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

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The Honorable James A. Haley
House of Representatives

Dear Mr. Haley:

This is in response to your request that we investigate complaints about the performance of Blue Cross and Blue Shield of Florida under the Federal Employees Health Benefits Program. The complaints were related primarily to delayed payment of claims, delayed and unresponsive replies to inquiries about claims, and confusing information about benefits.

We found that the complaints generally were justified and we made suggestions to Blue Cross and Blue Shield of Florida for improving their performance. As a result, some actions have been taken and others are planned which, if effectively carried out, should improve the quality of service provided to program beneficiaries in Florida.

The Civil Service Commission contracts with the Blue Cross Association and the National Association of Blue Shield Plans for the Service Benefit Plan of the Federal Employees Health Benefits Program. The associations in turn contract with 147 local Blue Cross and Blue Shield organizations to administer the plan. Blue Cross and Blue Shield of Florida administer the Service Benefit Plan for about 187,000 program participants in Florida.

Blue Cross pays for hospital costs, such as room and board, general nursing services, operating and recovery room fees, and medications received while in the hospital. Blue Shield pays for, as basic benefits, physician fees for inpatient services and certain outpatient services, such as X-ray and laboratory services. Blue Shield supplemental benefits cover the cost of prescription drugs, ambulance service, and certain physician and hospital services not covered by basic benefits. Separate departments process basic claims and supplemental claims.

During fiscal year 1975 Blue Cross and Blue Shield of Florida processed 367,200 claims and paid more than $40 million in benefits for the Service Benefit Plan, as follows:

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	Number of claims	Benefits paid
Blue Cross	95,819	$24,573,086
Blue Shield basic	219,128	12,771,859
Blue Shield supplemental	52,253	2,773,909
Total	367,200	$40,118,854

The cost to administer the plan was $2 million, or about 5 percent of benefits paid.

CLAIMS PROCESSING

Since the complaints about delayed payment of claims related only to Blue Shield claims, we did not review this aspect of Blue Cross. The standard for acceptable performance for claims processing, established by the National Association of Blue Shield Plans, provides that 90 percent of basic claims and 85 percent of supplemental claims be processed within 14 days.

We found no serious problems regarding the timeliness of processing supplemental claims. From May through September 1975 the Supplemental Department processed 72 to 76 percent of its claims within 14 days and during October 1975, 87 percent were processed within 14 days. From July 1974 through July 1975, the average processing time was 16 days, with monthly performance ranging from 23 days for January 1975 to 12 days for July 1975.

The Basic Department, however, fell far short of the National Association's standard. From May through October 1975, its monthly performance rate for claims processed within 14 days ranged from 12 to 55 percent. From July 1974 through July 1975, the average processing time for basic claims was 22 days, with monthly performance ranging from 17 days for November 1974 to 29 days for March 1975.

Reasons for delays

The relatively long time required by the Basic Department to process claims was attributed to high personnel turnover, lack of written procedures for newer employees, certain claims-processing procedures, excessive computer errors on claims data, and inadequate controls over claims received.

Personnel turnover

During fiscal year 1975 the personnel turnover rate for the Basic Department was 120 percent. The reasons former employees gave for leaving, as recorded in personnel records, revealed no particular reason for the high turnover rate. In a report on Medicare Part B claims processing by Blue Shield of Florida 1/ we noted that one apparent cause for the high turnover for Medicare claims examiners was their low pay as compared to claims examiners in other parts of the organization. This was not a factor in the turnover of Basic Department claims examiners, however, as they have always been paid at the highest level for that position.

Blue Shield officials believed that the high turnover rate for the Basic Department was caused by required overtime, which averaged 1.4 hours a day for each employee. In addition to requiring overtime, the Basic Department borrowed employees from other departments. In fiscal year 1975 borrowed services added an average of 95 hours a week to the Basic Department's work force.

The problems caused by inexperienced personnel resulting from the high turnover rate and the use of borrowed employees was compounded by the lack of written procedures for employees to follow in processing claims. Procedures were passed along by word of mouth.

A potential solution to the personnel problems would be to hire additional personnel to reduce the need for overtime and borrowed employees. An October 1975 study by Blue Cross and Blue Shield of Florida showed that the Basic Department needed 16 more employees to process claims in a timely and efficient manner. This conclusion was supported, in part, because even with the use of overtime and borrowed employees, the claims backlog was not eliminated.

After completing our fieldwork, Blue Shield officials said that they had hired 16 additional employees to process claims in the Basic Department. In addition, Blue Shield established a task force of nine people and trained them in claims processing for all Blue Shield of Florida plans, including the Service Benefit Plan. Task force members will

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1/"Delays In Processing Medicare Part B Payments To Program Participants In Florida," MWD-76-70, March 19, 1976.

fill temporary vacancies or assist in claims processing. When not working in claims processing, they will perform management studies. We were told also that written procedures would be developed for processing claims.

Processing procedures

Payment of claims was delayed when (1) processing of certain basic claims was suspended until Blue Cross processed the related claim for hospital costs, (2) claims contained both basic and supplemental charges, and (3) claims were received from persons covered by both Medicare and the Service Benefit Plan.

Diagnostic and custodial care are not covered benefits under the Service Benefit Plan. Blue Shield officials suspect that any hospital stay of less than 5 days may be for diagnostic purposes and that any stay exceeding 20 days may be for custodial purposes. Therefore, claims for physician services associated with hospital stays of these durations are not paid until Blue Cross processes the related hospital claim, which indicates that the care was not for custodial or diagnostic purposes. However, the lack of communication between Blue Cross and the Blue Shield Basic Department, as well as their failure to update computer files to show that Blue Cross had processed the claims, resulted in claims being suspended for unreasonable lengths of time.

In September 1975 we aged the unpaid Blue Shield basic claims awaiting Blue Cross disposition of related hospital costs. We found that 617 of the 674 unpaid claims were over 30 days old. (Five of the claims had been received in late 1974.) A review of the related Blue Cross claims showed that 283 had been processed and, therefore, the Blue Shield basic claims which had been suspended could have been processed. We suggested to Blue Shield officials that if Blue Cross has not processed its related claim after a reasonable length of time, the Basic Department should determine whether the claim should be paid and resume processing it. In December 1975 Blue Shield officials informed us that procedures had been changed and that when Blue Cross does not dispose of the related hospital claim within 30 days, Blue Shield determines whether the claim should be paid and, if so, resumes processing.

A second procedure that delayed payment involved claims containing both basic and supplemental charges. When the Basic Department receives such a claim, the basic benefits are paid. At the time of our review the subscriber was not notified to submit a separate claim for supplemental benefits; however, plans have been made to do so after July 1976. Blue Shield officials said that they could not process the supplemental benefits because they did not know whether the deductible requirements for supplemental benefits had been met. Basic benefits, however, are payable in full and apparently could be paid when they were included on supplemental claims.

When the Blue Shield Supplemental Department received a claim containing both basic and supplemental charges, only the supplemental charges were processed. Rather than preparing a basic claim for the remaining items and handing it to the Basic Department (located across the aisle), the Supplemental Department rejected the basic charges and sent a message to the subscriber stating that if the basic charges have not been reported previously, a separate claim should be submitted.

At our request, Blue Cross and Blue Shield officials studied the percentage of supplemental claims containing both basic and supplemental charges and whether separate claims had been made for the basic charges. Of 1,315 supplemental claims sampled, 376 were a combination of basic and supplemental charges. However, for 305 of the 376 claims, separate claims for the basic charges had been submitted by the subscriber and the claims were being processed.

Based on the study's results and the number of supplemental claims processed in fiscal year 1975 (52,253), the Supplemental Department would have to prepare less than 3,000 basic claims a year for those subscribers who might not understand that separate claims should be submitted for basic and supplemental benefits. We suggested to Blue Shield officials that basic claims be prepared by the Supplemental Department and forwarded to the Basic Department for processing when basic benefits are included on supplemental claims. They told us that the suggestion would be considered.

The third procedure that delayed payments involved claims from persons covered by both Medicare and the Service Benefit Plan. Claims were sent first to the Medicare carriers for payment of all costs covered by Medicare. The Medicare carriers then sent--to Blue Shield and to the subscribers--copies

of the Explanation of Medicare Benefits form which shows what was paid by Medicare and the reasons for nonpayment of claims.

At Blue Shield the forms were delivered to the Basic Department which paid any basic benefits due. However, if the form showed that the subscriber was entitled to supplemental benefits, these were not paid and the subscriber was not told of his entitlements. Between July 15 and August 15, 1975, 2,373 Explanation of Medicare Benefits forms were received in the Blue Shield Basic Department and 884 (37 percent), contained both basic and supplemental charges. Basic benefits of $36,800 were paid but the supplemental benefits of $11,600 were not.

Since Blue Shield waives the deductible and coinsurance requirements for supplemental benefits for enrollees also covered by Medicare Part B, Blue Shield should pay the supplemental benefits due. We discussed this with officials of the Blue Cross and Blue Shield Association responsible for the Federal Employees Health Benefits Program. After this discussion, all local Blue Shield Plans were notified that, effective January 1, 1976, claims received from Medicare Part B subscribers should be processed as supplemental claims. Thus, subscribers should receive payment for all basic and supplemental benefits not paid by Medicare without having to file both basic and supplemental claims.

Computer errors

When incorrect claims information is put into the computer, such as the wrong subscriber identification number or plan option code, the computer rejects the claim and further processing is suspended until the information is corrected.

Our analysis of 100 claims requiring over 30 days to process showed that the computer rejected 92 of them 168 times, with an average delay of about 6 days for each rejection.

Blue Shield officials attributed this problem primarily to (1) a lack of trained keypunch personnel recording information before computer processing and (2) problems resulting from a change in computer equipment about July 1975. Computer personnel were not familiar with the new equipment which initially did not function properly. Blue Shield officials said that these problems have been resolved.

Claim control

The Blue Shield departments had no procedures to insure that claims received were processed or that claims were processed on a first-in-first-out basis. Blue Shield officials said this lack of claim control was a problem, since it sometimes entailed considerable effort to locate claims that subscribers had inquired about. However, the officials did not believe the problems were important enough to warrant the added cost of additional controls.

To determine whether claims were being misplaced, we identified 300 claims and, 1 month later, tried to locate them in the processing system. We found all but 13 (about 4 percent). These claims could have been misplaced or returned to subscribers for additional information.

Although claim loss does not appear to be a major problem, we believe that the Blue Shield departments should insure that claims are processed on a first-in-first-out basis.

Blue Shield officials told us that by July 1976 claim processing for the Service Benefit Plan will be incorporated into a new automated system developed for the Blue Cross and Blue Shield private plans. This should provide the improvements needed in claim control, such as computerized information on outstanding, paid, rejected, and aged claims.

CORRESPONDENCE

Many beneficiaries complained that Blue Cross and Blue Shield replies to inquiries were untimely and that Blue Shield's replies were also frequently confusing and unresponsive. We found that Blue Shield's replies to subscribers' inquiries generally were made within a reasonable time. However, Blue Cross correspondence was backlogged and the response time was excessive. Unresponsive and long-delayed replies caused subscribers to write a second time, creating additional paperwork and further delays.

Correspondence processing time

Standards established by the National Association of Blue Shield Plans and the Blue Cross Association for correspondence provide that performance is acceptable when 85 percent of inquiries are replied to within 7 days and all are replied to within 30 days.

Our review of 99 inquiries from enrollees in the Service Benefit Plan about Blue Shield benefits disclosed that the average processing time was 17 days and that 27 percent were replied to within 7 days and 92 percent within 30 days. Although this did not meet the national standards, we considered it reasonable.

Blue Cross' correspondence department processes letters for several Blue Cross plans, including the Service Benefit Plan. Two clerks were assigned to handle Service Benefit Plan correspondence. One clerk researched the data needed for answering inquiries and the other dictated the replies.

Inquiries were filed alphabetically rather than by date received, with no control system to insure that replies were made within a reasonable period or at all.

To determine the average processing time--mailroom receipt date to reply letter date--we sampled 98 replies written between March 31 and August 11, 1975. The average processing time was 46 days.

According to Blue Cross officials, a high turnover of research clerks caused the excessive processing delays. Most research clerks stayed less than 5 weeks. This continuous rotation of research clerks caused an excessive accumulation of correspondence to be researched which, in turn, delayed responses. As of July 18, 1975, the correspondence backlog was 854 inquiries.

Blue Cross management was not aware of this backlog because information on correspondence for the Service Benefit Plan was merged with information pertaining to other plans. We discussed the correspondence backlog problem with Blue Cross officials. As of November 1975 the following actions had been taken.

--Statistical data for Service Benefit Plan correspondence was reported separately from the other plans.

--Controls had been established to insure a response to all correspondence.

--The backlog had been reduced to about 200 pieces of correspondence, none of which was over 14 days old.

--Three new pieces of equipment had been obtained to help speed up correspondence research.

In addition, in March 1976 Blue Cross officials said that two more correspondence clerks had been hired. We believe that the above actions should result in more timely responses to subscribers' inquiries.

Adequacy of replies

The complaints about unresponsive replies pertained only to Blue Shield. Therefore, we did not review the adequacy of Blue Cross replies to inquiries.

Because of the complexity of the Service Benefit Plan, explanations of payment denials or the need to resubmit claims should be explicit. For example, different claim forms are used for basic and supplemental benefits, and each is processed by a separate Blue Shield department. Claims submitted on the wrong forms are rejected and returned with an explanation that the claim be resubmitted to the appropriate Blue Shield department. However, this explanation is not sufficient because not all enrollees or providers of services are aware of Blue Shield's organizational setup--two different claim departments, neither of which passes claims on to the other.

Also, some claims could be categorized as either basic or supplemental, depending on the circumstances. For instance, doctors fees connected with a medical emergency are covered under basic benefits. However, if Blue Shield determines it is not a medical emergency, the claim may be covered under supplemental benefits. Other types of benefits which may be paid under basic or supplemental, depending on the circumstances, include X-ray, laboratory, and pathological services and machine diagnostic tests.

We reviewed Blue Shield correspondence files on 103 inquiries to determine the adequacy of the replies. The files were randomly selected from Blue Shield's correspondence dated August 11 through October 2, 1975.

We considered Blue Shield's replies to be unresponsive or inadequate in 31 (30 percent) of the cases. The following are examples of some replies.

1. By a letter dated August 15, 1975, a subscriber asked why a claim for hospital and doctor bills submitted in April 1975 had not been paid. Blue Shield replied that the doctor bills could not be paid until Blue Cross paid the hospital bill. No explanation was given as to why the hospital bill had not been paid or why the doctor bills could not be paid until after the hospital bill was paid.

2. After a claim had been rejected, the doctor gave additional information including the reason for the services performed. The claim was rejected again, but the letter to the subscriber gave no explanation for the rejection or for why the doctor's information was unacceptable.

3. After a claim had been rejected, the subscriber and doctor gave a detailed explanation for laboratory tests questioned by Blue Shield. Blue Shield rejected the claim again, informing the subscriber that it would reconsider the claim if the doctor would tell them the diagnosis or symptoms necessitating the services--information that the doctor had already provided.

Inadequate or unresponsive replies result in additional correspondence and lengthy delays in processing claims as indicated by excerpts from subscriber letters.

--"Two months have passed * * *. I feel that I am at least entitled to an acknowledgement of my June 23 letter and claim."

--"Enclosed are copies of claims we have submitted and resubmitted and your replies regarding them. This has now been going on for nine months * * *."

--"The attached bills have been submitted over and over again with a form completed each time. * * * I cannot understand what the delay and confusion is."

In March 1976 Blue Shield officials said that they had hired three additional people to work on Blue Shield correspondence, including one person to review, on a sample basis, outgoing correspondence to insure that inquiries were adequately answered.

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Our findings at Blue Cross and Blue Shield of Florida have been brought to the attention of the Civil Service Commission for followup during their periodic audits of Blue Cross and Blue Shield plans.

Sincerely yours,

Comptroller General
of the United States