17 for the Comprehensive Medical Plans. During the first 9 months of 1977, the monthly totals of claims onhand in the Government-wide Plans Division ranged from 948 in June to 1,501 in February. Annual salary costs for the claims appeal process were estimated at $639,000. (Author/SW)

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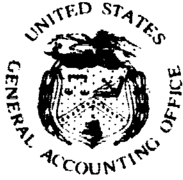


REPORT OF THE COMPTROLLER GENERAL OF THE UNITED STATES

04240

Information On The Appeals Process For Disputed Claims Under The Federal Employees Health Benefits Program

This is one of a series of reports on Federal agencies' response to and resolution of certain compensation claims. This one deals with the Civil Service Commission's treatment of disputed claims under the Federal Employees Health Benefits program.

GAO found

--the Commission met the Federal regulations' timeliness criterion for resolving disputed claims in less than 30 percent of the cases appealed to its Division of Government-wide Plans,

--the average time to resolve a disputed claim ranged from 45 to 142 days depending on which Commission division was involved, and

--annual salary costs for the claims appeal process are estimated at $639,000.

HRD-78-16

NOVEMBER 22, 1977

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

B-164562

The Honorable John E. Moss
House of Representatives

Dear Mr. Moss:

Your letter of March 11, 1977, asked us to evaluate the procedures of several Federal agencies, including the Civil Service Commission, for responding to and resolving certain compensation claims. Your letter included a list of specific questions for which you requested answers. This report deals with the Civil Service Commission's treatment of disputed claims under the Federal Employees Health Benefits program and is one of several reports we are submitting in response to your request.

Based on our review of claims and other information, we found that the Commission often took longer than regulations allow to resolve claims. This was especially true in cases of claims appealed to the Commission's Division of Government-wide Plans--the division responsible for resolving claims appealed by enrollees in the two largest health plans--Blue Cross and Blue Shield and Aetna.

Federal regulations on the claims appeal process (5 C.F.R. 890.105) require the Commission to notify the enrollee and the plan of its finding within 30 days after it receives all information it requested to aid in reviewing the case. We reviewed a random sample of disputed claims under the Government-wide Plans and found the Commission met this criterion in less than 30 percent of the cases. Of the claims we reviewed under the Employee Organization Plans and Comprehensive Medical Plans, 80 and 85 percent, respectively, of the claims were resolved within the established time frames. For the first 3 quarters of 1977, the disputed claims rate (the number of claims appealed to the Commission per 100,000 enrollees) was

--128 for the Government-wide Plans (41 for Aetna and 151 for Blue Cross and Blue Shield),

--30 for the Employee Organization Plans, and

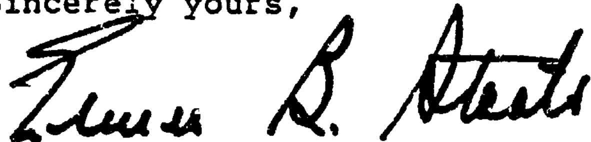
--17 for the Comprehensive Medical Plans.

We are also reviewing the Federal Employees Health Benefits program claims appeal process at the request of the Chairwoman, Subcommittee on Compensation and Employee Benefits, House Committee on Post Office and Civil Service. Our work for the Subcommittee is a more indepth determination of the adequacy and timeliness of the Commission's health insurance claims appeals process. We will provide you a copy of any report which results from that review.

Information on the Commission's health benefits claims appeal process and detailed answers to the questions contained in your letter are included in appendix I. We did not obtain written comments from the Commission on this report, but the contents have been informally discussed with Commission representatives.

As arranged with your office, we are sending a copy of this report to the Chairwoman, Subcommittee on Compensation and Employee Benefits, House Committee on Post Office and Civil Service. We will also send copies to the Civil Service Commission and make it available to the public 2 weeks after the date on the cover of the report.

Sincerely yours,



Comptroller General
of the United States

INFORMATION ON THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM CLAIMS APPEAL PROCESS

INTRODUCTION

The Federal Employees Health Benefits (FEHB) program, established by the Federal Employees Health Benefits Act of 1959 (5 U.S.C. 8901), provides health insurance coverage for about 3.3 million enrollees (Government employees and annuitants) and over 6.4 million dependents. The Government and enrollees share the program's cost which is estimated to be $2.8 billion for fiscal year 1977. The Civil Service Commission (CSC) contracts for coverage through the following types of health plans:

--Service Benefit Plan: A Government-wide plan under which the carrier, Blue Cross and Blue Shield, generally provides benefits through direct payments to physicians and hospitals. This plan covers about 1.9 million enrollees.

--Indemnity Benefit Plan: A Government-wide plan under which the carrier, Aetna Life Insurance Company, provides benefits by either reimbursing the 491,000 enrollees or, at their request, by paying physicians and hospitals.

--Employee Organization Plans: These plans, available only to employees and their families who are members of the sponsoring organizations, provide benefits either by reimbursing employees or, at their request, by paying physicians and hospitals. The 12 Employee Organization Plans cover about 637,000 enrollees.

--Comprehensive Medical Plans: These 46 plans, available only in certain localities, provide (1) comprehensive medical services by 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. These plans also provide hospital benefits. The plans provide benefits to about 291,000 enrollees.

Disputed claims appeal process

The health insurance plans review the health benefit claims to determine if they are payable under their contracts with CSC. However, enrollees may appeal a plan's

decision to CSC. Public Law 93-246, approved January 31, 1974, provides in part, "Each contract under this chapter shall require the carrier to agree to pay for or provide a health service or supply in an individual case if the Commission finds that the employee, annuitant, or family member is entitled thereto under the terms of the contract." Based on regulations (5 C.F.R. 890.105), if a claim or a portion of a claim is denied, an enrollee may request the plan to reconsider its original denial within 1 year. The enrollee's written request should contain the reasons for paying the denied claim. Upon reconsideration, the plan may pay the claim or must reaffirm its denial in writing to the enrollee, setting forth in detail the reasons for not paying the claim. Additionally, the plan must inform enrollees in writing of their right to request a CSC review whenever it reaffirms a denial of a claim.

If the plan either reaffirms its denial or fails to respond to the request for reconsideration within 30 days, the enrollee may ask CSC to review the claim and determine whether the denial was proper. CSC is required to notify the enrollee and the plan of its findings within 30 days after receiving all evidence it requested (see p. 3) to aid in reviewing the case.

CSC's review of disputed health benefits claims is conducted through its divisions of (1) Government-wide Plans, (2) Comprehensive Plans, and (3) Employee Organization Plans.

The disputed claims review processes in the Comprehensive Plans Division and the Employee Organization Plans Division are similar. Both divisions request information directly from the plans and both use CSC's Medical Division 1/ to review cases which CSC claims reviewers believe require a medical opinion.

In contrast, the Government-wide Plans Division requests information and reports from Blue Cross and Blue Shield's Federal Employee Program (FEP) office and the Aetna office in Washington, D.C. These offices then request information from the appropriate local Blue Cross and Blue Shield plans or Aetna paying offices. The FEP and Aetna Washington, D.C.,

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1/The Medical Division employs about 50 persons including 12 physicians. The division's responsibilities include working with CSC's disability retirement, physical qualifications, and medical standards programs. It also provides technical examining review service in difficult cases when required and gives medical opinions when requested by various CSC sources.

offices review the information and report their findings and conclusions to CSC.

When FEP and Aetna offices obtain and analyze the necessary information, they may either reverse the plan's or paying office's decision, modify the decision, or uphold it. 1/ In the first case, FEP or Aetna will usually notify CSC that the claim has been paid. In the latter two instances, the offices will send reports summarizing the claimant's symptoms, diagnosis, and vital information; and the history of the disputed claim to CSC's Government-wide Plans Division.

Once the Government-wide Plans Division receives the response, a "health benefits specialist," a CSC employee who must be knowledgeable of the Government-wide Plans' contracts and who has the authority to make decisions on disputed claims, reviews the case file. The health benefits specialists may (1) decide if the claim had been properly denied or (2) refer the case file to a CSC "medical records advisor" if a medical determination is necessary. Medical records advisors are registered nurses who work full time on disputed claims cases. The Government-wide Plans Division, the only division to employ nurses as medical records advisors, had four nurses as of September 1977. If a medical records advisor (1) believes that the report is not sufficient to make a decision or (2) disagrees with a carrier's conclusions, the advisor will visit the FEP office to review medical records and may discuss the case with a FEP nurse. According to CSC, all original medical evidence on Aetna disputed claims is reviewed because of the small volume of disputed claims.

VOLUME AND RATE OF DISPUTED CLAIMS

Based on CSC's 1977 monthly disputed claims reports, the Government-wide Plans Division received 2,832 Blue Cross and Blue Shield and 199 Aetna disputed claims and processed 3,042 2/ Blue Cross and Blue Shield and 196 Aetna disputed claims during the first 9 months of 1977. This division had 1,070 Blue Cross and Blue Shield and 11 Aetna disputed claims onhand at the end of September 1977.

1/According to carrier statistics for the first 6 months of calendar year 1977, FEP reversed the local plans' decisions in 6.9 percent of the claims being disputed for medical reasons. FEP could not provide the total percentage of reversals for all disputed claims; comparable Aetna percentages were not available.

2/Divisions may process more claims than received during a period because of claims onhand at the beginning of the period.

In contrast, the Comprehensive Plans Division received 50 disputed claims and processed 46 during the first 9 months of 1977. As of September 30, 1977, the Comprehensive Plans Division had 6 disputed claims onhand.

The Employee Organization Plans Division received 191 disputed claims and processed 188 during the first 9 months of 1977. The division had 7 disputed claims onhand at the end of September 1977.

For the first 3 quarters of 1977, the disputed claims rate (the number of claims appealed to CSC per 100,000 enrollees) was

--128 for the Government-wide Plans, (41 for Aetna and 151 for Blue Cross and Blue Shield),

--30 for the Employee Organization Plans, and

--17 for the Comprehensive Plans.

SCOPE OF REVIEW

We performed our review at the Civil Service Commission, Aetna's Indemnity Benefit Plan office, and Blue Cross and Blue Shield's Federal Employee Program office--all in Washington, D.C.

We examined

--all disputed claims files closed during the period December 1975 to May 1977 for the Comprehensive Plans;

--all disputed claims files closed during the period December 1975 to April 1977, which had required medical or other reports from the plans for the Employee Organization Plans; and additionally, all 1977 disputed claims files closed from January to April 1977, whether or not reports were obtained from the plans; and

--a random sample of 62 closed disputed claims files from a March and April 1977 listing containing 853 items prepared by CSC and relative to the Gov nment-wide Plans.

We also examined selected correspondence in the 1977 complaint and inquiry files at CSC. We reviewed appropriate legislation and Federal regulations and interviewed responsible officials. We made our review from April to October 1977.

QUESTIONS AND ANSWERS

Following are our answers to the questions you asked in your March 11, 1977, letter. The averages shown below are based on our review. We could not use all the disputed claims we reviewed to compute the averages in every category because not all documents and letters were dated. The table immediately below summarizes the total number of claims we reviewed in each CSC division. As used in the tables below, "Congressional intervention" indicates that a member of the Congress wrote to CSC in behalf of the enrollee.

Number of Claims Reviewed

Division	Without congressional intervention	With congressional intervention
Government-wide Plans	56	6
Comprehensive Plans	48	2
Employee Organization Plans	58	5
Total	162	13

On the average, how long does it take to respond to a case or claim, both with or without Congressional intervention?

The following tables show the initial response times--the number of calendar days from the date a division received a disputed claim to the date on the initial response letter--for the three CSC divisions.

Without Congressional Intervention

Division	Average initial response	Cases used to calculate averages	Range of responses
Government-wide Plans	17.8 days	52	1 to 48 days
Comprehensive Plans	11.5 days	33	2 to 38 days
Employee Organization Plans	7.1 days	32	1 to 27 days

With Congressional Intervention

Division	Average initial response	Cases used to calculate averages	Range of responses
Government-wide Plans	4.3 days	3	1 to 6 days
Comprehensive Plans	7.0 days	1	N/A
Employee Organization Plans	8.0 days	1	N/A

In our opinion, the number of cases with congressional intervention was too small to permit any generalizations. According to representatives of the three divisions, all cases with congressional inquiry receive priority processing.

On the average, how long does it take to resolve a case or claim, both with or without Congressional intervention?

The final response times shown in the tables below are the number of calendar days from the date a division received a disputed claim to the date of the final response letter. The final response time includes the time necessary to request and receive additional information from the plans so that CSC can review the disputed claim.

Without Congressional Intervention

Division	Average final response	Cases used to calculate averages	Range of responses
Government-wide Plans	142.1 days	56	23 to 375 days
Comprehensive Plans	68.1 days	38	8 to 182 days
Employee Organization Plans	45.3 days	43	3 to 200 days

With Congressional Intervention

Division	Average final response	Cases used to calculate averages	Range of responses
Government-wide Plans	a/135.0 days	3	96 to 183 days
Comprehensive Plans	37.0 days	2	24 to 50 days
Employee Organization Plans	24.8 days	4	13 to 48 days

a/Does not include responses concerning one disputed claim where CSC upheld the plan's denial prior to any congressional intervention. In this instance, the enrollee had contacted three Congressmen. In all three cases CSC's responses upholding the denials were given in less than 16 days.

According to the regulation (5 C.F.R. 890.105), CSC must notify the enrollee and the plan of its findings within 30 days of receiving all the information it had requested to aid

in reviewing the case. Based on our sample, the Government-wide Plans Division was in compliance with this regulation in less than 30 percent of the cases. The Comprehensive Plans Division and the Employee Organization Plans Division complied with the regulation in 85 and 80 percent, respectively, of the cases we reviewed. CSC attributed the low compliance rate in the Government-wide Plans Division to a shortage of staff. We plan to evaluate this CSC position in our more indepth review of the claims appeal process.

How large are the backlogs, in terms of numbers of cases, and how long it would take to eliminate them?

One way of measuring backlog is "claims onhand." The following table shows the number of disputed claims onhand as of September 30, 1977, and our estimates of the time required to resolve these claims. The time estimate is based on the average number of disputed claims resolved per month in the first 3 quarters of 1977.

Division	Claims onhand 9/30/77	Average number resolved per month, Jan. to Sept., 1977	Monthly range	Estimates of time to resolve all claims onhand
Government-wide Plans	1,081	360	a/163-556	3 months
Employee Organization Plans	7	21	13- 29	0.3 months
Comprehensive Plans	6	5	2- 10	1.2 months

a/Includes claims processed in overtime work.

During the first 9 months of 1977, the monthly totals of claims onhand in the Government-wide Plans Division ranged from 948 in June to 1,501 in February.

How many people and dollars are involved in each program?

The following table shows the number of CSC, FEP, and Aetna professional and support employees involved in the disputed claims process and the estimated annual salary costs allocated by agency officials for reviewing disputed health benefits claims. This table does not include salaries or employees in the CSC Medical Division.

Organization	Number of employees (note a)	Estimated annual salary cost related to disputed claims
Government-wide Plans (CSC)	39	$336,000
Comprehensive Plans (CSC)	20	35,000
Employee Organization Plans (CSC)	7	28,000
FEP (Blue Cross and Blue Shield)	28	140,000
Aetna	11	100,000
Total	105	$639,000

a/Reviewing disputed claims is only a part of these employees' responsibilities.

Are complaints routinely discarded if unaccompanied by a Congressional inquiry?

Based on our review, we believe CSC responds to all complaints and inquiries concerning FEHB claims.

What kinds of responses are sent; are they form letters or personalized answers delving into the facts of a case?

All final response letters are personalized answers delving into the facts of the case.

Where medical referrals are made to private doctors, how long is the response time on the part of physicians?

Physicians are sometimes used as consultants to review medical records on complicated disputed claims. However, in the records we reviewed no disputed claims were referred to an outside consultant. According to a Government-wide Plan Division official, it takes at least 30 days to receive a report from a private physician performing such a review. We were told that the Government-wide Plans Division had used consultants for six closed cases and that consultants were working on three pending cases.

Are doctors paid before they perform their services or afterwards?

Outside consultants are paid after they provide the services.

In the case of contract doctors, are they paid routinely or on the basis of services performed?

CSC does not contractually employ physicians to review disputed claims. Physicians informally have agreed to review cases for CSC as the need arises. They are paid on a case-by-case basis for services provided. The informal arrangements (dated in 1975) between CSC and several physicians showed suggested consultation fees of $50 to $100 an hour for reviewing disputed claims.

What recommendations, if any, does GAO have to alleviate or resolve these situations?

At this time, we have no recommendations for improving the administration of the FEHB program claims appeals process. We are, however, performing a more indepth review of the claims appeal process at the request of the Chairwoman, Subcommittee on Compensation and Employee Benefits, House Committee on Post Office and Civil Service. The review will address the adequacy of the medical information obtained and the level of medical review needed to resolve cases as well as the question of timeliness. We will provide your office with any report and recommendations which may result from our review for the House Subcommittee on Compensation and Employee Benefits.

JOHN E. MOSS
3RD DISTRICT
SACRAMENTO, CALIFORNIA

WASHINGTON OFFICE:
ADMINISTRATIVE ASSISTANT
KATHLEEN BENSON

LEGISLATIVE ASSISTANT
PATRICIA LYNCH
ROOM 2354
RAYBURN HOUSE OFFICE BUILDING
PHONE (202) 225-7163

DISTRICT OFFICE:
DISTRICT REPRESENTATIVE
JERRY WYMORE

DISTRICT ASSISTANT
PATRICIA LAROCHE
8058 FEDERAL BUILDING
650 CAPITOL MALL
SACRAMENTO, CALIFORNIA 95814
PHONE (916) 440-3543

CONGRESS OF THE UNITED STATES
HOUSE OF REPRESENTATIVES
WASHINGTON, D.C. 20515

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March 11, 1977

77 MAR 14 P 4: 39

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

Dear Elmer:

For some years the volume of constituent and Congressional staff complaints over difficulties in terms of response to and resolution of certain compensation claims has risen constantly. Consistently, I and my colleagues hear bitter recriminations from the average citizen over the difficulty they encounter in submitting a claim with documentation and receiving Federal compensation. Such complaints center around the Social Security Administration, the Labor Department, the Civil Service Commission and the Veteran's Administration. They deal with inordinate delays, lost documents, form letters, lengthy forms, huge backlogs, long delayed or perfunctory medical examinations and the like.

Labor's Workmans' Compensation Program, SSA's Appeals system and the entire range of U.S.C.S.C. programs are seemingly the worst offenders. Therefore, I would like GAO to evaluate the three largest programs in each of the four agencies mentioned, concentrating on seeking answers to the following questions:

1) On the average, how long does it take to respond to a case or claim, both with or without Congressional intervention?

2) On the average, how long does it take to resolve a case or claim, both with or without Congressional intervention?

3) How large are the backlogs, in terms of numbers of cases and how long it would take to eliminate them?

4) How many people and dollars are involved in each program?

5) Are complaints routinely discarded if unaccompanied by a Congressional inquiry?

6) What kinds of responses are sent; are they form letters or personalized answers delving into the facts of a case?

7) Where medical referrals are made to private doctors, how long is the response time on the part of physicians?

8) Are doctors paid before they perform their services or afterwards?

9) In the case of contract doctors, are they paid routinely or on the basis of services performed?

10) What recommendations, if any, does GAO have to alleviate or resolve these situations?

With respect to the USCSC, I wish GAO would examine retirement, refund and hospital claims. The contact on my staff for this letter is Franklin Silbey. Thank you.

Sincerely,

John E. Moss
Member of Congress

JEM:Ft