REPORT TO THE CONGRESS

Opportunity To Reduce Medicare Costs By Consolidating Claims-Processing Activities B-164031(4)

Department of Health, Education, and Welfare

Railroad Retirement Board

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

JAN. 21, 1971

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

B-164031(4)

To the President of the Senate and the
Speaker of the House of Representatives

This is our report on the opportunity to reduce Medicare costs by consolidating claims-processing activities of the Department of Health, Education, and Welfare and the Railroad Retirement Board.

Our review was made pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

Copies of this report are being sent to the Director, Office of Management and Budget; the Secretary of Health, Education, and Welfare; and the Chairman of the Railroad Retirement Board.

Elmer B. Staats

Comptroller General
of the United States

COMPTROLLER GENERAL'S REPORT TO THE CONGRESS

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D I G E S T

WHY THE REVIEW WAS MADE

Medicare costs increased by $1.3 billion--from $5.3 billion to $6.6 billion--from 1968 to 1969. Because of these sharply rising costs--about 25 percent in 1 year--the General Accounting Office (GAO) is exploring ways by which Medicare can be administered more effectively and economically.

Under Medicare, payments for physicians' services are made by 50 separate organizations called carriers under contract with the Social Security Administration (SSA) of the Department of Health, Education, and Welfare (HEW). Each carrier makes benefit payments in designated geographical areas of the United States.

The SSA carriers do not make Medicare payments on behalf of eligible railroad workers and annuitants of the Railroad Retirement Board. The Board, under a delegation of authority from SSA, contracted with The Travelers Insurance Company to make these payments for about 810,000, or approximately 4 percent, of the 18.9 million people eligible to receive Medicare benefit payments for physicians' services. (See p. 6.)

Because of the relatively small number of railroad workers and annuitants eligible for Medicare and because certain administrative functions of Travelers appeared to duplicate those of the 50 carriers, GAO questioned whether the use of a separate carrier to make payments for these beneficiaries was the most efficient, effective, and economical way to administer the program.

FINDINGS AND CONCLUSIONS

The present arrangement in which a nationwide carrier (Travelers) pays Medicare claims on behalf of railroad workers and annuitants of the Railroad Retirement Board--a relatively small, special group of beneficiaries--is not the most efficient nor the most effective arrangement for making Medicare payments.

Tear Sheet

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Under SSA regulations, information both on customary charges of individual physicians and on prevailing charges for specific medical services in a given area is needed to determine whether the fees charged by physicians are reasonable. In GAO's opinion, Travelers was unable to determine the reasonableness of charges on a nationwide basis because it did not have:

--Enough data on physicians' fees for services provided to railroad workers and annuitants to determine the customary charges of individual physicians. (See pp. 17 to 24.)

--Assurance that the volume and nature of data on physicians' fees pertaining to Travelers' commercial health insurance programs would enable it to determine customary charges for the majority of medical services furnished to Medicare beneficiaries. Also, there had been little exchange of customary-charge data between Travelers and the 50 carriers acting for SSA. (See pp. 18 to 22.)

GAO estimated that benefit payments by Travelers were about $2.9 million higher than the payments that would have been made by the SSA carriers for like medical services in fiscal year 1970. (See p. 29.)

GAO believes that any other carrier, under the same circumstances, would experience the same difficulties as did Travelers in operating a nationwide system for making benefit payments for such a small number of beneficiaries.

The use of a separate carrier to process the claims of railroad workers and annuitants, in GAO's opinion, also results in increased administrative costs. GAO's comparison of the estimated incremental costs that would be incurred by four SSA carriers making payments in nine States with the administrative costs incurred by Travelers showed that these carriers could process the railroad-related claims for $321,600 a year less than could Travelers. GAO believes that similar savings in administrative costs could be achieved at other locations.

If the estimates for the four SSA carriers are representative on a nationwide basis, administrative costs of as much as $2.8 million could be saved. These savings would accrue to the beneficiaries and the Federal Government, which share equally in financing the program.

For example, by consolidating the claims-processing activities, there would be an opportunity to reduce or eliminate:

--The necessity of maintaining 125 separate offices to pay claims of railroad employees and annuitants and the supervisory and administrative personnel needed for many small offices. (See pp. 41 to 43.)

--The additional overhead expenses arising from the separation of claims-processing activities for railroad-related claims and all other Medicare claims. (See pp. 43 and 44.)

--The duplication of effort involved when railroad-related claims are sent to the SSA carriers by mistake and have to be rerouted to the Travelers field offices. (See pp. 44 to 46.)

RECOMMENDATIONS OR SUGGESTIONS

The Secretary of Health, Education, and Welfare should arrange to have the railroad-related Medicare claims paid by the carriers paying such claims for all other Medicare beneficiaries in the same geographical area. (See p. 52.)

AGENCY ACTIONS AND UNRESOLVED ISSUES

HEW advised GAO that SSA was not prepared to accept GAO's recommendation without additional review of the Travelers-Board relationship in light of the views set forth by the Board and by Travelers. The Board had expressed the view that the interests of the railroad-related beneficiaries and of the Medicare program would best be served by continuing the existing arrangement. Travelers stated that its performance under its contract with the Board had been efficient and economical.

SSA acknowledged that the relatively small number of claims processed by Travelers involving railroad beneficiaries posed serious obstacles in its development of adequate customary-charge data and that the arrangement with Travelers as the sole carrier for railroad-related beneficiaries presented inherent administrative problems.

As an alternative to GAO's proposal, SSA stated that the Travelers-Board arrangement provided an excellent opportunity to experiment in determining reasonable charges by using fee limitations to establish the maximum allowable physicians' charges on a State-by-State basis.

Although the details of such proposed experiments have not been defined, GAO believes that Travelers essentially has been using such fee limitations since the inception of the Medicare Program. (See pp. 47 to 49.)

As for the administrative costs, SSA was of the opinion that the amount of savings through the consolidation of claims-processing activities had not been clearly shown and that, once these savings

Tear Sheet

could be reasonably estimated, SSA would then have to weigh the cost savings against the benefits derived from the contractual arrangements.

SSA also stated that, as an alternative way to achieve savings in administrative costs, the number of Travelers field offices processing railroad-related claims could be reduced. Travelers proposed to reduce the number of offices from 125 to 63 and to make corresponding reductions in personnel, which GAO estimated would save $352,000 annually. (See p. 50.) Travelers is presently consolidating its offices, and GAO believes that this is indicative of the even greater savings that could be realized by a full consolidation plan whereby the SSA carriers would assume the entire workload for railroad-related claims.

MATTERS FOR CONSIDERATION BY THE CONGRESS

Although GAO recognizes that the consolidation of the claims-processing activities would entail some diminution of the authority now delegated to the Railroad Retirement Board, GAO believes that an overriding consideration is that such action would simplify the administration of the Medicare program and would help reduce program costs. Therefore GAO is bringing the results of its review to the attention of the Congress for its consideration in future deliberations on amendments to the Social Security Act designed to improve the operating effectiveness of the Medicare program.

Also, in view of congressional interest regarding HEW plans for experiments affecting Medicare payments to institutions, the cognizant legislative committees of the Congress may wish to review the plans for the experiments proposed by SSA for Travelers and the Board in determining maximum allowable physicians' charges.

Contents

ABBREVIATIONS

CRVS	California relative-value studies
GAO	General Accounting Office
HEW	Department of Health, Education, and Welfare
RRB	Railroad Retirement Board
SSA	Social Security Administration

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CHAPTER 1

INTRODUCTION

The General Accounting Office has reviewed selected aspects of the administration of the supplementary medical insurance benefits (part B) portion of the Health Insurance for the Aged (Medicare) Program. Part B of the Medicare program covers physicians' services and a number of other medical and health benefits. Payments for these services and benefits are made primarily by 50 separate organizations under contract with the Department of Health, Education, and Welfare (HEW) to perform this function in specific geographical areas in the United States. These organizations are referred to as carriers.

The carriers under contract with HEW do not make payments on behalf of eligible railroad employees or individuals receiving annuities from the Railroad Retirement Board (RRB), who have enrolled under part B of Medicare. These payments are made on a nationwide basis by a separate carrier--The Travelers Insurance Company--under a contract with RRB, through its network of about 125 field offices. RRB entered into this contract pursuant to a delegation of authority from the Social Security Administration (SSA) which has primary responsibility for the administration of the Medicare program.

We examined into the practice of using a separate carrier to process Medicare part B claims on behalf of railroad employees and RRB annuitants to determine if it was the most efficient, effective, and economical way to administer this portion of the program.

The scope of our review is described in chapter 9. The principal officials of HEW and RRB responsible for the administration of the Medicare program are listed in appendix V.

CHAPTER 2

DESCRIPTION OF PERTINENT FEATURES

OF THE MEDICARE PROGRAM

Title XVIII of the Social Security Act (42 U.S.C. 1395--139511), which was enacted on July 30, 1965, established the Medicare program, effective July 1, 1966, to provide two basic forms of protection against the costs of health care to eligible persons aged 65 and over. One form, designated as Hospital Insurance Benefits for the Aged (part A), covers inpatient hospital services and posthospital care in an extended-care facility or in the patient's home. This form of protection is financed by a special social security tax paid by employers and their employees and by self-employed persons.

The second form of protection, designated as the Supplementary Medical Insurance Benefits for the Aged (part B) Program, is a voluntary program and covers physicians' services and a number of other medical and health benefits. This report concerns the administration of part B of the Medicare program. Part B is financed, in part, from premiums collected from each participating beneficiary who has elected to be covered under part B. The premiums are matched by equal amounts appropriated by the Congress, and the total amounts are deposited in the Federal Supplementary Medical Insurance Trust Fund. Effective April 1, 1968, the basic monthly premium was increased from $3 to $4; effective July 1, 1970, it was increased from $4 to $5.30.

Under part B of the Medicare program, the beneficiary is responsible for paying the first $50 for covered medical services in each year, and the Medicare program pays 80 percent of the reasonable charges for covered services in excess of $50 in each year. Claims under part B may be paid either to the patient or to the physician or others furnishing the services.

According to SSA statistics as of January 1, 1969, about 18.9 million persons were enrolled for supplementary medical insurance benefits. About 810,000 of the enrollees

were eligible for coverage by virtue of their entitlement to railroad retirement benefits, including 285,000 persons entitled to both social security and railroad retirement benefits on the basis of their earnings under both programs. Benefit payments on behalf of the 810,000 enrollees were made by Travelers under its contract with RRB.

PAYMENTS FOR SERVICES ON THE BASIS OF REASONABLE CHARGES

The Congress, in establishing the Medicare program, provided that payments for physicians' services be made on the basis of reasonable charges and that, in determining the reasonableness of charges, consideration be given to (1) the customary charges for similar services generally made by the physician and (2) the prevailing charges of physicians in the locality for similar services.

In regulations implementing the reasonable-charge criteria set forth in the Medicare law, SSA defined "customary charge" as the uniform amount that a physician charges, in the vast majority of cases, for a specific medical service. SSA recommended that the uniform amount be based not only on physicians' charges under the Medicare program but also on information obtained from other sources, such as the carriers' own medical insurance programs. If the individual physician varies his charges so that no one amount is charged in most cases, SSA instructions provide that the mean or median charge should be used as the customary charge for the service.

SSA regulations define "prevailing charges" as those charges falling within the range of charges most frequently and most widely charged by physicians in a locality for a particular medical service. The regulations state that, except for unusual circumstances, the upper limit of the range of prevailing charges is the highest amount that should be accepted as reasonable for a given medical service. According to the regulations, the upper limit is the average

(arithmetic mean) of the physician's customary charges for each service plus one standard deviation[1] above the mean.

In other words, in making benefit payments, a carrier is supposed to determine that the fees for medical services do not exceed (1) the individual physician's customary charge for the service rendered or (2) the upper limit of the prevailing charges in the area. Furthermore, the reasonable charge cannot exceed the actual charge made by the physician.

The following examples illustrate how this criteria is to be applied in determining reasonable charges under part B of the Medicare program. Assuming that the prevailing charge for a specific medical service is $100 in a certain locality and that Doctor A customarily charges $80 for this procedure and Doctor B customarily charges $125:

1. If Doctor A's bill is $75, the reasonable charge would be $75 since, under the law, the reasonable charge cannot exceed the actual charge.

2. If Doctor A's bill is $85, the reasonable charge would be $80 because that is his customary charge. Even though his actual charge of $85 is less than the prevailing charge, the reasonable charge cannot be more than his customary charge.

3. If Doctor A's bill is $80, the reasonable charge would be $80 because it is his customary charge and it does not exceed the prevailing charge for that locality.

4. If Doctor B's bill is $125, the reasonable charge could not be more than $100, the upper limit of the prevailing charge in the area.

For fiscal years 1968 and 1969, benefit payments made by carriers under part B of the Medicare program amounted to

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[1]Standard deviation--a basic statistical measure of the average difference of the amounts in a series measured from their mean.

about $1.3 billion and $1.5 billion, respectively, of which about 95 percent was for physicians' services. The administrative costs of the carriers making such benefit payments which are also borne by the Medicare program amounted to about $100 million and $118 million, respectively. Benefit payments made by Travelers under its contract with RRB for fiscal years 1968 and 1969 amounted to about $55 million and $60 million, respectively; and the related administrative expenses were about $4.2 million and $4.5 million.

CARRIERS' ROLE IN ADMINISTERING PART B OF THE MEDICARE PROGRAM

To administer the benefits under part B of the Medicare program, section 1842(a) of the Social Security Act authorized the Secretary of HEW to enter into contracts with carriers to (1) determine the rates and amounts of payments on a reasonable-charge basis and (2) receive, disburse, and account for funds used in making such payments. Section 1842(b) of the act provides that no such contract be entered into with any carrier unless the Secretary finds that the carrier will perform its obligations under the contract efficiently and effectively.

The reports of the House Committee on Ways and Means and the Senate Committee on Finance on the bill that became the Medicare law expressed the view that medical benefits under part B should be administered by private carriers because private insurers, group health plans, and voluntary medical insurance plans had had experience in reimbursing physicians. Both Committee reports also stated that the Secretary of HEW should, to the extent possible, enter into contracts with a sufficient number of carriers, selected on a regional or other geographical basis, to permit a comparative analysis of their performance.

SELECTION OF CARRIERS

In November 1965 SSA published qualification criteria which had to be met by prospective carriers before they could be selected to participate in the administration of part B of the program. The criteria provided that a carrier be able to administer its own health insurance programs which require many of the skills, statistical data, and experience needed to administer the part B program, including the ability to determine the reasonableness of charges.

Beginning in February 1966, SSA entered into contracts with 50 carriers to administer part B of the program in specific geographical areas of the country. Of these carriers, 33 were Blue Shield organizations, 16 were private insurance companies, and one was a State agency. Travelers was selected by SSA as the carrier for the State of Mississippi and for certain counties in Minnesota and Virginia.

DELEGATION TO RRB OF AUTHORITY TO SELECT CARRIERS

RRB was established by the Railroad Retirement Act of 1935 (49 Stat. 967) and derives its authority also from the Railroad Unemployment Insurance Act approved June 25, 1938 (45 U.S.C. 351-367). RRB administers a social insurance system outside the jurisdiction of SSA. The RRB programs provide a wide variety of benefits to railroad workers, including sickness, disability, unemployment, retirement, and survivors benefits. Upon the enactment of the Medicare law, RRB was given the responsibility for certifying to SSA the eligibility of railroad employees and RRB annuitants for hospital insurance benefits under part A of the Medicare program and for administering the part A program for these beneficiaries in Canada. RRB was also given the responsibility for enrolling RRB annuitants under part B of the Medicare program.

In May 1966 SSA, in an agreement with RRB, delegated certain of its responsibilities under part B of the Medicare program to RRB. Under this delegation of authority, RRB is responsible for (1) enrolling aged railroad workers and their spouses, (2) collecting premiums for about two thirds of the 810,000 RRB-related enrollees,[1] and (3) selecting the carriers to administer part B benefits for railroads employees and RRB annuitants. This delegation was made because, under the Medicare law, the authority to enter into contracts with carriers was vested only in the Secretary of HEW; RRB was not given such contracting authority.

Under the delegation of authority, the carriers selected by RRB would have to (1) meet the same criteria for experience and financial responsibility as those for the carriers selected by SSA and (2) follow the same policies and regulations as those for SSA for determining what

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[1] About 285,000 of the 810,000 RRB-related enrollees are also entitled to Social Security benefits. SSA collects the premiums for these individuals. The Social Security Amendments of 1970 (H. R. 17550) as passed by the House of Representatives on May 21, 1970, provides that RRB be responsible for collecting premiums from all RRB-related enrollees.

medical expenses are covered and paid under the Medicare program. According to the SSA-RRB agreement, the delegation of authority was considered advantageous because the program for aged railroad workers would be administered by the agency to which they turned during their working years and to which railroad annuitants regularly turn for all other matters having to do with their social insurance protection.

RRB advised us that the delegation of authority was advantageous because there was a logical connection between the payment of part B Medicare premiums and the payment of benefits that would lead the beneficiary to associate the two with the same agency. RRB stated that part B Medicare premium notices for active railroad employees, who are also covered by Travelers' health insurance policies, were given by these employees to their employers for payment by Travelers to the Medicare program. RRB stated that most of these employees whose part B Medicare premiums are paid by Travelers or collected by RRB would look to the RRB-Travelers operation for service in connection with their claims for Medicare benefits.

According to RRB, in the absence of the delegation of authority, RRB would be expected by its beneficiaries to provide claims service but would not be in a position to do so.

Selection of The Travelers Insurance Company

In January 1955 Travelers entered into a contract with numerous railroads and with certain unions of nonoperating railroad employees to provide health insurance for active nonoperating railroad employees, such as maintenance and shop personnel and their dependents. In 1966 the coverage was expanded to include active operating employees, such as enginneers and conductors and their dependents. The premiums for this health insurance were paid by the employers. We were advised by Travelers in March 1969 that its policies covered about two thirds of the 600,000 active railroad employees in the United States.

Travelers also offered, on a voluntary basis, group health insurance to retired railroad employees and their

dependents who had been covered as active employees. The premiums were paid by the beneficiaries. Upon the inception of Medicare, these policies for active and retired railroad employees and their dependents were revised to include only those benefits that were not covered under Medicare.

Because of their prior experience with Travelers and because they would continue to contact Travelers regarding complementary benefits not covered by Medicare, railroad union and management officials, in December 1965 and in January and February 1966, recommended to HEW that Travelers be selected as the nationwide part B carrier for railroad workers and RRB annuitants. These railroad officials stated that it would be more feasible for their members to deal with one carrier because such an arrangement would result in greater efficiency and more timely benefit payments. In February 1966 officials of railroad management and labor organizations pointed out to the Undersecretary of HEW that about 166,000 RRB-related beneficiaries who would be eligible for Medicare had health insurance with Travelers.

Accordingly, the selection of Travelers in July 1966 as the nationwide RRB carrier was made primarily for the convenience of about 22 percent of the 761,000 railroad workers and annuitants who were eligible for Medicare, or about 1 percent of the total 17.6 million beneficiaries who had enrolled under part B of the Medicare program. Further, of the 810,000 railroad workers and RRB annuitants who were eligible for part B benefits as of January 1, 1969, only about 125,000, or about 15 percent, had complementary coverage with Travelers.

CHAPTER 3

OPPORTUNITY TO REDUCE COSTS OF THE MEDICARE PROGRAM BY CONSOLIDATING CLAIMS-PROCESSING ACTIVITIES

Our review of Travelers' claims-processing activities under its contract with RRB indicated that, if the claims of railroad workers and RRB annuitants under part B of Medicare were processed by the same carriers that process the claims of other Medicare beneficiaries, (1) the benefit payments would be made on a more consistent basis and would have been about $2.9 million lower in fiscal year 1970 and (2) on the basis of projected fiscal year 1971 workloads, the costs of administering the program could be reduced by as much as $2.8 million annually. Our conclusions, which are discussed in detail in the following chapters of this report, were based on the following considerations:

--Under SSA regulations, information concerning both customary and prevailing charges is necessary for the proper determination of the reasonableness of charges upon which payments for physicians' services under part B of the Medicare program are to be based.

During the first 3-1/2 years of the program (July 1966 through December 1969), Travelers paid Medicare benefits of about $172 million under its contract with RRB. During this period, because of circumstances which were beyond Travelers' control, Travelers was not able to make reasonable-charge determinations in the manner prescribed by SSA, principally because the volume of RRB-related claims was not large enough to permit the determination of customary charges. (See ch. 4)

--The SSA delegation of authority provides that RRB ensure that payments made by Travelers for physicians' services conform as closely as possible to the payments made by the SSA carriers for comparable services in the same locality. During the first 2 years of the Medicare program, the incidence of inconsistencies in the amount of payments for comparable

services of the same physicians appeared to be relatively low because neither Travelers nor the SSA carriers were reducing many physicians' charges except in those few geographical areas where the SSA carriers had developed procedures to compare charges claimed with the physicians' customary charges.

SSA statistics showed, however, that during fiscal year 1970 SSA carriers' reductions to allowable physicians' charges had substantially increased after 1968 and that, on a nationwide basis, the SSA carriers, in determining reasonable charges, had reduced allowable charges by an average of $3 a claim more than Travelers. Had Travelers reduced allowable charges at the same rate as the SSA carriers, the benefit payments applicable to RRB-related beneficiaries would have been about $2.9 million lower in fiscal year 1970.

Our comparison of the reasonable-charge determinations made by selected Travelers field offices with those made by the SSA carriers operating in the same geographical areas showed that the $3 difference in the average reductions to physicians' allowable charges was almost entirely attributable to the SSA carriers' reducing claims that exceeded the physicians' customary charges whereas Travelers was unable to make such reductions because it could not determine customary charges. (See ch. 5.)

--A comparison of the estimates made by four SSA carriers making benefit payments in nine States of the increases in their total administrative costs with the administrative costs incurred by Travelers showed that administrative costs would be reduced if these SSA carriers were to add the relatively small number of RRB-related claims in a given locality to their existing workloads.

On the basis of these estimates by the four SSA carriers, we believe that, nationally, the elimination of a separate carrier to process RRB-related claims could result in lower Medicare administrative costs by as much as $2.8 million annually.

We believe that the estimates furnished by the four SSA carriers are reasonable because, by consolidating claims processing activities, there would be an opportunity to reduce or eliminate (1) the necessity of maintaining separate Travelers field offices along with many supervisory and administrative personnel, (2) the additional data processing and general overhead expenses arising from the separation of claims-processing activities between RRB-related claims and all other Medicare part B claims, and (3) the duplication of effort involved when RRB-related claims are erroneously sent to the SSA carriers, partially processed by them, and rerouted to Travelers for reprocessing. (See ch. 6.)

By letter dated March 19, 1970 (see app. II), HEW advised us that, although SSA agreed that the arrangement with Travelers as the sole carrier for RRB beneficiaries presented inherent administrative problems, SSA was not prepared to accept our proposal to consolidate claims-processing activities. HEW suggested as an alternative that the Travelers-RRB arrangement provided an opportunity to experiment in determining the reasonableness of charges on the basis of prevailing charges only. Our views concerning the alternative proposed by HEW are discussed in chapter 7.

CHAPTER 4

INABILITY OF TRAVELERS TO MEET SSA REQUIREMENTS FOR MAKING REASONABLE-CHARGE DETERMINATIONS

During the 3-1/2 year period July 1, 1966, through December 31, 1969, Travelers paid Medicare benefits of about $172 million under its contract with RRB. Although Travelers made various efforts to comply with SSA regulations regarding the screening or comparing of claims against a physician's customary charge for a particular service, these efforts were severely hampered by the lack of volume of data for physicians' charges applicable to RRB-related beneficiaries. As a result, Travelers was not able to determine the physicians' customary charges for the vast majority of medical and surgical services for which benefit payments had been made.

EARLIER EFFORTS TO ESTABLISH CUSTOMARY CHARGES

In July 1967, Travelers established procedures for developing profiles of physicians' charges at each of its 125 offices which processed RRB-related Medicare claims. For each physician within the area served by a Travelers field office, the profile listed all charges submitted to that office for railroad employees and RRB annuitants during the preceding 6 months. From these profiles, which were updated periodically, the Travelers field offices were supposed to determine how much each physician customarily charged for his services.

Data furnished us by Travelers in April 1968 showed that about 87 percent of the charges included in the profiles for all Travelers RRB field offices were for single instances of medical or surgical performed by individual physicians. Under these circumstances, physicians' customary charges could not be established for the vast majority of services. Moreover, during our visits to 11 Travelers field offices during 1968, we observed that these offices were not using the profiles in processing claims because they rarely

contained enough data which could be used to determine a physician's customary charge.

For example, at one Travelers field office, we examined the physicians' profiles applicable to four surgical procedures for the 6-month period ended March 31, 1968. According to SSA statistics, these four procedures (cataract, transurethral resection of the prostate, herniotomy, and cholecystectomy) were the most common surgical procedures performed on Medicare beneficiaries and accounted for about 33 percent of the total amount of Medicare surgical charges and about 14 percent of the total number of surgical procedures performed. For these four surgical procedures, the physicians' profiles at the Travelers field office contained charges for 32 operations which were performed by 31 different physicians, or, essentially, one operation for each physician.

At two other Travelers field offices, we made similar analyses of physicians' profiles for the same four surgical procedures for the 6-month period ended September 30, 1968. At one field office, the profiles contained charges for 57 operations which were performed by 51 different physicians; at the other field office, the profiles contained charges for 51 operations performed by 45 different physicians. There was, therefore, not enough data on physicians' charges applicable to railroad employees and RRB annuitants to enable Travelers to properly establish customary charges for any of the physicians performing these four procedures, although they were the most common surgical services rendered to beneficiaries under the Medicare program.

In December 1966, SSA instructed its carriers that an exchange of reasonable-charge data between Travelers and the carriers acting for SSA was necessary to ensure comparability in amounts paid for like medical services. In April 1968, however, we were informed by Travelers that, although it obtained information on prevailing charges from 28 of the 50 SSA carriers, Travelers had been successful in obtaining customary-charge data from only one SSA carrier. SSA carriers were apparently not complying with SSA's instruction because (1) many had not compiled physicians' customary-charge data for their own use in processing Medicare claims

or (2) they considered information on individual physicians' charges, some of which related to their own commercial insurance activities, to be proprietary in nature.

RECENT EFFORTS TO ESTABLISH CUSTOMARY CHARGES

In December 1968, SSA requested advice from Travelers as to how and when Travelers would improve its methods of determining the reasonableness of charges in paying Medicare claims for physicians' services. In January and February 1969, Travelers made proposals to SSA and RRB that featured the inclusion of charge data from Travelers' commercial insurance business into the physicians' profiles. Travelers stated, however, that this step would increase the annual administrative costs under the RRB contract by $548,000 and that only a small percentage of claims under its commercial insurance business would be relevant to the Medicare program.

Because of the additional administrative costs involved and because there was no assurance that the volume and nature of Travelers' commercial-charge data would enable Travelers to develop physicians' customary charges on a nationwide basis for the vast majority of medical and surgical procedures furnished to Medicare beneficiaries, SSA did not approve Travelers' proposal.

In April 1969, however, SSA approved an alternate proposal by Travelers under which it would develop more sophisticated profiles of the physicians' charges applicable to RRB-related claims to show a specific amount--rather than a listing of a physician's previous charges--which would represent the customary charge of a physician for a specific medical or surgical procedure. In accordance with guidelines approved by SSA in July 1969, Travelers would need 10 or more prior charges made by a physician to establish the physician's customary charge for each medical, X-ray, or laboratory procedure and five or more charges to establish each physician's customary charge for each surgical procedure.

Although this proposal was approved, in a letter to RRB dated September 29, 1969, SSA pointed out that it did not believe that this or any other methodology could effectively bring meaningful results and that the factor of insufficient volume of prior charge data would continue to be the primary obstacle in properly developing customary charges.

In December 1969, Travelers advised SSA and RRB that revised physicians' profiles had been developed and used in processing RRB-related Medicare claims from September 1, 1969.

We inquired into the methods used by Travelers in developing these revised profiles and reviewed their usefulness in determining customary charges for 100 claims paid in March 1970 at each of four Travelers field offices, including three field offices we had previously visited in 1968. We found that the contents of the revised profiles were essentially a rerun of 1968 charge data and, although Travelers had produced profiles in a more readable format, they were of little more use, if any, than the profiles initially developed in July 1967 because the basic problem of insufficient volume of data still existed.

Included in the 400 claims reviewed by us were 719 different physician/procedure combinations (i.e., one physician charging one or more beneficiaries for one specific procedure represents a physician/procedure combination; another physician charging one or more beneficiaries for another specific procedure represents another physician/procedure combination). Of the 719 different combinations, the Travelers field offices had customary-charge data in the profiles for 113, or only about 16 percent. Of the physicians' charges of $25,587 included in the 400 RRB-related claims, Travelers field offices were able to compare charges of only $2,491 to the physicians' customary charge profiles, or only about 10 percent of the charges. Our findings at each of the four Travelers field offices are summarized in the following table.

Travelers field office	Number of claims reviewed	Number of physician/ procedure combinations	Number of combinations for which customary charges were available	Percent of total	Total amount of physicians' charges	Amount of charges compared with customary charges	Percent of total
A	100	153	11	7.2	$ 5,638	$ 527	9.4
B	100	182	17	9.3	8,590	335	3.9
C	100	242	34	14.0	6,925	614	8.9
D	100	142	51	35.9	4,434	1,015	22.9
	400	719	113	15.7	$25,587	$2,491	9.7

In summary, for the vast majority of medical and surgical services, Travelers had not been in a position to comply with SSA regulations for developing customary charges because (1) there was not enough data on physicians' charges relating solely to RRB-related beneficiaries from which customary charges could be determined, (2) there was no assurance that the volume and nature of physicians' charge data applicable to Travelers' commercial health insurance programs would enable the carrier to determine customary charges for the services provided to Medicare beneficiaries, and (3) there had been little exchange of customary-charge data with SSA carriers.

TRAVELERS' METHOD FOR MAKING PREVAILING-CHARGE DETERMINATIONS

As discussed on page 7, SSA regulations provide that, in establishing the upper limits of prevailing charges in a locality for specific medical services, the carrier should use the average (arithmetic mean) of the physicians' customary charges for each service plus one standard deviation above the mean. Because Travelers did not have adequate customary-charge data applicable to its RRB business, it did not initially establish its prevailing charges (fee limitations) by the method prescribed by SSA but used an alternate method. The resulting fee limitations were the primary control used by Travelers for determining reasonable charges for RRB-related claims.

The alternate method used by Travelers featured the use of the California relative-value studies (CRVS). CRVS, which was initially developed in 1956 by the California Medical Association, has been periodically updated. Essentially, CRVS consist of five separate sections or studies (medicine, anesthesia, surgery, radiology, and laboratory) and show within each section the relative value of one service or procedure to another.

For example, in the surgery section, CRVS assigns a value of 40 units to an appendectomy and 80 units to a cataract operation. This is another way of saying that a physician's fee for a cataract operation should be twice as much as his fee for an appendectomy. Under Travelers' system, for a given locality a fixed-dollar conversion value per unit was established. For example, if a $6 conversion value was established, the prevailing charge for these surgical procedures would be computed as follows: appendectomy, 40 units x $6 = $240; cataract operation, 80 units x $6 = $480.

From the inception of the Medicare program in July 1966, CRVS have been used by all Travelers field offices as the principal basis for making reasonable-charge determinations for RRB-related claims; however, the fixed-dollar conversion value varied among field offices to reflect the differences in the prevailing charges in each locality.

For the 11 field offices visited by us in 1968, the unit conversion value ranged from $5 to $7.50.

Travelers, concurrently with implementing the revised customary-charge profiles in September 1969, also developed fee limitations in accordance with the SSA-prescribed criteria. We noted, however, that SSA had authorized Travelers to use a single charge by a physician as a customary charge for the purpose of developing the revised prevailing charges. Because the revised prevailing charges were generally higher than the fee limitations then in effect which were based on the CRVS factors, SSA did not authorize Travelers to use these new fee limitations because of SSA's policy that carriers were to use fee limitations, in effect in February 1969, through June 1970.

CHAPTER 5

COMPARISON OF REASONABLE-CHARGE DETERMINATIONS MADE BY TRAVELERS AND SSA CARRIERS

The SSA delegation of authority, which gave RRB the authority to contract with carriers to process the Medicare part B claims of railroad employees and RRB annuitants, provides that:

> "The Railroad Retirement Board shall take such action as may be necessary to assure that payment made for services by the *** [carriers] it selects will conform as closely as possible to the payments made for comparable services in the same locality by any *** [carriers] acting for the Social Security Administration."

The purpose of this provision was to reduce disparities between reasonable-charge determinations for similar services furnished by the same physicians by the two carriers operating in the same geographical area.

We noted that the differences between charges allowed or allowable in the same geographical areas by Travelers and by the SSA carriers during 1968 and in 1970 increased partially because the SSA carriers began screening claims against the physicians' customary charges. The differences between charges allowed by Travelers and by the SSA carriers became larger because the SSA carriers were making significantly larger reductions in physicians' allowable charges. Had Travelers reduced allowable charges at the same rate as the SSA carriers, the benefit payments applicable to RRB-related claims would have been about $2.9 million lower in fiscal year 1970.

Our comparison in 1968 of charges allowed at the 11 Travelers field offices with charges allowed or allowable

by the seven SSA carriers operating in the same areas showed some inconsistencies at almost every office. The potential for inconsistent reasonable-charge determinations between Travelers and the SSA carriers appeared to be greatest at those few locations where the SSA carriers at that time were screening Medicare claims against both the physicians' customary charges and the fee limitations. As discussed in chapter 4, Travelers had not made such customary-charge determinations nor does it appear that it is in a position to do so.

COMPARISON OF REASONABLE-CHARGE DETERMINATIONS DURING 1968

In the areas served by two of the 11 Travelers field offices, we noted that, at the time of our visits in 1968, the two SSA carriers serving the same areas were screening Medicare claims against the physicians' customary charges and the fee limitations.

In areas served by the remaining nine Travelers field offices, we noted that, at the time of our 1968 field reviews, the five SSA carriers serving the same areas were not screening Medicare claims against the physicians' customary charges. The five SSA carriers were reviewing Medicare claims in essentially the same manner as Travelers--by comparing the amounts charged by the physicians with overall fee limitations.

Our review indicated, however, that the SSA carriers' difficulties in developing customary-charge screens involved problems which appeared susceptible of solution, such as (1) a high incidence of errors in recording physicians' charges, which resulted in the accumulation of unreliable data that the carrier was reluctant to use (2) the limitations in carriers' data-processing capabilities, and (3) the failure to use customary-charge data that had been developed.

In establishing prevailing charges during 1968, four of the five SSA carriers were also using relative-value studies which were the same as or similar to the CRVS used by Travelers with some differences in the unit conversion factors. We noted that, although there was some exchange of

prevailing-charge data among the nine Travelers field offices and the five SSA carriers, the fee limitations used by the carriers varied in many instances.

For example, in one field office, Travelers would allow $480 for a cataract operation and, at another field office in the same State, Travelers would allow $400, whereas the SSA carrier serving generally the same areas as these two offices would allow $430. A third Travelers field office would allow $480 for a prostate procedure, whereas the SSA carrier would allow $440. Similiar variances in the allowable charges were noted at every field office visited.

SSA statistics, based on a 5-percent sample of paid claims, showed that, during fiscal year 1968, about 99 percent of the number of charges claimed for services furnished to RRB-related beneficiaries were allowed by Travelers without being reduced and that the total amount of reductions amounted to about 1 percent of the total charges. During the same period, the seven SSA carriers allowed from 99.8 percent to 93.5 percent of the number of charges without making reductions and the total amount of reductions ranged from one tenth of 1 percent to about 4 percent of the total charges. The two SSA carriers that were making customary-charge screens in 1968 had the highest percentage of both the number and amounts of reductions.

Under these circumstances, the incidence of actual inconsistent payments made to the same physicians by Travelers and by the SSA carriers for like services would be relatively low because neither Travelers nor the SSA carriers were making many reductions in the physicians' allowable charges except in those few areas where the SSA carriers were making customary-charge screens.

COMPARISON OF REASONABLE-CHARGE DETERMINATIONS IN 1970

SSA data compiled for fiscal year 1970 indicated that both the incidence and amounts of SSA carrier reductions in physicians' allowable charges had significantly increased. Although SSA's fiscal year 1968 data is not entirely comparable to the data compiled for fiscal year 1970, our analysis indicated that the rate of reductions in amounts allowed for physicians' charges had more than doubled and that the Travelers' rate of reductions for RRB-related claims was much lower than the national average for the SSA carriers.

As shown in the following table, the national average of reductions by all carriers in the charges allowed for physicians' services was $2.94 a claim more than those reported by Travelers for the quarters ended September 30 and December 31, 1969, and $2.96 and $3.09 more than those reported by Travelers for the quarters ended March 31 and June 30, 1970, respectively. Also the number of claims reduced by Travelers was much lower than the national average for all carriers.

	Reductions in allowable physicians' charges as a result of reasonable-charge determinations		
	Average for all carriers	Average for RRB-related claims processed by Travelers	Difference
Average reduction per allowed claim (note a):			
Quarter ended September 30, 1969	$4.38	$1.44	$2.94
" " December 31, 1969	4.83	1.89	2.94
" " March 31, 1970	5.01	2.05	2.96
" " June 30, 1970	5.77	2.68	3.09
Percentage of allowed claims reduced:			
Quarter ended September 30, 1969	25.6	6.0	19.6
" " December 31, 1969	28.7	10.2	18.5
" " March 31, 1970	32.3	12.7	19.6
" " June 30, 1970	35.3	14.0	21.3

[a]An allowed claim represents a claim submitted on an SSA Form 1490 which was either paid or applied toward the $50 deductible payable by the beneficiary. (See p. 6.) The SSA Form 1490 is the form used to claim part B benefit payments for physicians' services when the physician has not made arrangements with a hospital or extended-care facility to bill Medicare on his behalf.

As shown above, there was almost a $3 difference between the reductions per allowed claim made by Travelers under its contract with RRB and the national average of reductions for all carriers. Because Travelers processed about 1.3 million allowed claims in fiscal year 1970, the $3 a claim difference in reductions amounts to about $3.9 million for that year. After subtracting the portion of charges payable by the beneficiaries for deductibles and coinsurance (about 27 percent of the allowed charges for paid claims), the difference represents about $2.9 million in benefit payments.[1] For example, if Travelers had achieved the same rate of reductions in allowable charges for physicians' services on a nationwide basis as the SSA carriers, the benefit payments for RRB-related beneficiaries would have been about $2.9 million lower in fiscal year 1970.

Although there may be a number of reasons for the difference between Travelers and the SSA carriers in the reductions in allowable physicians' charges such as lower physicians' charges for RRB-related claims, our analysis of selected payments showed that the difference were actually caused by variances in the amounts determined as reasonable charges and that Travelers made higher benefit payments than the SSA carriers for like services involving the same physicians.

ANALYSIS OF VARIATIONS IN PHYSICIANS' CHARGES ALLOWED BY TRAVELERS AND BY THE SSA CARRIERS

To obtain information on the reason for the differences between the reductions per allowed claim made by Travelers and the national averages, we compared the amounts Travelers

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[1] Although it is unlikely, this estimate may be overstated by as much as 12 percent, because available SSA statistics relating to the beneficiaries' share of the allowed charges were based on paid claims and did not include those claims where the allowed charges were applied wholly toward the $50 deductible.

allowed for 362 claims which were systematically selected at four field offices to the amounts the SSA carriers would have allowed as reasonable charges for these claims.[1]

As shown by the following table, in each of the four field offices, Travelers was allowing from $2 to $3.31 a claim (overall average of $2.67 a claim) more than the SSA carriers for like medical and surgical procedures.

Travelers field office	Number of claims reviewed	Physicians' charges allowed by Travelers (note a)	Physicians' charges allowable based on SSA carriers' reasonable-charge criteria (note a)	Difference between charges allowed by Travelers and the charges allowable by the SSA carriers			
				Travelers' allowances		Net difference	Average difference per claim
				Higher	Lower		
A	100	$ 5,467	$ 5,227	$ 295	$ 55	$240	$2.40
B	100	8,380	8,049	405	74	331	3.31
C	100	6,606	6,334	280	8	272	2.72
D	62	2,173	2,049	125	1	124	2.00
Total	362	$22,626	$21,659	$1,105	$138	$967	$2.67

[a]Amounts adjusted to eliminate any differences due to disallowances for noncovered services.

As previously stated, in making benefit payments, a carrier is required to consider the prevailing charge, which

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[1]One Travelers field office which we visited was processing nearly all RRB-related claims for two States, as well as all RRB-related claims for annuitants who were members of the Union Pacific Railroad Employees Hospital Association regardless of the State in which the services were rendered. Of the 100 claims selected for review, 38 were for annuitants who were members of the Association in eight other States. Because there were eight States involved we did not compare any charges allowed by Travelers with the amounts that the SSA carriers would have allowed for these 38 claims. This accounts for the difference between the 400 claims selected for review (see p. 21) and the 362 claims for which comparisons were made with the SSA carriers' reasonable-charge determinations.

sets the upper limit, and the customary charge, which is the amount an individual physician usually charges. Having considered these factors, the carrier should allow the lesser of the two but no more than the actual charge. Because the prevailing charge is the upper limit, we believe that Travelers, in having to rely only on this factor as a guide in making benefit payments more frequently than the SSA carriers have to rely only on this factor, would tend to allow higher charges than the SSA carriers.

This was borne out by our review. For example, at Travelers field office A, of the $240 in higher charges allowed by Travelers, $218 pertained to 11 claims for which the SSA carrier had the physicians' customary charge for 14 procedures, whereas Travelers did not. Likewise, at field office B, of the net difference of $331 in higher charges allowed by Travelers, $306 pertained to 12 claims for which the SSA carrier had the physicians' customary charges for 14 procedures, of which 12 were less than Travelers' prevailing charge and two were greater. Travelers had a customary charge for one of the 14 procedures but did not apply it because it was higher than the prevailing charge.

In commenting on our analysis of the variations in physicians' charges allowed by Travelers and by the SSA carriers, RRB and Travelers stated that the analysis involved a small sample of claims which was not necessarily representative of the whole distribution of charges and services for all SSA carriers and Travelers. (See apps. III and IV.) Travelers also suggested that our analysis included a built-in bias because the SSA carriers knew the purpose of the analysis and knew that their determinations of allowable physicians' charges would be subject to our review.

We acknowledge that the sample of claims we selected for analysis was relatively small and may not necessarily be representative on a national basis. For example, for the quarter ended March 31, 1970, the average reduction of an allowed claim for all carriers was $5.01 whereas the average reduction of an allowed claim for the four SSA carriers was $3.56, which suggests that, had we selected four other SSA carriers, the variations noted in our sample may have been even greater. Nevertheless the $3 difference for

fiscal year 1970 between the reductions of an allowed claim made by Travelers and the national average of such reductions was not based on a sample. This data was based on reports submitted to SSA by the SSA carriers and by Travelers and related to total claims processed during the year. The purpose of our analysis of selected claims at the four Travelers field offices was to ascertain a plausible explanation for this difference. For the field offices visited, we found that the differences in reductions to allowable charges was due to Travelers' inability to make customary-charge determinations which, we believe, has resulted in higher benefit payments for RRB-related beneficiaries.

Also, we do not believe that our analysis was biased, because, as explained previously, the variations in physicians' charges allowed by Travelers and by the SSA carriers were principally due to the fact that the SSA carriers had determined the physicians' customary charges for specific medical services whereas Travelers had not. We verified that either the SSA carriers had the customary-charge data or they did not have it; and if they did not have it, there was not much they could do to develop the data during the brief periods of our visits.

The RRB and Travelers also pointed out that effective July 1, 1970, SSA had included in its contracts with the SSA carriers a specific provision for the transfer of customary- and prevailing-charge data between the SSA carriers and the RRB carrier. According to RRB and Travelers, this action should minimize the variances in the physicians' charges allowed by Travelers and by the SSA carriers.

This contract provision had not been implemented at the time of our field reviews, and therefore we were not in a position to evaluate its effectiveness nor to determine whether any increased administrative costs would result--particularly in the voluminous exchange of customary-charge data involving specific physicians. Nevertheless it seems to us that a requirement to exchange detailed customary-charge data between the SSA carriers and the RRB carrier is inconsistent with SSA's March 1970 proposal (see ch. 7) to use the Travelers-RRB arrangement as a basis for determining reasonable charges using only prevailing charges (fee limitations).

CHAPTER 6

POTENTIAL FOR SAVINGS IN ADMINISTRATIVE COSTS BY USING SSA CARRIERS TO PROCESS RRB-RELATED MEDICARE CLAIMS

During fiscal year 1969, Travelers incurred administrative costs of about $4.5 million under its contract with RRB as the nationwide carrier for railroad employees and RRB annuitants under part B of the Medicare program. During the same period, the 50 SSA carriers incurred administrative costs of about $113.9 million under their contracts with SSA.

The carriers' administrative costs are paid from the supplementary medical insurance trust fund which is financed by the premiums paid by part B beneficiaries and by matching funds appropriated by the Congress. Because the portion of the program administered by Travelers at each of its 125 field offices under its contract with RRB is relatively small as compared with the portion being administered by each of the 50 SSA carriers, we believe that it would be feasible to give the SSA carriers responsibility for processing the Medicare part B claims presently being processed by Travelers.

On the basis of estimates furnished by four SSA carriers, we estimate that the consolidation of these claims-processing activities on a nationwide basis would decrease the overall administrative costs of the Medicare program by as much as $2.8 million annually because of the economies[1] that are present in the larger claims-processing operations of the SSA carriers.

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[1] These economies refer to factors that reduce the average unit-processing costs as the number of units processed increases.

SMALL NUMBER OF RRB-RELATED ENROLLEES AND CLAIMS

SSA statistics show that, as of January 1, 1969, there were about 18,872,000 persons enrolled in the supplementary medical insurance program;[1] of this number, 810,000, or about 4.3 percent, were railroad employees or RRB annuitants. The percentage of railroad employees and RRB annuitants enrolled in part B in each State to the total number of persons enrolled in the part B program in the State ranged from a high of 10.3 percent in Wyoming to a low of about 1 percent in Rhode Island. The largest number of RRB-related beneficiaries was in Pennsylvania, which had about 72,000 enrollees. A comparison of the number of RRB-related beneficiaries to the total number of persons enrolled for each of the 50 States and other areas as of January 1, 1969, is shown in appendix I.

SSA statistics show also that, during fiscal year 1969, about 31.2 million Medicare payment records[2] were processed for payment, of which about 1.2 million, or about 3.8 percent, were applicable to RRB-related claims processed by Travelers. Thus, on the basis of the number of railroad employees and RRB annuitants enrolled in part B of the Medicare program and the number of payment records processed, the portion of the program administered by Travelers nationwide is small in relation to the size of the total Medicare part B program.

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[1] Of the 18.9 million persons enrolled in the supplementary medical insurance program, about 270,000 persons are members of group practice prepayment plans which deal directly with SSA and which are reimbursed for their services to Medicare beneficiaries on the basis of reasonable costs.

[2] A payment record is a standard work unit measure used by SSA and excludes claims which do not result in benefit payments, such as claims which are applied against the $50 deductible. Also, when a claim submitted by a beneficiary involves more than one physician or supplier, it results in more than one payment record.

DESCRIPTION OF ADMINISTRATIVE COSTS AND RRB'S AND TRAVELERS' VIEWS AS TO THE CONSOLIDATION OF CLAIMS-PROCESSING ACTIVITIES

The administrative costs incurred by Travelers in making benefit payments under its contract with RRB were for the salaries, payroll taxes, and employee benefits of field office employees who examined Medicare claims and for related overhead expenses in the 125 field offices. Overall, the field office expenses represented about 64 percent of Travelers' administrative costs for fiscal year 1969. The balance of Travelers' administrative costs was for other expenses directly related to the carrier's functions under its contract with RRB and indirect expenses, such as home office general and administrative expenses, which were allocated to Travelers' Medicare and non-Medicare activities on the basis of direct labor costs. From the inception of the program on July 1, 1966, through June 30, 1971, the administrative costs incurred by Travelers under its RRB contract will amount to about $22 million.

Because these administrative costs are similar to those incurred by the SSA carriers operating in the same geographical areas, we expressed the opinion in a draft of this report that the consolidation of claims-processing activities would provide a potential for savings in administrative costs.

In earlier comments on our draft report, RRB and Travelers stated that our conclusion was not supported and that such consolidation would result in increased administrative costs. Travelers' and RRB's position was based on the following considerations.

1. According to RRB and Travelers, all cost measurement indicators showed that, under its contract with RRB, Travelers was operating below the average cost of all the SSA carriers. Travelers stated that, for the first 9 months of fiscal year 1969, its ratio of administrative costs to benefits paid on behalf of RRB-related beneficiaries was 7.38 percent; the

average cost for each payment record processed was $3.49 whereas the national averages were 7.79 percent and $3.53, respectively.

Although Travelers' administrative cost experience compares favorably with other carriers, we believe that Travelers' position is not related to the central issue, which is whether administrative costs could be reduced if the SSA carriers assumed the Travelers' RRB-related workload. As discussed in further detail in this chapter, we believe that the annual incremental costs[1] which would be incurred by the SSA carriers would be significantly less than the annual administrative costs of about $4.5 million incurred by Travelers.

2. RRB and Travelers stated that certain costs incurred for the total Travelers' Medicare involvement were shared by SSA and RRB on the basis of number of payment records processed and that these costs would not be eliminated by transferring the RRB part B program to SSA carriers but would result in the costs' being absorbed by the Travelers' part B operation. Examples of these costs identified by Travelers were programming and systems efforts in establishing physicians' profiles and developing programs to produce statistics on physicians receiving Medicare payments of $25,000 or more a year.

We agree that some of the costs incurred by Travelers would be transferred to the SSA contract under which it acts as the SSA carrier in three States if the RRB contract was terminated. Although the amount of such transferable costs is not susceptible to precise determination because of the operating changes that could result from limiting Travelers' Medicare part B activities to the three States, we estimate--on the basis of the items of cost identified by Travelers

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[1]Incremental costs are defined as the changes in aggregate cost that accompany the addition or subtraction of a unit of output. As applied to claims processing, this means that the increase in the total costs of each carrier to process RRB-related claims would be the incremental cost to the program.

during our field review--that these transferable costs amounted to about $54,000 during fiscal year 1969.

We also identified other items of cost which were relatively fixed, such as Medicare administration and home office claim administration, and which would probably be allocated to the SSA contract in greater amounts if there were decreases in the volume of RRB-related claims processed. We estimate that such costs identified by us would amount to about $28,500 a year. Therefore, our analysis of the allocation of administrative costs between RRB and SSA indicated that the total amount which would have been absorbed by SSA for fiscal year 1969, if the RRB contract had been terminated, would have been only about $82,500, or 7 cents a payment record.

3. RRB and Travelers indicated that, assuming consistent, equitable, and proper accounting practices for all carriers, savings in indirect cost items would not be realized by transferring the claims-processing function to the SSA area carriers. According to Travelers, the cost of such activities as accounting, internal auditing, office services, and general and administrative costs are developed as a relationship to direct labor costs; and, if the direct labor costs were transferred to the SSA carriers, it would follow that these carriers would account for and claim the related indirect costs, therefore resulting in no savings.

On the basis of our discussions with officials of four SSA carriers and our analysis of their methods of allocating indirect costs to the SSA contracts, we believe that RRB's and Travelers' assumption that indirect costs were consistently developed as a relationship to direct labor costs is incorrect; therefore, it does not follow that indirect costs would always be increased if the SSA carriers' direct labor costs were increased. We found that two of the four SSA

carriers did not use direct labor costs as a basis for distributing indirect costs such as general and administrative expenses.[1]

One of the two carriers had separate field offices for its part B operations, each of which accounted for payroll and administrative expenses directly in expense accounts used solely for Medicare. When personnel of the home office performed support operations for Medicare, the time was charged directly to the SSA contract from daily time reports. The other SSA carrier, depending upon the type of indirect cost involved, developed a variety of allocation ratios. Officials at both of these SSA carriers advised us that, if the RRB-related claims workload were taken over by them, increases would not be made in the amounts of general and administrative expenses allocated to the SSA contract.

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[1]Our comparative analysis covered only four SSA carriers making benefit payments in nine states. Data on two additional carriers for which we have this information also showed that direct labor was not the only basis used to allocate overhead expenses. Some of these expenses were charged directly to Medicare whereas others were allocated on various bases such as square footage and time studies.

ANALYSIS OF ESTIMATES FURNISHED BY SSA CARRIERS SHOWS POTENTIAL FOR SAVINGS BY CONSOLIDATING ACTIVITIES

To obtain additional information as to the potential for savings in administrative costs by consolidating claims-processing activities, we requested four SSA carriers (two commercial insurance companies and two Blue Shield organizations) to furnish us with estimates of the incremental costs that each would incur if they were to process the RRB-related claims in addition to their other Medicare claims. We examined these estimates and tested their validity by verifying the workload statistics of claims examiners used in the estimates and by comparing the estimated costs with budgeted amounts and actual costs for previous years. These four SSA carriers processed part B claims in nine States and, during fiscal year 1969, made about 9 percent of the total benefit payments under part B of the Medicare program.

Our analysis of the data furnished by these four SSA carriers showed that they could process the additional RRB-related workload in the nine States at an incremental cost ranging from $0.35 to $1.87 a payment record, or an overall average of $1.30 a payment record. These incremental costs ranged from $3.96 to $1.64 less a payment record than the costs incurred by Travelers during fiscal year 1969 in the nine States. The overall average of estimated savings was about $2.40 a payment record.

Therefore, considering the incremental costs that would be incurred, and the Travelers' administrative costs which would be absorbed by SSA (see p. 37), the four SSA carriers could process the RRB-related claims for their nine States for about $321,600 less than Travelers. The results of our analysis are presented below by carrier and by State.

SSA carrier (1)	State (2)	Amounts per unit (payment record): Travelers' cost for fiscal year 1969 (3)	SSA carriers' incremental cost (4)	Gross savings (5)	Travelers' cost to be absorbed under its SSA contract (note a) (6)	Net savings (col. 5 - col. 6) (7)	Estimated number of RRB-related units to be processed during fiscal year 1971 (8)	Estimated savings (col. 7 x col. 8) (9)
I	1	$3.95	$1.87	$2.08	$0.07	$2.01	33,000	$ 66,330
II	2	3.08	0.57	2.51	.07	2.44	8,300	20,252
III	3	4.18	1.65	2.53	.07	2.46	19,500	47,970
III	4	3.77	1.83	1.94	.07	1.87	10,800	20,196
III	5	3.20	1.56	1.64	.07	1.57	19,900	31,243
IV	6	3.08	.48	2.60	.07	2.53	6,700	16,951
IV	7	4.31	.35	3.96	.07	3.89	8,400	32,676
IV	8	3.59	.80	2.79	.07	2.72	27,800	75,616
IV	9	3.32	.37	2.95	.07	2.88	3,600	10,368
Total		$3.70	$1.30	$2.40	$ .07	$2.33	138,000	$321,602

[a]See page 37 for an explanation of Travelers' administrative costs which would be absorbed under Travelers' contract with SSA to make part B benefit payments in three States.

If the estimates of incremental costs furnished by the four carriers paying part B benefits in nine States are representative of the incremental costs that would be incurred by other SSA carriers, we estimate that, on a nationwide basis, the SSA carriers could process RRB-related claims for as much as $2.8 million a year less than Travelers. This potential savings represents about 2.4 percent of the total fiscal year 1969 administrative costs incurred by carriers under part B.

FACTORS SUPPORTING THE SSA CARRIERS' ESTIMATES AND THE POTENTIAL FOR SAVINGS

We believe that there are several factors which explain why the carriers' estimates of their incremental costs to process RRB-related claims were substantially less than the costs incurred by Travelers to process the claims. These factors, including Travelers' comments thereon (see app. IV), are discussed below.

Elimination of Travelers field offices and reductions in related claims processing personnel

In evaluating the SSA carriers' estimates of the incremental costs to process RRB-related claims, we analyzed the major elements of administrative costs incurred by Travelers and related these costs to the incremental costs that would be incurred by the SSA carriers if they assumed the increases in workload. The single largest factor contributing to the potential administrative cost savings is the capability of the SSA carriers to assume the additional workload with little or no increase in claims-processing personnel and no overall increases in supervisory personnel or office space. This capacity exists, in our opinion, because of the economies which are present in a going concern capable of processing a large volume of claims as compared with the Travelers field offices which process relatively smaller volumes, ranging from under 1,000 to 60,000 claims during fiscal year 1969.

The additional volume of claims which would be assumed by the four SSA carriers represents only a relatively small part of their projected monthly workload for fiscal year 1971. The following table shows the relationship of the RRB-related claims which would be assumed by the SSA carriers to their projected workload on annual and monthly bases.

Carrier	State	Estimated payment records to be processed during fiscal year 1971: SSA carriers' projected workload, Yearly	SSA carriers' projected workload, Monthly	Travelers' projected workload for RRB-related claims, Yearly	Travelers' projected workload for RRB-related claims, Monthly	Percent increase in SSA carriers workload
I	1	1,576,000	131,300	33,000	2,800	2.09
II	2	100,000	8,300	8,300	700	8.30
III	3	410,500	34,200	19,500	1,600	4.75
III	4	369,400	30,800	10,800	900	2.92
III	5	373,300	31,100	19,900	1,700	5.33
IV	6	116,000	9,700	6,700	600	5.78
IV	7	126,900	10,600	8,400	700	6.62
IV	8	558,700	46,600	27,800	2,300	4.98
IV	9	33,400	2,800	3,600	300	10.78
Total		3,664,200	305,400	138,000	11,600	3.77

The additional workloads in the nine States which would be assumed by these four carriers averaged 3.77 percent of their projected fiscal year 1971 workload, which is comparable to the nationwide relationship of RRB-related claims to total Medicare part B claims of 3.8 percent as discussed on page 34.

This increased workload does not exceed the normal fluctuations of the four SSA carriers' monthly workloads. For example, the additional projected workload for carrier I would average only 2,800 claims a month, yet the fluctuation in the regular workload of this carrier varied from 4,777 fewer payment records processed in February than in January 1970 to 31,040 more payment records processed in March than in February 1970. This latter monthly fluctuation is about the same as the yearly workload for RRB-related claims to be processed by the corresponding Travelers field office. For the other three SSA carriers, there were smaller but still significant fluctuations in workloads.

According to one of the four SSA carriers, the relatively small increases in the number of payment records to be processed could easily be absorbed by the existing work forces. In some instances, however, the SSA carriers included in their estimates the costs for the additional claims examiners that would be required on the basis of the number of claims processed by each examiner. In no instance, however, did an SSA carrier estimate that additional

supervisory or administrative personnel would be required or that additional office space would be needed.

In commenting on this factor, Travelers pointed out that the assimilation of the RRB-related claims by the SSA carriers would increase the base from which fluctuations were determined and would not be handled within the existing fluctuations, thereby increasing the direct and indirect costs of the SSA carrier.

In our opinion, this observation is not entirely germane to the basic point which is that the SSA carriers' workloads are not static but vary from month to month. For example, during the 6-month period ended June 30, 1970, the total number of claims processed by all carriers varied by about 6 percent to 18 percent from the previous month's activity; whereas, during the same 6-month period, the ratios of the RRB-related claims processed to all part B claims processed ranged from about 3.1 percent to 3.8 percent. Therefore, it seems reasonable to us that the addition of the relatively few RRB-related claims to the SSA carriers' fluctuating workloads would not be disruptive to their Medicare claims-processing systems.

Reductions in data processing and general overhead costs

Data-processing costs and general overhead costs were other elements of costs where there are potential administrative cost savings. We were advised by two of the four SSA carriers[1] that the incremental computer running time that would be required to process RRB-related claims would be negligible. Further, although the initial cost of a computer and the system design and programming effort may be

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[1]One SSA carrier was in the process of changing to a new data-processing system and was reluctant to provide us with other than a straight-line projection (i.e., total costs divided by units of production). Another SSA carrier was in the process of finalizing a contract with an independent computer firm to handle its data-processing function on the basis of a unit price for each payment record processed.

substantial, an increase in the volume of claims processed, particularly the relatively small volume of RRB-related claims, would not increase the data-processing costs. Therefore, it appears that certain SSA carriers could process the RRB-related claims with negligible incremental cost increases. During fiscal year 1969, Travelers incurred data-processing costs of about $1.1 million to process these claims.

Also, as stated on page 38, two of the four SSA carriers advised us that their assumption of the RRB-related workload would not result in any increases in the amount of general and administrative expenses allocated to the SSA contract. For the remaining two carriers, increases in the general and administrative expenses which would be allocable to the SSA contract were included in their estimates. During fiscal year 1969, Travelers charged about $313,000, in general and administrative expenses, to the RRB contract.

In commenting on data-processing costs, Travelers stated that, assuming average efficiency of all carriers and equivalent computer running time costs, it was difficult for it to see how any savings in data-processing costs would result through the consolidation of claims-processing activities.

According to officials of the two SSA carriers that had estimated negligible incremental data-processing cost increases, the carriers had relatively high fixed costs and were operating their data-processing systems at less than optimum capacity; therefore, the assimilation of the RRB-related claims workload would have the effect of reducing their unit-processing costs.

Elimination of misrouted claims

Another problem--which would be eliminated if the SSA carriers processed RRB-related claims--is the SSA carriers' receiving and, in many instances, processing up to the point of payment a substantial percentage of the RRB-related claims. This problem arose partially because 285,000 RRB

annuitants[1] are also eligible for Medicare benefits by virtue of their entitlement to Social Security cash benefits and have SSA identification numbers.

These claims were generally sent to the SSA carrier; and, in many instances, it was not until the SSA carrier queried SSA headquarters in Baltimore, Maryland, regarding the eligibility of the claimant that the carrier found that it was an RRB-related claim which should be paid by Travelers. In other instances, even though the RRB beneficiaries had RRB identification numbers, the claims were sent to the SSA carrier by mistake, apparently because the physicians were accustomed to dealing with SSA carriers.

This problem was one of the reasons why the SSA carriers estimated that little or no increase in claims-processing personnel would be required if they processed the RRB-related claims. For example, personnel at one Travelers field office advised us that 90 to 95 percent of its claims were received from the SSA carrier.

For the 21-month period ending March 31, 1970, an average of about 1,200 claims a month were misrouted and had to be rerouted to the Travelers field office by the SSA carrier. The SSA carrier estimated that about 25 percent of these misrouted claims were detected during various stages of processing, and the remaining 75 percent were processed up to the point of payment. In other words, except for printing and issuing the payment checks, these claims were processed twice--once by the SSA carrier and once by the Travelers field office. In addition to the duplicate claims processing, the SSA carrier estimated that about 10 days elapsed before it detected that these claims had been misrouted.

Each of the other three SSA carriers advised us that it was experiencing similar problems with misrouted claims

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[1]See footnote[1] on page 11 regarding the proposed change in legislation. This problem may be alleviated if the premiums for those beneficiaries who are eligible for benefits under both programs are collected by RRB and RRB Medicare identification cards are issued.

but not of the same magnitude as this particular SSA carrier. In our opinion, the high incidence of misrouted claims does not seem to support RRB's contention that most of its beneficiaries look to the RRB-Travelers operation for service in connection with Medicare part B benefit payments. (See p. 12.)

CHAPTER 7

COMMENTS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE AND THE RAILROAD RETIREMENT BOARD AND GAO'S EVALUATION

In our draft report we proposed that SSA withdraw RRB's authority to select carriers to make part B benefit payments for railroad employees and RRB annuitants and that RRB-related claims be processed by the SSA carriers that make benefit payments for all other Medicare part B beneficiaries in the same general geographical areas.

In response to this proposal, HEW advised us by letter dated March 19, 1970 (see app. II), that SSA was not prepared to accept this proposal without considerable additional review of the Travelers-RRB relationship.

SSA acknowledged that the relatively small number of RRB-related claims had posed serious obstacles in Travelers' development of adequate customary-charge profiles and that the arrangement with Travelers as the sole carrier for RRB-related beneficiaries had presented inherent administrative problems. SSA also stated, however, that unilateral action on its part to revise the delegation of authority to RRB could be regarded as unwarranted interference with RRB administration and could result in harm to RRB programs.

As an alternative to our proposal to consolidate the claims-processing activities, SSA stated that the Travelers-RRB arrangement provided an excellent opportunity to experiment, in determining the reasonableness of charges, with the use of only prevailing-charge screens on a State-by-State basis. According to SSA, such an experiment would give SSA an opportunity, within given geographical areas, to measure

the results of differing reasonable-charge methodologies. The experiments would feature relative-value studies employing a system of conversion factors.[1]

SSA stated also that these experiments would yield information useful to both the legislative and executive branches in improving the administration of the Medicare program. SSA concluded that the potential advantage in conducting such experiments evinces the merit of continuing the current arrangement. In a letter to us, dated October 7, 1970 (see app. III), RRB endorsed SSA's proposal. RRB stated that the reasons for the delegation of authority were still valid and justified the continuance of the delegation. (See pp. 11 to 13.)

In March 1970 SSA advised us of its planned experiments, but the details for the proposed experimentations had not been defined by June 1970 and therefore we were unable to fully evaluate the SSA proposal. Although experiments in the determination of reasonable charges for physicians' services may be a desirable objective in order to develop alternatives to the present customary- and prevailing-charge criteria, we question whether the Travelers-RRB arrangement provides the most appropriate vehicle for such experimentation. SSA already has had considerable experience in using only prevailing-charge screens (fee limitations) featuring relative-value studies in evaluating the reasonableness of physicians' charges. Travelers essentially has been using them since the inception of the Medicare program in July 1966, and many SSA carriers used them during the earlier years of the program. This approach was unsatisfactory to SSA, however, and the carriers were required to establish customary-charge profiles as a condition for further participation in the program.

Further, because the RRB-related portion of the Medicare program represents such a relatively small part of the total program in a given geographical area, the experiments, even if successful, would not necessarily demonstrate their

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[1]Relative value studies are discussed on page 23.

general acceptance by the beneficiaries and the physicians on a programwide basis. We believe that, although experimentation in determining the reasonableness of physicians' charges may be desirable, it would be more appropriate to conduct such experimentation in a given geographical area where the general acceptance and feasibility of the experiments could be better demonstrated.

As for the potential savings in administrative costs through the consolidation of claims-processing activities, SSA was of the opinion that the amount of savings that would result from the termination of the RRB-Travelers contract had not been clearly shown and that, once these savings could be reasonably estimated, SSA would have to weigh the cost savings against the benefits derived from the RRB-Travelers contractual arrangement and the possibilities that this arrangement offered for creative experimentation. SSA stated that this left it in a position of being unable to ascribe sufficient weight to the administrative costs factor to tilt the scale in favor of our proposal.

Because SSA was unable to ascribe sufficient weight to this factor without an estimate of the savings involved, we obtained additional information showing the potential savings in administrative costs from four SSA carriers that were making part B benefit payments in nine States. As discussed in chapter 6, our analysis of the estimates of incremental costs furnished by these SSA carriers showed that they could process the RRB-related claims at a cost which was about $321,600 a year less than the cost incurred by Travelers in these nine States. Also, if the estimates of incremental costs furnished by the four SSA carriers are representative of the incremental costs that would be incurred by other SSA carriers, we estimate that, on a nationwide basis, the potential for savings in administrative costs by consolidating claims-processing activities could amount to as much as $2.8 million a year.

SSA also stated that, as an alternative way to achieve savings in administrative costs, certain efficiencies could be realized by reducing the number of Travelers field offices involved in processing the RRB-related claims. We inquired into this alternative at the Travelers home office and learned that Travelers had proposed to reduce the number of

its field offices processing RRB-related claims from 125 to 63. A Travelers' study indicated that there would be a corresponding reduction of 71 man-years, which we estimate would save about $352,000 annually.

Travelers is presently consolidating its field offices and, although we agree that there should be some savings, we believe that this action is indicative of the even greater savings that could be realized by a full consolidation plan under which the SSA carriers would assume the entire workload for RRB-related claims. In our opinion, the Travelers' study further supports our conclusion that there is a potential for administrative costs savings by having RRB-related claims processed by the SSA carriers that make benefit payments for all other Medicare part B beneficiaries in the same geographical area.

CHAPTER 8

CONCLUSIONS, RECOMMENDATION, AND MATTERS FOR CONSIDERATION BY THE CONGRESS

CONCLUSIONS

At the time of our field reviews in 1968 and in 1970, Travelers had not made, and in our opinion was not in a position to make, reasonable-charge determinations on a nationwide basis in the manner prescribed by SSA regulations and instructions. Our review showed that, primarily because of the relatively small volume of RRB-related claims processed by Travelers field offices, Travelers had been unable to accumulate enough data to determine physicians' customary charges for the vast majority of medical services.

The use of two separate carriers in the same geographical area to pay part B claims has resulted in inconsistencies in making reasonable-charge determinations for physicians' services. We observed that such differences had tended to increase as the SSA carriers improved their systems for making reasonable-charge determinations.

We found that the amounts allowed by Travelers as reasonable charges for medical services for RRB-related claims often differed from the amounts allowed by the SSA carriers for comparable medical services in the same geographical areas. This situation was inconsistent with the SSA delegation of authority which provides that the payments made by Travelers conform as closely as possible to the payments made by the SSA carrier for comparable services in the same locality. We estimated that, in fiscal year 1970, Travelers made benefit payments which were about $2.9 million higher than the payments that would have been made by SSA carriers for like medical services.

We believe that the use of a separate carrier to pay RRB-related claims, in addition to resulting in the lack of uniformity in part B benefit payments for physicians' services, also results in additional administrative costs of as much as $2.8 million a year to the Medicare program.

Finally, we believe that the primary reason for selecting Travelers as the nationwide RRB carrier was for the convenience of certain beneficiaries who had complementary medical insurance with Travelers. Although beneficiary convenience is an important consideration in the administration of any health insurance program, we noted that, as of January 1, 1969, this consideration applied to about 15 percent of the RRB-related beneficiaries--about 1 percent of the total 18.9 million beneficiaries enrolled under part B. In our opinion, this consideration is not of sufficient importance to offset the economies and improved administration that could result from discontinuing the use of a separate nationwide carrier to pay RRB-related claims.

In summary, it is our opinion that the existing arrangement under which a separate carrier makes benefit payments on a nationwide basis on behalf of a relatively small special group of beneficiaries is neither efficient nor effective and that any other carrier, under the same circumstances, would experience the same difficulties as Travelers.

RECOMMENDATION TO THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE

In line with the foregoing conclusions, we recommend that the necessary arrangements be made to have the RRB-related Medicare part B claims paid by the carriers paying such claims for all the other Medicare beneficiaries in the same geographical area.

MATTERS FOR CONSIDERATION BY THE CONGRESS

Although we recognize that the consolidation of the claims-processing activities would entail some diminution of the authority now delegated to RRB, we believe that an overriding consideration is that such action would simplify the administration of the Medicare program and would help reduce program costs. Therefore we are bringing the results of our review to the attention of the Congress for its consideration in future deliberations on amendments to the Social Security Act designed to improve the operating effectiveness of the Medicare program.

Also, regarding SSA's proposal to use the Travelers-RRB arrangement as a basis for experimentation in making reasonable-charge determinations for physicians' services, we noted that, in the Committee on Ways and Means report (H. Rept. 91-1096) on the Social Security Amendments of 1970, interest was expressed in reviewing HEW plans for experiments and demonstration projects involving payments or reimbursements to institutions under the Hospital Insurance Benefits for the Aged (part A) portion of the Medicare program.

According to the Committee report, such reviews would provide an opportunity for congressional study before the reimbursement experiment or project is carried out. Because a cognizant legislative committee of the Congress had expressed an interest in reviewing experimental reimbursement projects under part A of the Medicare program, the cognizant committees may also want to review the reimbursement experiments proposed by SSA for Travelers and RRB under part B of the program when SSA finalizes its plans relating to the experiments.

CHAPTER 9

SCOPE OF REVIEW

We evaluated (1) the role of Travelers under its contract with RRB as the nationwide part B carrier for making benefit payments on behalf of eligible railroad employees and RRB annuitants, (2) the methods used by Travelers for determining the reasonableness of charges for physicians' services, and (3) the administrative costs incurred by Travelers in comparison with the incremental administrative costs that would be incurred by the SSA carriers if they processed the RRB-related claims.

We reviewed the Medicare law, its legislative history, and SSA regulations and related instructions dealing with the reasonableness of charges for physicians' services.

We reviewed also records and other data at the Travelers home office in Hartford, Connecticut, and reviewed selected claims data at 11 Travelers field offices in 1968 and at four field offices during April, May, and June 1970. In addition, we reviewed the methods for making reasonable-charge determinations for physicians' services used by nine SSA carriers operating in the same geographical areas as the Travelers field offices visited by us. For four of these SSA carriers operating in nine States, we also compared their estimates of incremental costs that would be incurred for processing RRB-related claims with the costs incurred by Travelers.

In addition, we reviewed various statistical reports and other data relating to carriers' claims-processing activities at SSA Headquarters in Baltimore, Maryland.

APPENDIXES

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PERCENTAGE OF RRB-RELATED ENROLLEES TO TOTAL ENROLLEES UNDER PART B OF THE MEDICARE PROGRAM BY STATE AS OF JANUARY 1, 1969 (note a)

Area of residence	Total enrollees	RRB-related enrollees	Percentage of RRB-related enrollees to total enrollees
	(000 omitted)		
TOTAL	18,872	810	4.29
NEW ENGLAND	1,227	28	2.28
Maine	115	5	4.35
New Hampshire	76	2	2.63
Vermont	47	2	4.26
Massachusetts	614	13	2.12
Rhode Island	99	1	1.01
Connecticut	276	5	1.81
MIDDLE ATLANTIC	3,745	148	3.95
New York	1,880	54	2.87
New Jersey	662	22	3.32
Pennsylvania	1,203	72	5.99
EAST NORTH CENTRAL	3,634	168	4.62
Ohio	942	48	5.10
Indiana	466	25	5.36
Illinois	1,045	59	5.65
Michigan	727	20	2.75
Wisconsin	454	16	3.52

PERCENTAGE OF RRB-RELATED ENROLLEES TO TOTAL ENROLLEES

UNDER PART B OF THE MEDICARE PROGRAM

BY STATE

AS OF JANUARY 1, 1969 (note a)
(continued)

Area of residence	Total enrollees	RRB-related enrollees	Percentage of RRB-related enrollees to total enrollees
	(000 omitted)		
WEST NORTH CENTRAL	1,842	103	5.59
Minnesota	398	24	6.03
Iowa	342	16	4.68
Missouri	531	29	5.46
North Dakota	64	3	4.69
South Dakota	78	2	2.56
Nebraska	175	11	6.29
Kansas	254	18	7.09
SOUTH ATLANTIC	2,580	116	4.50
Delaware	42	3	7.14
Maryland	260	13	5.00
District of Columbia	62	2	3.23
Virginia	331	22	6.65
West Virginia	188	14	7.45
North Carolina	376	10	2.66
South Carolina	175	5	2.86
Georgia	338	14	4.14
Florida	808	33	4.08

PERCENTAGE OF RRB-RELATED ENROLLEES TO TOTAL ENROLLEES

UNDER PART B OF THE MEDICARE PROGRAM

BY STATE

AS OF JANUARY 1, 1969 (note a)
(continued)

Area of residence	Total enrollees	RRB-related enrollees	Percentage of RRB-related enrollees to total enrollees
	(000 omitted)		
EAST SOUTH CENTRAL	1,173	57	4.86
Kentucky	323	20	6.19
Tennessee	360	18	5.00
Alabama	298	12	4.03
Mississippi	192	7	3.65
WEST SOUTH CENTRAL	1,688	66	3.91
Arkansas	220	10	4.55
Louisiana	268	10	3.73
Oklahoma	279	8	2.87
Texas	921	38	4.13
MOUNTAIN	633	43	6.79
Montana	67	6	8.96
Idaho	64	4	6.25
Wyoming	29	3	10.34
Colorado	179	11	6.15
New Mexico	61	4	6.56
Arizona	135	7	5.19
Utah	71	6	8.45
Nevada	27	2	7.41

PERCENTAGE OF RRB-RELATED ENROLLEES TO TOTAL ENROLLEES

UNDER PART B OF THE MEDICARE PROGRAM

BY STATE

AS OF JANUARY 1, 1969 (note a)
(continued)

Area of residence	Total enrollees	RRB-related enrollees	Percentage of RRB-related enrollees to total enrollees
	(000 omitted)		
PACIFIC	2,236	79	3.53
Washington	305	12	3.93
Oregon	208	10	4.81
California	1,677	57	3.40
Alaska	5	(b)	
Hawaii	41	(b)	
OTHER AREAS	114	2	1.75

[a]Prepared from data recorded as of July 10, 1969, by the Office of Research and Statistics, Social Security Administration.

[b]Less than 500 enrollees.

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
WASHINGTON

OFFICE OF
THE SECRETARY

MAR 19 1970

Mr. Philip Charam
Associate Director, Civil Division
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Charam:

Enclosed are the Department's comments on GAO's draft audit report entitled, "Opportunity for Improvement in Administration of the Medicare Program by Consolidation of Claims Processing Activities Covering Physicians' Services". We understand that you have already received directly from the Railroad Retirement Board copies of the comments you requested us to get from RRB and the Travelers Insurance Company.

We appreciate this opportunity to express our views prior to publication of the final report.

Sincerely yours,

James F. Kelly
Assistant Secretary, Comptroller

Enclosure

OPPORTUNITY FOR IMPROVEMENT IN ADMINISTRATION OF THE MEDICARE PROGRAM BY CONSOLIDATION OF CLAIMS PROCESSING ACTIVITIES COVERING PHYSICIANS' SERVICES
(GAO draft report transmitted October 31, 1969)

Proposed Recommendation

"We recommend that the Secretary provide for amending the SSA delegation of authority to RRB by withdrawing RRB's authority to select carriers to administer Part B benefits for railroad employees and RRB annuitants. We recommend also that provision be made for RRB-related claims under Part B to be processed by the carriers operating under contracts with SSA in the various geographical areas which make benefit payments applicable to all other Part B Medicare beneficiaries."

SSA is not prepared to accept this proposed recommendation without considerable additional review of the relationship in the light of more recent developments as well as the considerations set forth by the Railroad Retirement Board (RRB) and the Travelers Insurance Company in their responses to the draft report.

Of great importance is the consideration now being given to some revision of the legislative provisions dealing with reasonable charge determinations. Some possible revisions were discussed at the recent hearings before the Senate Finance Committee. Whatever the developments may be in this area, however, it appears the Government would be served better by turning the RRB-Travelers arrangement to advantage as the basis for experiments on controlling payments to physicians than by taking the action recommended by the auditors. These experiments would yield information useful to both the legislative and executive branches in improving Medicare administration. For purposes of experimentation, Travelers nationwide set-up offers some unique advantages that cannot otherwise be easily duplicated. In brief, we think that important gains can be realized by taking positive action in this situation, rather than just the negative action of terminating Travelers.

It appears that SSA would be advantaged by using the RRB-Travelers arrangement for an experiment in determining reasonable charges on a prevailing charge screen only. This screen could be established, perhaps, on a State-by-State basis. It would utilize a relative value study approach employing a system of conversion factors. Such an experiment would give SSA opportunity within given areas to measure the results of differing reasonable charge methodologies. The potential advantage to SSA in conducting such an experiment evinces the merit in continuing the current arrangements, with a careful reassessment made by GAO after sufficient data is secured. Accordingly, GAO may wish to consider rewording the audit recommendation.

As requested by GAO, we obtained comments from RRB and the Travelers Insurance Company so that we could consider the views of these organizations in preparing our response to the draft report. In comments transmitted

by letter dated December 3, 1969, to SSA, with a copy to GAO, RRB vigorously argued for continuance of its authority to select carriers to handle claims from railroad workers and RRB annuitants, and for continuance of the resultant contract between RRB and Travelers. RRB maintained that the present arrangement was necessary for effective administration of its programs and to enable RRB to provide, in an economical and expeditious manner, the claims service expected by its constituency. Similarly, in comments dated December 2, 1969, Travelers maintained that the existing arrangement should be continued.

When making the original delegation of authority, SSA foresaw that special problems might arise; however, it appeared that the delegation was necessary to serve RRB administrative needs. Now that the RRB-Travelers set-up is in existence and has been operative for some $3\frac{1}{2}$ years, the matter takes on a new dimension since changing our original decision would require making a number of adjustments that could have an adverse effect on the relationships RRB has with its beneficiaries who have been conditioned to look to RRB and Travelers as their sources for information and service. Unilateral action on our part could, therefore, be regarded as unwarranted interference with RRB administration, with resultant harm to RRB programs. Although SSA agrees that the existing arrangement with Travelers as the sole Medicare carrier for RRB beneficiaries presents some inherent administrative problems, we think it is apparent that any corrective action ought to be acceptable to RRB as well as to us. In view of RRB's vigorous opposition to GAO's proposed recommendation, it is obvious that the audit recommendation would not meet this criterion of being mutually acceptable.

Certainly, some of the observations made in the GAO report represent valid appraisals of the experience in the first years of the program's operation. It should be recognized, however, that there are potential changes which on implementation can perhaps overcome the deficiencies or difficulties identified. In addition, gains may be achieved through a closer operating liaison both between SSA and RRB and between Travelers and the area carriers. In this connection, some recent SSA actions should minimize the reoccurrence of whatever liaison problems there may have been in the past. These actions include the placement of a resident representative in Travelers Hartford office and the designation of a single liaison point in the Bureau of Health Insurance to assure that copies of all pertinent material, including material originating in our regional offices, are provided RRB. We are obliged, however, to take issue with the charges in RRB's comments of past lack of cooperation on our part. An objective review of SSA's coordination efforts, giving due consideration to the administrative complexities of the medical insurance program and the many coordination points involved, will not sustain such charges.

The proposed audit recommendation results from three GAO findings:

1. Under the circumstances, it is impossible for Travelers to make reasonable charge determinations on a nationwide basis in the manner prescribed by SSA regulations and related instructions.

2. The existence of two separate carriers in the same geographical area gives rise to inconsistent reasonable charge criteria; differences in criteria can be expected to increase as the SSA carriers improve their systems.

3. Consolidation of claims processing activities in one area carrier would reduce administrative costs.

Our views on these GAO conclusions are given below.

Inability of an RRB carrier to meet requirements for determining reasonable charges

Certainly, the lack of volume in Travelers RRB related operations poses serious obstacles to its development of adequate customary charge profiles. The basic concern is whether the RRB carrier could get in the position of making accurate reasonable charge determinations under the prescribed criteria and in so doing achieve consistency with the determinations made by the area carrier. With the difference in the data base available to the area carrier and Travelers RRB operation, even with precise application of the customary and prevailing charge criteria by each there would undoubtedly be differences in the identification of reasonable charges for some services rendered by some physicians.

Considering that the basic problem is control of program cost, however, and the appropriateness of experimenting with other approaches to determining reasonable charges, it appears, as mentioned earlier, that we could be advantaged at this time by utilizing the RRB carrier operation as the base for a special study. The use of a relative value study approach in determining reasonable charges would build on the method Travelers is currently using but would introduce the use of conversion factors tailored to State or regional medical fee experience. Additional controls would be added, as deemed essential, such as appropriate recognition of differences between specialists and non-specialists. In pursuing such an approach, we would expect to establish a range of controls over the data collected to assure effective comparison of results of the experimental methodology with experience of the area carrier.

Differences in reasonable charge determinations

These differences, and the consequent disparity in payments by carriers, have created some problems particularly from the standpoint of acceptance by the public (physicians and beneficiaries). However, if SSA deliberately experiments with differing reasonable charge methodology in a given area, ample notice would be given to the physician community. Accordingly, while disparity in reasonable charge determination would be a matter of interest and perhaps some concern, depending on the results, it would not occasion the adverse reaction that is now obtained when the two carriers involved are supposedly following the same methodology.

Even under present methods and procedures there is a requirement to report disparities to SSA or RRB, which is designed to assure that both agencies

are continually aware of the dimensions of the problems and to permit the resolution of specific cases at the local level. There is reason to believe that, with continued attention to detection and resolution of disparities on the local level, the instances of incomparability of payments will be reduced to an acceptable minimum.

Reduction in administrative costs

The amount of savings that would result from termination of the RRB-Travelers contract has not been clearly shown. GAO recognizes that some of the costs incurred by Travelers would have to be picked up by the SSA carrier were there no RRB-Travelers contract. Once these savings could be reasonably estimated, we would then have to weigh the cost against the benefits derived from the contractual arrangement and the possibilities it offers for creative experimentation. This leaves us in a position of being unable to ascribe sufficient weight to the cost factor to tilt the scale in favor of the GAO recommendation.

As an alternative way to achieve savings, it would seem that certain efficiencies could be obtained by reducing the number of Travelers' field offices involved in carrying out the functions of the RRB contract. Not only might this reduce costs, but the consolidation of Medicare capability should improve quality of administration and simplify cooperation and coordination among SSA, RRB, the other carriers, and Travelers.

UNITED STATES OF AMERICA
RAILROAD RETIREMENT BOARD
844 RUSH STREET
CHICAGO, ILLINOIS 60611

HOWARD W. HABERMEYER
CHAIRMAN
THOMAS M. HEALY
NEIL P. SPEIRS

OCT 7- 1970

Mr. Philip Charam
Associate Director, Civil Division
U. S. General Accounting Office
Washington, D. C. 20548

Dear Mr. Charam:

We appreciate very much the opportunity of reviewing the draft report of the General Accounting Office on the Railroad Retirement Board's operation under the delegation of authority from the Social Security Administration.

In our opinion, the reasons for the delegation set out on Pages 7-10 of the draft report are just as true now as they were when the delegation was made, and they justify continuance of the delegation.

We endorse the proposal of the Social Security Administration that the Railroad Retirement Board--Travelers arrangement be used as an experiment for determining physician fees. Suggestions have been made to Social Security for an experimental approach along the lines mentioned in their comments.

The potential for savings in administrative costs that the report finds for the transfer of Travelers' work may be applied as well to other carriers. More important considerations of service to beneficiaries, and the need for comparative analysis of performance, appear to have been behind contracts by Health, Education and Welfare with as many as 50 carriers. (cf Reports of House Ways and Means Committee No. 213, Page 46, and Senate Finance Committee No. 404, Part I, Pages 53-54, on H.R. 6675 of the 89th Congress, 1st Session.)

Progress is being made in bringing about greater uniformity between reasonable charge determinations of Travelers and area carriers. The disparities reported by GAO between reasonable charge determinations of Travelers and area carriers are for a small sample of cases and not necessarily representative of the whole distribution of charges and

services for all area carriers and Travelers. Nevertheless, action is being taken with the cooperation of SSA to provide for greater sharing of customary and prevailing rate information by area carriers with Travelers. Contracts with carriers now provide specifically for the release of this information to Travelers.

We are reasonably confident that Travelers' performance has improved and will continue to improve in the areas in which the report indicates improvement is needed.

On the basis of the evidence so far submitted, the Board firmly supports the continuance of the delegation.

Sincerely yours,

Howard W. Habermeyer
Chairman

THE TRAVELERS

THE TRAVELERS INSURANCE COMPANY

GROUP DEPARTMENT

ONE TOWER SQUARE
HARTFORD, CONNECTICUT 06115

December 7, 1970

Mr. Philip Charam
Associate Director, Civil Div.
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Charam:

Attached are The Travelers comments on the GAO report Opportunity To Reduce Costs Of The Medicare Program Through The Consolidation Of Claims Processing Activities.

It is our understanding with Mr. Louis Lucas of your office that these comments will be inserted as an appendix to the report.

Sincerely yours

J.E. Carter

LEC:O
Enc.

L. E. Carter
Secretary
Medicare

cc: Mr. Louis Lucas
U.S. General Accounting Office
1903 John F. Kennedy Federal Bldg.
Government Center
Boston, Massachusetts 02203

The Travelers Insurance Company
Comments on General Accounting Office Draft Report
Entitled: "Opportunity to Reduce Costs of the Medicare
Program Through The Consolidation of Claims Processing Activities"

We appreciate this opportunity to comment on the General Accounting Office Report. Although we feel that our comments previously made to the Draft Report of October 31, 1969 remain valid, changes have occurred in both the Medicare Program and the administration of it since that time.

The report reaches the conclusion that the responsibilities of The Travelers as carrier for the Railroad Retirement Board under Part B of Medicare should be transferred to the SSA area carrier. In reaching its conclusion, the report is concerned primarily with two areas, administrative costs and claims processing. Our comments are designed to provide additional information as to both of these areas and are brief due to our previous comments on the earlier draft.

In developing its position that transfer of the RRB-related claims to the SSA area carriers will result in a reduction in benefit payments under the program, the report relies on the premise that because in some areas volume is relatively low (in connection with RRB-related Medicare claims) The Travelers is unable to produce sufficient data as to physicians customary charges, thus resulting in a lack of substantial reasonable charge profiles.

Having reached this conclusion based upon a survey of four field offices of The Travelers and corresponding claim offices of SSA area carriers, the report then utilizes Bureau of Health Insurance statistics on reasonable charge determinations to project reductions in benefit payments. As to the survey utilized in the report, given the nature of medical care, neither the size of the sample (.022% of the universe) nor the sample selection process produce a satisfactory reliability level for purposes of projection. Variations in conditions between offices are shown by the fact that the average dollar per claim reduced in The Travelers offices selected was $9.97, whereas the national average for all Travelers offices was $17.52.[1] Also, we have not been convinced that the comparison process itself - involving review by area carriers of claims previously processed by The Travelers - did not contain a built-in bias due to knowledge by area carriers of the purpose of the review and that these specific determinations by the area carriers would themselves be subject to General Accounting Office review. Also, since many claims fall into a judgment area (whereunder, for example, consideration as to effect on beneficiaries must be taken into account) a carrier making determinations without having to consider effect of the determination on beneficiaries, vendors, etc., could not be expected to carry out the claims processing function in complete routine.

[1] GAO note: These reduction amounts are not on a comparable basis to the average reductions per allowed claim for Travelers shown on the table on page 28.

Bureau of Health Insurance statistics utilized in the report in projecting savings show only the average reduction in physician charges per claim. Therefore, they do not show total charges made by the physicians nor the amount paid on the charges. This is significant for statistics are available (c.f. Senate Finance Committee Staff Report - Feb. 7, 1970, Table II) which indicate that charges made to RRB-related beneficiaries tend to be less than those made to SSA-related beneficiaries.[1]

Also, the GAO report itself shows total lower payments per enrollee for RRB-related beneficiaries than for SSA-related beneficiaries (RRB-related beneficiaries payments accounted for 4.2% of total payments in Fiscal Year 1968 and 4% of total payments in Fiscal Year 1969, whereas such beneficiaries account for 4.3% of total beneficiaries).

Overall, various factors and statistics support the possibility that there may be sufficient differences between RRB-related beneficiaries and SSA-related beneficiaries based upon economic and other reasons which run counter to attempts to treat the two groups as equal.

The low volume of RRB-related claims in some areas is stressed as the key factor in The Travelers inability to produce customary charge profiles acceptable to the General Accounting Office. The Travelers agrees that its profiles in low volume areas would be significantly improved by the addition of information as to reasonable charges from the area carriers. Cooperation between the RRB carrier and the SSA carriers was called for in the original delegation of authority and there has been significant cooperation. However, in order to stimulate cooperation, in negotiating revised contracts for all carriers effective July 1, 1970, SSA included a specific provision for transfer of data between SSA carriers and the RRB carrier. This specific contractural obligation to exchange necessary data has already produced significant increased cooperation between The Travelers and area carriers. Full cooperation between The Travelers and area carriers will result in minimal differences in reasonable charge determinations.

In addressing itself to administrative costs, the report acknowledges that The Travelers performance compares favorably with other carriers, as is indicated by SSA figures as to ratio of administrative costs to benefits and unit costs per payment record. However, the report states the central issue as one of potential savings through application of incremental costs theories of accounting rather than the relative efficiency of The Travelers and area carriers. This approach goes beyond the proper scope of our response; however, it should be indicated that to a greater or lesser degree this concept could be applied to the consolidation of any area carriers activities into those of any other area carrier.

In estimating savings as to administrative costs the same offices of both The Travelers and the area carriers as used with respect to reasonable charge determinations were surveyed and compared. Here

[1]GAO note: The statistics cited relate to fiscal year 1968 claims activity.

again, statistics can be pointed to which run contrary to the results projected (e.g., for the first three quarters of Fiscal Year 1969, the national average for administrative costs per payment record increased from $3.06 to $3.14, whereas comparable figures for the states sampled decreased from $2.84 to $2.78; also, the cost per payment record for The Travelers offices sampled was substantially higher than The Travelers actual overall figures).

Several specifics concerning projected savings of administrative costs are commented on as follows:

In the area of direct claim costs, the report concludes that claims processing of RRB-related claims can be assumed by area carriers "with little or no increase in claims processing personnel and no increase in indirect or supervisory personnel or office space." This area accounts for the most important portion of projected savings and is based upon application of "incremental costs" theories.

According to the report the average workload increase of area carriers in assumption of RRB-related claims would be within average workload fluctuations and therefore can be assimilated with the above results. This application is contrary to normal budget routines in the Medicare Program. Further, we feel any such increase would in fact increase the base from which fluctuations are determined and not be merely handled within fluctuations, thereby increasing both direct and indirect costs of the area carrier. Equally as important, any average workload increase figure appears meaningless in this situation since the percentage increase with respect to each carrier must be taken into account in considering the effect on its operation.

The report indicates the second largest element of cost where there is potential cost savings is that of data processing. It states that the incremental computer running time of area carriers for assumption of RRB-related claims would be negligible and therefore assumes that a substantial portion of present Travelers RRB-related claims costs in this area would be avoided. Assuming average efficiency of all carriers and equivalent computer running time costs it is difficult to foresee any savings in this area. Also, since The Travelers is an SSA area carrier it must have computer capability established and in fact utilizes the same computer programs in processing both RRB- and SSA-related claims. In the data processing area as in other areas costs of The Travelers are shared by SSA and RRB. Although the report acknowledges that certain costs are shared and that those costs would not be eliminated, but only transferred to SSA, it does not fully take into account the amount of shared costs which would not be eliminated.

As indicated in the report, The Travelers had previously questioned projected savings in indirect administrative costs upon transfer of functions from The Travelers on the theory that such costs could well be a function of direct labor costs in the area carriers accounting. Nevertheless, the report projects savings on the theory that there would be no increase in area carriers general and administrative expenses despite the fact that, according to the report itself, only two of the four carriers surveyed support this premise.

In conclusion, while we feel that the General Accounting Office's study will be a stimulus to continuous review of program performance, the above comments, as summarized in part in the table below (figures taken from GAO's report) show that The Travelers performance on RRB-related claims has been efficient and economical. Further, that benefit payments to RRB-related beneficiaries are not greater than those for SSA-related beneficiaries.

ITEM	NUMBER		PERCENT	
	All	Railroad	All	Railroad
Enrollees	18.9 million	810,000	100%	4.3%
Benefit Payments				
1968	$1.3 billion	$55 million	100%	4.2%
1969	$1.5 billion	$60 million	100%	4.0%
Administrative Costs				
1968	$100 million	$4.2 million	100%	4.2%
1969	$118 million	$4.5 million	100%	3.8%

PRINCIPAL OFFICIALS OF THE DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE AND THE RAILROAD RETIREMENT BOARD RESPONSIBLE FOR THE ADMINISTRATION OF THE MEDICARE PROGRAM

	Tenure of office	
	From	To
SECRETARY OF HEALTH, EDUCATION, AND WELFARE:		
Elliot L. Richardson	June 1970	Present
Robert H. Finch	Jan. 1969	June 1970
Wilbur J. Cohen	Mar. 1968	Jan. 1969
John W. Gardner	Aug. 1965	Mar. 1968
COMMISSIONER OF SOCIAL SECURITY:		
Robert M. Ball	Apr. 1962	Present
CHAIRMAN, RAILROAD RETIREMENT BOARD:		
Howard W. Habermeyer	Nov. 1956	Present

U.S. GAO Wash., D.C.