BY THE U.S. GENERAL ACCOUNTING OFFICE

Report To The Chairman, Subcommittee
On Commerce, Transportation And Tourism
Committee On Energy And Commerce
House Of Representatives

Use Of A Separate Carrier To Process Medicare Claims For Railroad Retirement Beneficiaries

This report updates the findings and conclusions of a previous GAO report. That report recommended that the Medicare claims for physicians' and other medical services applicable to beneficiaries of the Railroad Retirement Board be processed by the same contractors that process such claims for most other Medicare beneficiaries. Since the inception of Medicare, the claims of the railroad beneficiaries have been processed by a separate carrier. GAO believes that its earlier recommendation is still valid and would result in estimated annual savings of about $6 million.

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HUMAN RESOURCES
DIVISION

B-216368

The Honorable James J. Florio
Chairman, Subcommittee on Commerce,
Transportation and Tourism
Committee on Energy and Commerce
House of Representatives

Dear Mr. Chairman:

This report is in response to your letter of August 22, 1983, requesting that we update and analyze the findings and conclusions in chapter 9 of our June 1979 report on Medicare claims processing.[1] This chapter pointed out that Medicare's annual administrative costs could be reduced about $6.6 million by eliminating the Railroad Retirement Board's (RRB's) contracting authority, which has been used since the inception of Medicare[2] to contract with the Travelers Insurance Company to serve as the national carrier for RRB part B beneficiaries.[3] Most

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[1]More Can Be Done to Achieve Greater Efficiency in Contracting for Medicare Claims Processing (HRD-79-76, June 29, 1979).

[2]The Social Security Amendments of 1972 (Public Law 92-603) provided RRB with contracting authority. Previously this authority was pursuant to a delegation of authority from the Secretary of the Department of Health, Education, and Welfare; now the Department of Health and Human Services (HHS).

[3]Medicare has two parts. Part A--Hospital Insurance for the Aged and Disabled--principally covers inpatient hospital care and is primarily financed by taxes on earnings paid by employers, employees, and self-employed persons. Part B--Supplementary Medical Insurance for the Aged and Disabled--generally covers 80 percent of the reasonable charges or costs for physicians' and other medical and health services subject to an annual $75 deductible. Enrollment in part B is voluntary, and it is mostly financed by beneficiaries' monthly premium payments and appropriations from the general revenues of the U.S. Treasury. For 1983, about 22 percent of the income to the part B trust fund represented beneficiary premiums, about 74 percent represented appropriations, and the other 4 percent represented income on trust fund investments.

other part B beneficiaries use area carriers under contract with the Health Care Financing Administration (HCFA) that serve specific geographical areas, such as a state.

In addition to updating our June 1979 study and analyzing the results, you also asked that we consider the following factors:

--the advantage to RRB beneficiaries of having a single carrier nationwide;

--the importance of a competitive bidding framework for choosing a contractor, whether the choice is made by HCFA or RRB;

--whether the ability of RRB to choose the contractor and the requirement that HCFA provide reimbursement creates any disincentives to cost efficiency; and

--whether Travelers' participation in other insurance programs provided to employees in the railroad industry and the institutional arrangements, both formal and informal, create any disincentives for efficiency.

This response consists of two parts--one part essentially updates the data used in our June 1979 report to the Congress and is presented in more detail in appendix I. The second part responds to the four additional factors specifically listed in the request.

OBJECTIVES, SCOPE, AND METHODOLOGY

Our objectives were to update the data used in our June 1979 report and analyze these data as they related to the four factors listed in the request. The principal data sources used were HCFA's carrier workload reports, administrative cost reports, and quality assurance reports. We did not independently verify these reports. Because of the time and costs involved, we did not update our June 1979 report with regard to (1) developing beneficiary and provider questionnaires to determine the level of satisfaction with Travelers' services or (2) measuring the extent of variation between Travelers-RRB and the area carriers in determining payment amounts for the same services by the same providers. In updating the information

from the area carriers on the number of misrouted claims,[4] we attempted to use the same carriers used in our June 1979 report; but this was not always possible because of carrier reconfigurations, such as changes in area designations since that time.

In addition, we reviewed the legislative changes to Medicare since 1979 to determine the extent that such changes and their implementing regulations and instructions could affect our prior findings and conclusions.

We also considered the report of the President's Private Sector Survey on Cost Controls, commonly known as the Grace Commission, dated May 26, 1983, as it related to the issues in the Subcommittee request and the July 20, 1983, communication to the Subcommittee outlining Travelers' reasons for rejecting HCFA's proposal to shift RRB part B claims processing to its area carriers.

Except as noted above, our review was made in accordance with generally accepted government auditing standards.

UPDATING DATA USED IN THE JUNE 1979 REPORT

Briefly restating our June 1979 report, we pointed out that between September 1976 and March 1978, Travelers had consolidated its RRB claims processing activities from 62 field offices to 5 regional claims processing centers[5] at a cost of about $4.8 million. As a result, in fiscal year 1978 the accuracy and timeliness of RRB claims processing activities compared favorably with the national averages for HCFA area carriers.

Further we reported that in fiscal year 1978, the trend of escalating RRB claims processing unit costs from one year to another since 1974 had been reversed, but that RRB's unit cost was still $1.06 per claim above the national average cost per claim of $2.84. We estimated that savings of at least $6.6 million in fiscal year 1979 and each subsequent year could be realized if HCFA area carriers processed the RRB workload. The $6.6 million estimate consisted of (1) $5.4 million representing the lower

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[4]These are RRB-related claims which are sent to the HCFA area carriers by mistake and need to be rerouted to Travelers for processing.

[5]Augusta, Georgia; Albany, New York; Salt Lake City, Utah; Lansing, Illinois; and Garland, Texas.

incremental cost[6] for the area carriers to absorb the RRB workload and (2) $1.2 million by eliminating misrouted claims.

These savings estimates were based on studies at 14 area carriers to determine the additional total costs each would incur in fiscal year 1979 if they were to process the relatively small volumes of RRB claims in their service areas and the additional costs to be incurred in 1979 for handling misrouted RRB claims. These studies showed that (1) because certain types of total carrier costs do not vary much with workload, the incremental costs of such small workload increases would be 66 percent of the area carriers' overall average costs and (2) their costs of misrouted claims were about $1 a claim.

We analyzed updated statistics through fiscal year 1983. This analysis showed that since 1978, Travelers' error rates ranged from about 0.4 to 1.0 percent of submitted charges, lower than the national error rates for all carriers as measured by HCFA's quality assurance program. However, the differences in average claims processing times had changed from Travelers-RRB being 5 days shorter than the area carriers in 1978 to being 1 day longer in 1983;[7] further, since 1978, Travelers' average unit cost per claim had dropped from $3.90 in 1978 to an estimated $2.55 in 1983. The area carriers' average unit costs had also decreased from $2.84 to $2.31 per claim in 1983; therefore, the difference decreased from $1.06 per claim to $0.24 per claim. There was a 63-percent increase in the RRB claims volume, from 3.5 million claims in 1978 to 5.6 million claims in 1983.[8]

There have been two methods used to estimate savings which might result from using HCFA area carriers to process the RRB

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[6]Incremental costs are the difference between total costs projected at increased volume levels. Incremental unit costs are the difference in the total costs divided by the difference in claims volume. For example, if a carrier with a volume of 100,000 claims could process 10,000 more claims at an increased total cost of $10,000, the incremental unit cost would be $1.

[7]The Travelers-RRB claims processing times are understated because they do not include the time lost for rerouting the misrouted RRB claims.

[8]Since 1970, the RRB claims workload had generally increased from 8 to 12 percent each year.

workload. One method simply projects the above difference between the average costs per claim to the RRB claims volume. For 1983, this method produces an estimated savings at $0.24 a claim, or $1.3 million. In our opinion, a more realistic method used in our 1979 report projects the difference between the Travelers-RRB cost per claim and the area carriers' incremental cost per claim to the RRB claims volume.

Because the relationship between the area carriers' workload-related costs per claim (such as claims review, data entry, and computer usage) and their total administrative costs per claim has not significantly changed since 1979, we believe that our prior incremental cost studies at the 14 carriers are still valid. Therefore, applying the 66-percent factor to the area carriers' average cost per claim of $2.31 for 1983 produces an estimated savings at $1.03 a claim, or about $5.8 million.

Regarding the problem of misrouted claims in our 1979 report, we estimated that for fiscal year 1977, about 31 percent of Travelers-RRB claims had originally been sent to the area carriers and then rerouted to Travelers for processing. For 1982, this incidence of misrouted claims had been reduced to 20 percent; however, because of the increase in the RRB claims volume, the number of misrouted claims and the probable additional costs to the area carriers of $1.2 million has remained about the same. We characterized this estimate as "probable" because we did not obtain current data as to when the misrouted claims were identified during the area carriers' claims processing cycle as was done for our 1979 report.

Travelers, in commenting on our June 1979 report, in its July 20, 1983, letter to the Subcommittee, and in our recent discussions with its officials, has emphasized that the estimated budgetary savings in administrative costs to be realized by having HCFA area carriers process the RRB workload (based on the difference in the average cost per claim method) would be more than offset by higher "incorrect" benefit payments. The rationale for this assertion is that HCFA's part B quality assurance statistics show that the Travelers-RRB payment deductible error rates, particularly the overpayment error rates, have been less than the national average for all carriers.

Although HCFA's quality assurance statistics have shown lower payment error rates for Travelers-RRB, there are two factors which negate the relevance of these statistics for estimating budgetary savings. First, Travelers-RRB uses its historical claims data on providers' charges to determine payment amounts. Because Travelers has such a low volume of claims in

any particular area as compared with the HCFA area carrier, these amounts often differ from those based on historical claims data used by area carriers to determine their payment amounts for the same services by the same providers. Our June 1979 report, which illustrates this point, showed that of the claims sampled, Travelers-RRB, using its historical charge data, paid different amounts than the area carriers would have paid about 80 percent of the time.[9] Because carriers' payment "errors" are measured against their respective historical charge data, the differences between the Travelers-RRB and the area carriers' data bases are not considered in developing the error rates. Thus, by comparing Travelers-RRB lower error rates to the national average error rates, it does not necessarily follow that if the area carriers made the payments on the same claims, as Travelers does now, the payments would be more than the payments made by Travelers.

Second, even if such statistics could be used to make valid comparisons and projections for budgetary savings purposes, we believe that it is unrealistic to consider overpayments alone. Overpayments would have to be offset by underpayments, and such an analysis would show little, if any, budgetary savings from Travelers' better payment error rates.

Because of these factors, we believe that Travelers' claimed budgetary savings in benefit payments are not supportable due to limitations in the methodology used to compute them.

Finally, according to Travelers, Medicare would have to pay over $1 million in termination costs if the RRB arrangement were canceled. Any termination costs would decrease the first year savings by an equal amount.

In summary, although the unit cost difference between Travelers-RRB and the HCFA area carriers has been significantly narrowed since our 1979 report, the potential savings through consolidating the RRB workload with the rest of Medicare's workload remain about the same under the incremental cost method principally because of increased RRB claims volume and reductions in the HCFA carriers' average unit costs.

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[9]The total amounts where the area carriers would have paid lower amounts than Travelers-RRB were about the same as the total amounts where the area carriers would have paid more; thus, on an aggregate basis the total payment amounts were about the same.

RESPONSES TO SPECIFIC FACTORS

The following summarizes our evaluation of the four issues listed in the Subcommittee request.

Advantages to RRB beneficiaries of having a single nationwide carrier

The differences in performance between Travelers-RRB and the area carriers with regard to the accuracy and timeliness of claims processing activities have usually been expressed in terms of national averages. However, there may be advantages or disadvantages to individual beneficiaries, depending on where they live. Some area carriers have better performance statistics than Travelers-RRB, whereas most others do not. For example, Travelers is also the HCFA area carrier for Mississippi and parts of Virginia and Minnesota, but in these areas it processes the RRB beneficiary claims under its RRB contract through several of its regional processing centers. A comparison of its performance statistics as an area carrier and under the RRB contract for fiscal years 1982 and 1983 is shown in the following table.

Travelers as a Medicare carrier for	Payment/deductible error rate[a]		Average claims processing time	
	1982	1983	1982	1983
	----(percent)-----		----(days)-----	
Minnesota	0.5	0.6	5.2	5.8
Virginia	0.7	0.9	4.8	5.7
Mississippi	1.4	1.4	4.9	6.5
RRB	0.8	1.1	7.7	11.1

[a]See definition on page 2 of appendix I.

This comparison indicates that in terms of accuracy and timeliness, Travelers often has better performance statistics as an area carrier than it does as the nationwide carrier for RRB beneficiaries. Thus, RRB beneficiaries living in these areas could be disadvantaged by the single nationwide carrier arrangement.

On the other hand, because of substandard service by HCFA area carriers for a 2-year period during 1979 through 1981 in Illinois and for a 6- to 9-month period starting in 1981 in Texas, we believe that it was clearly advantageous for RRB beneficiaries in those states to have a separate carrier.

An important advantage to RRB beneficiaries cited by the railway industry is that Travelers offers insurance which supplements Medicare[10] and the nationwide carrier arrangement facilitates the coordination of benefit payments. According to Travelers officials, as of August 1983, about 25 percent of RRB beneficiaries had supplemental health insurance with Travelers; however, according to the Congressional Budget Office (CBO), about 66 percent of all Medicare beneficiaries have private insurance to supplement Medicare, so it seems reasonable to assume that there are a large number of RRB annuitants who have health insurance supplementing Medicare from insurers other than Travelers.

RRB has pointed out that the single nationwide carrier arrangement has facilitated the Board's effectiveness as a liaison between its beneficiaries and the carrier; however, in terms of advantages to beneficiaries, this position seems to raise the question as to whether this liaison function could not be performed just as effectively by HCFA as it does for RRB beneficiaries under the Hospital Insurance part A portion of Medicare.

Historically, however, the principal justification for the existing arrangement in terms of advantages to RRB beneficiaries as a group was summarized in the Board's comments on our June 1979 report and in the railroad labor organizations' March 1981 testimony before the Subcommittee on Health, House Committee Ways and Means, which stated:

> ". . . Many of these railroad employees are insured by one of the Travelers group policies while they are working and by one of their supplemental policies after they become eligible for Medicare. They are accustomed to dealing with The Travelers and Board personnel. If area carriers were to process railroad Medicare medical insurance claims, railroad employees and beneficiaries would be required to deal with a new organization; this could be a difficult and confusing experience for railroad senior citizens."

Although we cannot quantify the impact of this continuity of service and convenience factor in terms of dollars, if RRB beneficiaries paid the additional costs of maintaining the existing arrangement, it would increase their monthly part B premiums by $0.10 or about $0.50 depending on the methodology

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[10]This is sometimes referred to as Medi-Gap Insurance.

used to estimate the increased cost.[11] Further, as noted in our June 1979 report, although the level of beneficiary satisfaction with Travelers' claims processing services was high, whether it would be worth a portion or all of the added cost is a matter of conjecture.

The importance of a competitive bidding framework for choosing a contractor whether the choice is made by HCFA or RRB

Traditionally, the Medicare part B carriers have not been selected through a competitive bidding process because the statute provided for cost reimbursement contracts. Although there have been several reconfigurations and consolidations of the area carrier territories, of the 39 carrier entities in place in June 1983, at least 35 have been functioning as carriers since the inception of the program.

In March 1977, using its authority to experiment under section 222 of the Social Security Amendments of 1972, HCFA initiated its first experiment with choosing a carrier under a competitive bidding framework when the incumbent carrier in Maine decided to withdraw from Medicare. Later experiments with competitive fixed-price contracting were undertaken in Upper New York State and in Illinois.[12]

RRB has never selected its nationwide carrier by competitive bidding. Therefore, there is limited experience on which to assess the relative importance of this question. Nevertheless, we believe that this factor involves essentially two different issues. One issue is whether there should be a single nationwide carrier for RRB beneficiaries; the second issue appears to involve the question of who should select the carrier and how should the selection be made--by competitive bidding or otherwise?

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[11]The monthly part B premium from July 1982 to December 1983 was $12.20. In January 1984 it increased to $14.60.

[12]These experiments are discussed in our December 1, 1981, report to the Congress entitled Experiments Have Not Demonstrated Success of Competitive Fixed-Price Contracting in Medicare (HRD-82-17).

As a practical matter, given (1) RRB's historical preference for the existing arrangement with Travelers and (2) Travelers' above average performance on factors other than unit costs, we question whether other potential contractors would be willing to expend the time, effort, and money to develop a competitive proposal if factors other than price were to be considered and RRB were to continue to make the selection.

If HCFA were to make the selection of a nationwide RRB carrier by competitive bidding under its existing experimental authority, we are uncertain as to the probable response from the contractor community.

In summary, because we believe that a single nationwide carrier for one class of beneficiaries has not proven to be the most efficient or the most economical arrangement for the government, the importance of the method of selecting such a carrier appears to us to be a secondary issue.

Whether the ability of RRB to choose the contractor while HCFA provides reimbursement creates disincentives to cost efficiency

This issue was discussed in the Grace Commission report, which pointed out that the adoption of its recommendation to remove RRB's contracting authority under part B of Medicare would improve accountability in government by removing decisionmaking power from an agency which does not have to pay for the consequences of those decisions. Although, in the past, we have not addressed the issue in these terms, we believe that, in principle, the Commission's observation has merit.

Travelers-RRB administrative costs for fiscal year 1983 were about $15.9 million and were reimbursed from the Medicare part B trust fund. These costs were included in HCFA's appropriation for program management (which totaled about $1,085 million in fiscal year 1983) just like the administrative costs of the HCFA contractors. No funds for RRB's carrier contract with Travelers were included in its 1983 appropriation limit for administration of about $47.8 million. Thus, HCFA pays for any increased administrative costs resulting from RRB's selection of the carrier.

Section 1842(g) of the Social Security Act, as amended, provides that RRB shall, in accordance with such regulations as the Secretary of the Department of Health and Human Services

(HHS) may prescribe, contract with a carrier or carriers to perform the functions set out in that section for qualified RRB beneficiaries. Accordingly, the language of the statute itself does not require a single nationwide carrier for RRB beneficiaries, but authorizes RRB to contract with the same carriers that HCFA uses. RRB has elected not to do this, however, and HCFA pays for the additional administrative costs involved. According to the President's Budget for 1985, HCFA wants its area carriers to process RRB claims instead of the separate RRB contractor. HCFA estimated a $1.5 million savings, but requires legislation to accomplish this.

In commenting on this point (see app. IV), RRB pointed out that in administering its contract with Travelers, it follows HCFA guidelines and criteria for evaluating contractor performance and coordinates its approval of Travelers' financial operating plans with HCFA. While this may be true, HCFA cannot override RRB's decision in selecting a carrier, and HCFA must pay any associated increased administrative costs resulting from RRB's decision.

The Grace Commission report offered an alternative solution by suggesting that if the railroad community wanted to maintain its separate system, it, rather than the taxpayers, could pay the additional costs.

Whether Travelers' participation in other insurance programs involving the rail industry creates disincentives to efficiency

As previously discussed, a principal justification for the existing Travelers-RRB arrangement has been that RRB beneficiaries have become accustomed to dealing with Travelers during their working years by virtue of its role as the insurer of the Health and Welfare Plan of the nation's railroads and the railway labor organizations. This relationship with the railroad industry has existed in some form since 1955. The current arrangement covering the health and welfare plan of the nation's railroads and railway labor organizations is described in Group Policy Contract GA-23000, as amended, effective January 1, 1979, issued by Travelers. This contract covers (1) life insurance and accidental death and dismemberment benefits for certain railroad employees, (2) health benefits for certain railroad employees and their dependents, and (3) life insurance benefits for retired employees.

The policy holder of this contract is comprised of railroad management and labor unions. Also, RRB's governing board includes representatives of railroad management and labor so that the principal contracting authority under both RRB's private and Medicare contracts represents essentially the same interests. Thus, dissatisfaction with Travelers' performance under either of these contracts could adversely affect the other. Although our views in this regard are somewhat speculative and would depend on the continued use of Travelers by the railroad industry, we believe that this situation would tend to provide Travelers with incentives to be efficient, particularly since there is no provision for a profit under its Medicare contract.

From a more practical standpoint, we believe that Travelers' participation in private health insurance involving the railroad industry would tend to facilitate the effective implementation of section 116 of Public Law 97-248, the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA); however, this advantage applies to a very small group of RRB beneficiaries. Section 116 of TEFRA provides that effective January 1, 1983, Medicare payments would be secondary[13] for workers aged 65 through 69 and their dependent spouses aged 65 through 69 covered under employee group health plans--if the employees elect to make their group plan primary to Medicare.

According to CBO, the budgetary savings to part B Medicare associated with section 116 of TEFRA were as follows:

Fiscal year	Amount
	(millions)
1983	$ 75
1984	110
1985	130
	$315

[13]Under this arrangement, the private insurance would pay first; Medicare then would provide coverage only to the extent that benefits available under it are greater than those available from the private insurer.

According to Travelers officials, there were about 10,000 active railroad employees covered under its Policy Contract GA-23000 who were also eligible for Medicare, and virtually all of them had elected to make this group policy primary to Medicare. The claims for the beneficiaries were being processed at the same five regional processing centers that process RRB part B Medicare claims, and Travelers had installed computer edits to identify any Medicare claims for individuals that should be paid first under its private group contract.

In contrast, according to HCFA's July 1983 instructions, the implementation of section 116 of TEFRA by its area carriers depends to a large extent on information provided by beneficiaries or providers on the Medicare claims forms, but without the corresponding computer edits established by Travelers. Therefore, although we cannot attribute any budgetary savings to this factor, we believe that at least initially, Travelers' implementation of section 116 under its RRB contract is likely to be more effective and efficient than the implementation of this provision by the area carriers for a relatively small group of the working aged.

In commenting on this matter (see app. II), the Office of Management and Budget (OMB) pointed out that these payment safeguards were limited to the 10,000 active railroad employees or about 1 percent of the 860,000 RRB beneficiary population and excluded any other working aged beneficiaries who might be employed outside the railroad system. Because available data show that overall about 10 percent of the aged Medicare beneficiaries are employed, and may be covered by private insurance, it appears that for a vast majority of the RRB working aged, Travelers is probably in no better position than HCFA area carriers with respect to implementing section 116 of TEFRA. Further, both OMB and HHS (see app. III) stated that systems changes were being implemented for HCFA area carriers to enable them to better implement the new law so that this purported advantage would be temporary.

CONCLUSIONS

In our June 1979 report we recommended that the Congress enact legislation to terminate RRB's authority to select a nationwide carrier and to turn over the responsibility for processing and paying RRB beneficiary claims to HCFA area carriers paying the claims for most other beneficiaries. Although we believe that this recommendation is still valid and represents the most preferable course of action, it has proven to be controversial, and the Congress has chosen not to adopt it. As

indicated in this report, Travelers-RRB performance over the past 5 or 6 years has been above average. Nevertheless, we believe we have demonstrated that (1) there are additional administrative costs associated with the existing arrangement irrespective of how they are estimated and (2) Travelers' assertion of offsetting budgetary savings in lower benefit dollars is not supportable due to limitations in the methodology used to compute them.

Finally, the Grace Commission's report (using data from our 1979 report as well as some analysis of its own) came to essentially the same conclusions we have regarding the additional costs associated with maintaining a separate Medicare carrier to process the part B claims for RRB beneficiaries. Although the Commission's report included a recommendation for the Congress to place RRB beneficiaries under the HCFA carrier system, it also suggested an alternative that would allow the railroad community to maintain its separate system if it was willing to pay the additional costs. We believe this alternative suggestion also has merit.

AGENCY COMMENTS AND OUR EVALUATION

We requested and obtained comments on a draft of this report from OMB (app. II), HHS (app. III), RRB (apps. IV and IVA), and Travelers (app. V). Except as noted in the report and appendix I, OMB and HHS agreed with our findings and conclusions. HHS stated that

> ". . . Because of the low RRB claim volume and its dispersal nationwide, this additional cost of processing RRB claims is inherent in the present system and cannot be eliminated even by improvement in the efficiency of the RRB contractor operations."

RRB supported the existing arrangement and stated that it believed our estimate of potential savings using the incremental cost methodology was overstated because the area carrier workload-related costs, which are sensitive to changes in claims volume, had increased from 75 percent of total unit costs in 1979 to 80 percent of total unit costs in 1983. However, we believe that this is a relatively modest change, considering the fact that the area carriers' total claims volume had increased from 121.7 million claims in 1979 to 186.4 million claims in 1983--an increase of 53 percent. In contrast, absorbing the RRB workload would involve an increase in the area carriers' claims volume of less than 5 percent for the vast majority of carriers. In addition, some of RRB's concerns were similar to Travelers' and are addressed in our analysis of Travelers' comments.

Travelers took numerous exceptions to the report and introduced additional cost factors which it believes should be considered. However, because Travelers' lengthy comments included many statements, assumptions, comparisons, and projections that we do not agree with, they are not summarized here but are analyzed in detail in appendix V.

Unless you publicly announce the report's content earlier, no further distribution will be made until 30 days from its issue date. At that time, we will send copies to interested parties and make copies available to others upon request.

Sincerely yours,

Richard L. Fogel

Richard L. Fogel
Director

Contents

ABBREVIATIONS

CBO	Congressional Budget Office
HCFA	Health Care Financing Administration
HCPCS	Standardized Procedural Coding System
HHS	Department of Health and Human Services
OMB	Office of Management and Budget
RRB	Railroad Retirement Board
TEFRA	Tax Equity and Financial Responsibility Act

APPENDIX I

UPDATED STATISTICAL DATA ON PERFORMANCE AND COSTS OF A SEPARATE CARRIER TO PROCESS MEDICARE CLAIMS FOR RAILROAD RETIREMENT BENEFICIARIES

BASIC PROGRAM DATA

The relationship of RRB beneficiaries to the overall part B program has not changed significantly since the early days of Medicare. As of July 1982, there were about 860,000 eligible RRB beneficiaries enrolled in part B, or about 3 percent of the approximately 28 million aged and disabled enrollees. In fiscal year 1983 Travelers-RRB processed about 5.6 million claims, or about 3 percent of the 204 million claims processed nationwide.[1] In 1969 (the first year for which we have data) there were about 810,000 RRB beneficiaries, or about 4 percent of the total 18.9 million aged enrollees at that time, and during 1969 Travelers-RRB processed about 1.4 million claims, or about 4 percent of the overall part B workload.

In 1969, about 125,000 workers and annuitants, or about 15 percent of RRB beneficiaries, had supplementary insurance coverage with Travelers to help pay their medical bills not covered and/or paid by Medicare. According to Travelers' officials, in 1983 about 215,000 workers or annuitants, or 25 percent of those enrolled in part B, had supplementary coverage with Travelers.

PERFORMANCE STATISTICS

Our June 1979 report pointed out that since the conversion to a regional on-line claims processing system in March 1978, Travelers-RRB had improved the accuracy and timeliness of its claims processing activities as compared with the HCFA area carriers. According to HCFA's quality assurance and workload reports, Travelers-RRB has generally continued to compare favorably with the area carriers with regard to quality, but for timeliness, the comparative performance statistics have changed since our June 1979 report.

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[1]Includes claims processed by the Health Care Financing Administration's (HCFA's) fixed price contractors which were not included in the unit cost analysis (see p. 4).

These comparisons are shown in the following tables:

Fiscal year	Payment/deductible error rates[a] National average[b]	Travelers RRB	Difference
	(percent)		
1978	2.2	1.5	0.7
1979	2.2	1.7	0.5
1980	2.2	1.2	1.0
1981	1.9	0.9	1.0
1982	1.7	0.8	0.9
1983	1.5	1.1	0.4

[a]The payment/deductible error rate represents the estimated dollar errors (including amounts overpaid that should have been paid but were not, and dollar amount incorrectly applied to the beneficiaries' annual deductible) for every $100 in submitted charges for the universe of the carriers' adjudicated claims.

[b]Includes Travelers-RRB errors.

Fiscal year	Average claims processing times National average[a]	Travelers RRB[b]	Difference
	(days)		
1978	13.0	8.0	5.0
1979	13.2	7.0	6.2
1980	13.0	9.6	3.4
1981	12.2	7.2	5.0
1982	10.4	7.7	2.7
1983	9.9	11.1	(1.2)
1984 (Oct. 1983 to Mar. 1984)	11.0	8.4	2.6

[a]Includes Travelers-RRB claims.

[b]As correctly pointed out in the Department of Health and Human Services (HHS) comments on the report, these numbers are understated because they do not include the time lost for re-routing the misrouted RRB claims.

APPENDIX I

ESTIMATED COST SAVINGS FOR AREA CARRIERS TO PROCESS RRB WORKLOAD

There have been two methods employed to estimate the additional administrative costs associated with using a single nationwide carrier to make benefit payments for RRB beneficiaries. One method employed by Travelers and HCFA merely projects the difference between the average cost per claim for Travelers-RRB and the nationwide average cost per claim to the total number of claims processed by Travelers. For fiscal years 1982 and 1983, using this method we compute an annual savings of $2.4 million and $1.3 million, respectively, through using area carriers to process RRB claims. The other method, which has been used by GAO and the President's Private Sector Survey on Cost Controls (also known as the Grace Commission), projects the difference in the average cost per claim for Travelers-RRB and the incremental cost per claim that would likely be incurred by the area carriers times the total number of claims processed by Travelers. This method results in estimated savings of about $5 to $6 million a year. Although we believe that the latter method results in a more realistic assessment of what would actually occur if the RRB claim workload were processed by the same carriers that process the claims for other Medicare beneficiaries, we are presenting the updated information under both methods.

Average cost per claim differences

Our June 1979 report compared the Travelers-RRB unit cost per claim with the national average unit costs for fiscal years 1970 through 1978. The updated information through fiscal year 1983 is summarized in the following table and excludes the claims volumes and costs for areas covered during all or part of the 5-year period under HCFA's experimental fixed-price contracts in Maine, Upper New York State, and Illinois.[2]

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[2]The purpose of these exclusions is to better assure comparability from one year to another in a cost-type contract environment.

APPENDIX I

Fiscal year	Area carriers		Travelers-RRB		Difference in unit cost
	Claims processed	Average unit cost	Claims processed	Average unit cost	
	(millions)		(millions)		
1979	121.7	$2.77	3.9	$3.25	$0.48
1980	138.7	2.68	4.4	3.06	0.38
1981	155.0	2.67	4.8	2.97	0.30
1982	169.8	2.44[a]	5.1	2.91[a]	0.47
1983	186.4	2.31[b]	5.6	2.55[b]	0.24

[a]The reported amounts for 1982 for the area carriers and Travelers-RRB were $2.50 and $2.95, respectively, or a difference of $0.45 per claim; however, because of the prepayment adjustments discussed in note b, the area carriers' and Travelers' costs were adjusted for the fiscal year 1982 prepayments which were added back for the fiscal year 1983 costs.

[b]The reported amounts for fiscal year 1983 for the area carriers and Travelers-RRB were $2.36 and $2.86, respectively, or a difference of $0.50 a claim; however, because Travelers-RRB reported costs included about $1.9 million in prepaid expenses applicable to the fiscal year 1984 workload, we adjusted the reported amounts for both the area carriers and Travelers-RRB to exclude such prepayments.

Travelers processed about 5.6 million claims during 1983, which, when applied to the difference in the adjusted average unit cost of $0.24 a claim, results in a savings of about $1,344,000 for fiscal year 1983. The comparable estimated savings for fiscal year 1982 were $2.4 million.

Incremental cost per claim difference

The savings estimate in our 1979 report was based on studies at 14 area carriers to determine the additional costs each might incur in fiscal year 1979 if they were to assume responsibility for processing the relatively small volumes of RRB claims in their service areas.

The basic methodology employed involved examining each functional type of cost (e.g., claims review, data entry, computer usage, accounting, and administration) and asking the area carriers how much each functional cost would change by adding the RRB-related claims volume, which involved workload increases of only 3 to 5 percent at the various carriers. The average estimated incremental or additional costs for these 14 carriers was $1.76 per claim, or 66 percent of their overall

APPENDIX I

average approved budgeted cost of $2.66.[3] We pointed out that these data were consistent with the information in chapter 4 of the 1979 report, which showed that historically from fiscal year 1975 through 1978 the percentage increases in the volume of part B Medicare claims from one year to another were more than the comparable increases in the total administrative costs which, in turn, resulted in progressively lower average unit costs irrespective of inflation. We expressed the view that these data supported our incremental cost approach that recognized certain carrier costs were fixed and thus would not change as a result of relatively small increases or decreases in the number of claims processed. Updated information through fiscal year 1983 for area carriers and excluding Travelers-RRB and the areas involved in the fixed-price contracts shows that, except for 1981, this condition has continued.

Fiscal year	Administrative costs			Claims volume			Unit cost	Incremental unit cost unadjusted for inflation
	Total	Increase over previous year	Percent increase	Claims volume	Increase over previous year	Percent increase		
	(millions)			(millions)				
1979	$337.6	$28.3	9.1	121.7	11.7	10.6	$2.77	$2.42
1980	371.2	33.6	10.0	138.7	17.0	14.0	2.68	1.98
1981	414.6	43.4	11.7	155.0	16.3	11.8	2.67	2.66
1982	414.2[a,b]	(.4)	-	169.8	14.8	9.5	2.44	[b]
1983	430.5[a]	16.3	3.9	186.4	16.6	9.8	2.31	0.98

[a]Adjusted for prepayments. (See p. 4.)

[b]Fiscal year 1982 was not a typical year in that HCFA's cost-type carriers absorbed their increased claims volumes at no increased total costs. We believe that this occurred because the appropriation or budget level for all contractor activities (including the part A fiscal intermediaries) increased from 1981 to 1982 by $10.0 million, or only about 1.5 percent of the fiscal year 1981 funding levels, which necessitated the carriers to cut back on various activities and services.

Budgetary limitations and the nonrecurring or extraordinary costs associated with implementing changes to Medicare contained in the various Budget Reconciliation Acts during the past 3 years tend to distort the costs to claims volume relationships from one year to another. Nevertheless, we believe that the

[3]The actual fiscal year 1979 average unit cost for these carriers was $2.68 a claim, which indicates that, overall, their budget estimates were highly accurate.

continued progressive reductions in average unit costs despite inflation are consistent with the incremental cost studies in our prior report.

In addition, the relationship between the area carriers' workload-related costs per claim (such as claims review, data entry, and computer usage), which are sensitive to volume changes, and their total administrative costs, which also include systems support, professional relations, accounting, and administration, has not significantly changed since 1979.[4] This condition also leads us to believe that our prior incremental cost studies at the 14 carriers are still valid.

Therefore, applying the 66-percent factor to the 1983 area carriers' average adjusted unit costs of $2.31 results in an average incremental cost of $1.52, which is $1.03 less than the Travelers-RRB adjusted unit costs of $2.55. This $1.03 difference times the 5.6 million RRB claims processed in 1983 results in an estimated savings of $5,768,000. Using essentially the same methodology and an incremental cost of $1.73 a claim, the Grace Commission estimated 1982 savings of about $6 million based on data for the October-December 1981 quarter.

In commenting on the report, RRB questioned how the incremental costs could be 66 percent of total costs if the workload-related costs which are sensitive to volume changes were 75 or 80 percent of total costs. We see no inconsistency in these percentages because the principal workload-related functional costs (i.e., claims review) that we used include the costs of related management and support activities, such as supervisors and secretaries, which would not necessarily increase with a modest increase in clerical personnel to handle the increases in claims volumes.

Misrouted claims--some improvements

A misrouted claim is a request for payment of an RRB part B claim that has been sent by either an RRB beneficiary or a provider to an area carrier instead of to Travelers. Thus, the area carriers incur costs to identify, handle, and redirect the misrouted claim to Travelers for payment.

In our 1979 report we pointed out that in fiscal year 1977, about 31 percent of the total claims processed by Travelers in 11 states had been misrouted and that the extra costs of the

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[4]These workload-related costs were about 75 percent of total unit costs in 1979 and about 80 percent in 1983.

area carriers in handling such misrouted claims were about $1 a claim based, in part, on the point in the area carriers' claims processing cycle that the misrouted claims were identified and rerouted to Travelers. We estimated that nationwide, about 964,000 RRB claims had been misrouted in fiscal year 1977. Using 1979 RRB claims volumes, we estimated an increased cost of about $1.2 million.

In commenting on our 1979 report, RRB and Travelers indicated that changes in Medicare instructions should alleviate the problem of misrouted claims although RRB acknowledged it would never be eliminated. To determine the extent that the problem had been resolved, we contacted the area carriers for 13 areas and learned that in fiscal year 1982 about 20 percent of the total claims processed by Travelers in these areas had been misrouted. About 47 percent of Travelers' total 1982 RRB claims volume of 5.1 million claims originated in these 13 areas. Thus, nationwide, we estimate that about 1 million RRB claims were misrouted.[5]

Travelers' officials told us that the misrouted claims problem involved providers rather than beneficiaries. We believe this assessment is probably correct based on our prior work involving responses to provider and beneficiary questionnaires in 1979 and the fact that the relative incidence of misrouted claims in 1982 appeared higher in states where most Medicare claims were submitted directly by providers. In summary, since our prior work the relative incidence of misrouted claims has been reduced from 31 to 20 percent, but because of the increase in claims volume, the estimated number of misrouted claims (1 million) and the related cost have probably remained about the same. We characterize this cost estimate as "probable" because we did not obtain current data on when the misrouted claims were identified during the area carriers' claims processing cycle as was done for our June 1979 report.

Inappropriate use of quality assurance statistics to compute savings in benefit payments

Travelers' basic position is that any savings in administrative costs (using the average cost per claim difference) resulting from the HCFA area carriers processing of the RRB workload would be more than offset by higher overpayments in part B benefits. This position is based on the fact that under HCFA's

[5]5.1 million claims times 20 percent.

part B quality assurance program, Travelers-RRB payment deductible error rates and related overpayment error rates expressed as a percent of submitted charges were considerably lower than the overall average of the area carriers' error rates. The fiscal year 1982 quality assurance error rates used in Travelers' calculations were as follows:

	Total payment deductible error rate	Over-payment error rate	Under-payment error rate	Deductible error rate
National average	1.7[a]	0.9	0.6	0.1
Travelers-RRB	0.8	0.5	0.3	0.0
Difference	0.9[a]	0.4	0.3	0.1

[a]Does not add due to rounding.

Because the Travelers-RRB submitted charges in fiscal year 1982 were about $664 million, Travelers calculated that the lower 0.4-percent overpayment error rates had resulted in "savings" in benefit overpayments of $2,657,188. Putting this number in perspective, this savings represents about 0.02 percent of the total $12 billion in benefit payments made by the Medicare part B carriers in fiscal year 1982.

In our opinion, Medicare's quality assurance statistics cannot be used to compute budgetary savings in this manner. The clear implication of Travelers' calculations is that if HCFA's area carriers processed and paid the RRB claims workload, the benefit payments in fiscal year 1982 would have been about $2.7 million more than they actually were. This is not necessarily true, however, because Travelers-RRB has different data bases than the area carriers for determining reasonable charges (and related payment amounts) and those different data bases are not considered in ascertaining "errors" under Medicare's quality assurance program. The effects of these differences were illustrated in our June 1979 report (p. 133) discussing the differences in payment determinations for RRB beneficiaries and other Medicare beneficiaries in the same areas. These differences occur primarily because the area carriers have much larger claims volumes than Travelers in a given area with which to compute payment amounts.

To determine the effects of the difference between Travelers-RRB and the area carriers for fee screen year 1979 (July 1, 1978, through June 30, 1979) reasonable charge screens[6] for the same providers and the same procedures, we compared a sample of actual RRB claims paid by Travelers selected from its quality assurance sample to what 42 area carriers would have paid on the same claims. The final sample consisted of 287 RRB claims with submitted charges of about $90,000. Of the 287 RRB claims, the area carriers would have paid a different amount on 233, or about 80 percent of them. Specifically, the area carriers would have paid about $4,055 less than Travelers on 111 claims and about $3,920 more than Travelers on 122 claims for a net difference of $135 less.

Although these differences in payment determinations were offsetting, the impact of these differences in the data bases used in the calculation of total payment errors under Medicare's quality assurance program would not be offsetting. As previously discussed, the payment/deductible error rates include overpayments and underpayments. Assuming that under HCFA's requirements the area carriers' reasonable charge screens are more accurate than Travelers' because they include more claims data, the $4,055 where the area carriers would have paid less than Travelers translates into an overpayment error rate of 4.5 percent and the $3,920 where the area carriers paid more is the equivalent of an underpayment error rate of 4.4 percent--or a total payment/deductible error rate of 8.9 percent as a result of the differences in the data bases.

The impact of those variations in the data bases used to compute Medicare reasonable charges and related payments are many times the estimated error rates for either Travelers-RRB or the area carriers. Therefore, we believe it would be virtually impossible to conclude from Medicare's quality assurance statistics alone whether, in actual practice, the area carriers would have paid more or less than Travelers on the same claims much less how much the actual difference was.

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[6]Under Medicare, carriers make payments to providers and beneficiaries based on "reasonable charges." These reasonable charges consider the "customary" charge of a particular provider for a particular service and the "prevailing" charge of most providers in an area for the same service. At the time, carriers were required to update their reasonable charges each year effective July 1 through June 30 of the next year (fee screen year) based on the provider charges submitted during the prior calendar year.

Further, even if HCFA's quality assurance statistics could be used to compute budgetary savings in the unique Travelers-RRB situation, the true impact on outlays for benefit payments would be the net difference between overpayments and underpayments, not just gross overpayment errors. Although Travelers has argued that the differences in underpayments should be disregarded because these would work to the disadvantage of the beneficiaries, this would only apply if the underpayments involved unassigned claims,[7] which occurs about 50 percent of the time. On the other hand, if one was to accept Travelers' argument and only consider overpayments, then there could have been savings to Medicare of $29,880,000 in benefit payments in 1982 by eliminating the Travelers-RRB arrangement as a result of lower "overpayments" through the use of the area carriers' more accurate reasonable charge screens ($664 million times the reasonable charge overpayment rate of 4.5 percent).

In summary, we believe that HCFA's quality assurance statistics only show that given their respective different data bases for determining reasonable charges as well as other variances among carriers in making payment determinations, Travelers-RRB claim processing activities are more accurate than most area carriers'.

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[7]On unassigned claims payment is made to the Medicare beneficiary, and the beneficiary is responsible for the difference between the providers' charge and what Medicare allows. In contrast, on assigned claims payments are made to the provider who agrees to accept Medicare's reasonable charge as the full charge.

APPENDIX II

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

JUN 2 0 1984

Mr. William J. Anderson
Director
General Government Division
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Anderson:

Thank you for the opportunity to comment on the GAO draft report entitled "Use of a Separate Nationwide Carrier to Process Medicare Part B Claims for Eligible Beneficiaries of the Railroad Retirement Board".

In general, we concur with the conclusion that GAO's 1979 recommendation that Congress enact legislation to include Railroad Retirement Board (RRB) beneficiaries in the regular Health Care Financing Administration (HCFA) area carrier system remains as valid today as it was then. That the basic evidence supporting your 1979 recommendation has changed so little in five years is testimony to the high quality and insightful analysis in both this and the 1979 report, and the basic soundness of that recommendation.

As the draft report points out, the President's FY85 Budget proposes to include RRB Medicare beneficiaries in the same area carrier system covering all other Medicare beneficiaries. RRB beneficiaries would enjoy the better service provided by HCFA and the area carriers, and would be relieved of the many vexing problems -- such as frequently misrouted claims and slow payment for services -- that have plagued the RRB carrier. Your report provides striking evidence of the advantages of the area carrier system, correctly pointing out that Travelers provides much better service -- and at a lower cost -- as an area carrier for HCFA than it does as a nationwide carrier for RRB. Aside from the substantial savings that your report confirms would result from this proposal, there is simply no rationale for the general taxpayer subsidizing a separate system for the railroad sector, especially when the separate system provides worse service.

Although the report does a good job analyzing and refuting many of the fallacious arguments put forward by proponents of the separate RRB carrier, it does not fully address the issues surrounding implementation of Section 116 of the Tax Equity and Fiscal Responsiblity Act (TEFRA). In particular, some have argued that a separate RRB carrier has an advantage enforcing the requirement that Medicare be secondary payer to private insurance for the working aged. The draft report does not point out that Travelers' purported advantage extends

APPENDIX II

only to a very limited class of Medicare beneficiaries -- those who are eligible for Medicare, employed by railroads, and not receiving railroad retirement. This enforcement arrangement automatically excludes almost one million persons -- nearly the entire RRB annuitant population who may not both be employed by railroads and concurrently receive railroad retirement. Travelers' inability to implement fully effective enforcement thus increases the Medicare costs funded through the Medicare trust fund, thereby lowering the resources available to the beneficiaries. Again, the RRB beneficiary will suffer because its unique carrier cannot effectively implement this portion of the law.

In addition, the President's FY85 Budget proposes $3 million in funding that would enhance all area carriers' ability to match their Medicare enrollment files with their private business files to determine if private coverage exists. Thus, all HCFA area carriers would have enhanced ability to implement Section 116 successfully.

Thank you again for the opporunity to review and comment on this report while in draft form.

Sincerely,

Joseph R. Wright, Jr.
Deputy Director

cc: Honorable Charles Bowsher
Honorable Robert A. Gielow

APPENDIX III

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

MAY 18 1984

Mr. Richard L. Fogel
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Fogel:

The Secretary asked that I respond to your request for our comments on your draft of a proposed report "Use of a Separate Nationwide Carrier to Process Medicare Part B Claims for Eligible Beneficiaries of the Railroad Retirement Board." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Bryan Mitchell
for Richard P. Kusserow
Inspector General

Enclosure

APPENDIX III

COMMENTS OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ON THE GENERAL ACCOUNTING OFFICE DRAFT REPORT, "USE OF A SEPARATE NATIONWIDE CARRIER TO PROCESS MEDICARE PART B CLAIMS FOR ELIGIBLE BENEFICIARIES OF THE RAILROAD RETIREMENT BOARD"

We have reviewed the findings outlined in the report and are in agreement with their related implications. More particularly, we have long favored the elimination of a special carrier for Railroad Retirement Board (RRB) beneficiaries. The present arrangement adds unnecessary complications to the Medicare Part B central record keeping operation, special query/query reply procedures, and special handling and routing operations by area carriers. Furthermore, the fact that Travelers-RRB claims are paid using different historical data for reasonable charge determinations than that used by the area carriers makes it possible to generate different Medicare payments for the same service in the same locality depending on whether the payment is made by RRB or the area carrier.

In addition to this payment peculiarity, the present arrangement is administratively more costly, a fact that has long been known to exist, and is verified by the GAO findings. Because of the low RRB claims volume and its dispersal nationwide, this additional cost of processing RRB claims is inherent in the present system and cannot be eliminated even by improvements in the efficiency of the RRB contractor operations.

Two quantifiable justifications have been offered to counterbalance this increased cost for processing RRB claims.

- The Travelers-RRB average claims processing time is less than the average claims processing time for area carriers nationwide;

- because of edits which Travelers-RRB has installed in its claims processing system to match Medicare claims with its own complimentary insurance records, its success rate in identifying cases in which Medicare is the secondary payor has been higher than the area carrier rate.

With respect to the first point, the data may not be entirely reliable. Carrier claims processing time is computed from the date the claim is received by the carrier. The GAO data show that at least 20 percent of the RRB claims are misrouted. The time lost in rerouting and transferring claims is not counted in determining claims processing time. If it were possible to factor in this lost time with respect to RRB claims, it might be found that the average claims processing time for RRB claims is not significantly different from that of the area carriers.

With respect to the second point, it is true that the success rate in identifying cases in which Medicare is the secondary payer has been low to date. It is quite likely that the current Travelers' success rate in this respect is higher than the average for area carriers. However, we are about to install a modification to our query reply system which will greatly enhance the area carriers' ability to identify these cases. After this system is in operation, there is every reason to believe that the success rate for area carriers in this respect will be equivalent to that of Travelers-RRB.

APPENDIX III

In summary, we believe that the elimination of the special RRB contractor arrangement would greatly improve the efficiency of the Medicare claims process with no adverse effects on RRB beneficiaries, and with substantial savings in administrative cost.

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

May 18, 1984

Mr. Richard L. Fogel, Director
Human Resources Division
U.S. General Accounting Office
441 G Street, N.W.
Washington, D.C. 20548

Dear Mr. Fogel:

We appreciate this opportunity to comment on the proposed U.S. General Accounting Office (GAO) report entitled "Use of Separate Nationwide Carrier to Process Medicare Part B Claims for Eligible Beneficiaries of the Railroad Retirement Board." The Board is pleased that your report shows that:

-- the Board's part B carrier continues to have a higher accuracy rate for claims processing than the national average,

-- the Board's part B carrier, like other carriers, has made significant reductions in unit processing costs since 1979, consistent with national trends, and

-- there has been a large reduction, since GAO's 1979 report, in the percentage of claims that are misrouted.

Regarding timeliness of claims processing, the performance of the Board's part B carrier has improved recently. Mean processing time for the first 6 months of fiscal year 1984 was approximately 8.4 days, which compares favorably with the 1983 national average of 9.9 days cited in your draft report. Claims received and claims processed were about 9.6 percent and 14.3 percent respectively, above the 1983 levels.

The report presents an evenhanded analysis of the advantages to railroad retirement beneficiaries of having a single nationwide carrier. We agree that Travelers' long-term relationship with the railroad industry provides incentives for efficiency and will facilitate its implementation of Section 116 of the Tax Equity and Fiscal Responsibility Act of 1982. Effective implementation of the Tax Equity and Fiscal Responsibility Act of 1982 will reduce the government's Medicare costs.

We believe that GAO has overestimated the savings that would result from eliminating the Board's contracting authority for a national carrier. We note that $5 million of the estimated savings results from assuming that an incremental cost factor developed over 5 years ago is still valid. As

APPENDIX IV

indicated in the enclosure to the draft report, however, workload related costs, which accounted for 75 percent of total unit costs in 1979, increased to 80 percent in 1983. We believe that this increase in workload related costs should result in an increase in the incremental cost factor used in the report. In fact, it seems questionable that the area carriers' incremental cost per claim would be only 66 percent of total unit cost if, as you say on page 7 of the enclosure, the "workload related costs per claim (such as claims review, data entry and computer usage) which are sensitive to volume changes..." (underscoring supplied), were 75 to 80 percent of total unit costs.

The balance of the estimated savings -- $1.2 million -- results from elimination of the problem of misrouted claims. As the report points out, significant improvements have occurred since 1979 with regard to the proportion of claims that are misrouted. The report states that because of the increased volume of claims the number of misrouted claims has remained about the same, making these savings possible. The Board is optimistic regarding further improvements.

The report recognizes that termination costs would be substantial if the Board's contracting authority were eliminated. We believe that a detailed cost analysis would surface additional costs. Area carriers would also incur costs in the conversion of railroad benefit histories, provider files, and other data that are essential for detecting duplication of benefits and overutilization.

Regardless of whether Health Care Financing Administration (HCFA) quality assurance program statistics can be used to project budgetary savings, they do provide a gauge of the overall quality of carrier performance. Travelers' high quality performance, as measured by HCFA's quality assurance program, should not be minimized.

As the report indicates, disincentives to cost efficiency, in theory, could result from a situation in which an agency has decisionmaking power but does not have to pay for the consequences of its decisions. This does not apply to the Board's administrative responsibilities with regard to the Medicare program. The Board administers the Medicare program in accordance with guidelines that were originally established by the Social Security Administration and those subsequently established by HCFA. The performance of the Board's carrier is evaluated in accordance with criteria contained in HCFA's Contractor Performance Evaluation Program, Quality Assurance Program, Carrier System Testing Project, and other reviews that are conducted on an as-needed basis. In addition, the Board coordinates the approval of its carrier's financial operating plans with HCFA. It does not have sole authority for the approval.

The report indicates that the President's fiscal year 1985 budget proposes to eliminate the Board's authority to select a separate Medicare carrier for railroad retirement beneficiaries. The Board believes that its one-carrier arrangement and its administration of other aspects of the Medicare program provide uniform, high quality service to all of its beneficiaries who qualify for Medicare. Before any changes are made in the present structure for

administering the Medicare program for qualified railroad retirement beneficiaries, careful consideration should be given to the advantages of the present structure and to the impact of any change on the 860,000 railroad retirement beneficiaries presently enrolled in the program.

Again, we appreciate the opportunity to comment on your proposed audit report.

Sincerely,

Beatrice Ezerski BE

FOR THE BOARD
Beatrice Ezerski
Secretary to the Board

APPENDIX IVA

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

June 14, 1984

Mr. Richard L. Fogel, Director
Human Resources Division
U.S. General Accounting Office
441 G Street, N.W.
Washington, D.C. 20548

Dear Mr. Fogel:

On May 18, 1984, we provided you with our comments on the proposed GAO report entitled "Use of Separate Nationwide Carrier to Process Medicare Part B Claims for Eligible Beneficiaries of the Railroad Retirement Board." Recently, we received comments on that report from the Chairman of the Health and Welfare Committee of the Railway Labor Executives' Association. He is authorized to express the views of railroad labor and management on the subject matter contained in the proposed report.

We have enclosed a copy of his comments. Please consider them in preparing your final report.

Sincerely,

Beatrice Ezerski

FOR THE BOARD
Beatrice Ezerski
Secretary to the Board

Enclosure

cc: Mr. Fred A. Hardin, Chairman of the
Health and Welfare Committee of the
Railway Labor Executives' Association

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June 4, 1984

Ms. Beatrice Ezerski
Secretary
Railroad Retirement Board
544 Rush Street
Chicago, IL 60611

Dear Ms. Ezerski:

I understand the Railroad Retirement Board ("RRB") intends to submit comments on the proposed U.S. General Accounting ("GAO") report entitled "Use of Separate Nationwide Carrier to Process Medicare Part B Claims for Eligible Beneficiaries of the Railroad Retirement Board." As Chairman of the Health and Welfare Committee of the Railway Labor Executives' Association, I am writing to request that the RRB submit this letter to GAO as an addendum to the RRB comments. I am authorized to express the views of railroad labor and management on the subject matter of the GAO draft report, and thus the views expressed herein on behalf of the RRB program's beneficiaries should be incorporated by GAO along with the comments submitted by other interested parties.

Railroad management and labor would oppose any recommendations that would weaken or eliminate the RRB's legislative authority to select a nationwide carrier to process Medicare medical insurance claims for qualified railroad retirement beneficiaries. We firmly believe as a matter of public policy that Medicare medical insurance claims should be processed on a uniform basis and that the RRB should retain legislative authority to select any carrier best suited to serve the needs of qualified railroad retirement beneficiaries. Because of the uniqueness of the railroad retirement system, a centralized, federally-adminsitered social insurance program has been provided for the railroad industry. The concept of a nationwide carrier developed from that origin. Throughout its 44-year history, the railroad retirement system has been based on a series of collective bargaining agreements negotiated by representatives of railroad labor and management. Both parties supported the idea of a separate railroad Medicare carrier in 1966, and railroad labor and management continue to support this concept. Any abandonment of this agreement would in effect nullify the collective bargaining process.

Since the program began, the RRB has contracted with a single nationwide carrier to provide uniform service to all beneficiaries who qualify for Medicare. If the Board lost its authority, the 860,000 railroad beneficiaries who qualify for Medicare would be forced to deal with over 40 carriers rather than with a single nationwide carrier. This would be detrimental to the interests of railroad retirement beneficiaries. The Board's effectiveness as a liaison between the beneficiaries and

APPENDIX IVA

the carrier--and the resulting accountability--would be severely weakened. The beneficiaries themselves would be confused by the proliferation of carriers, and the problem of misrouted claims, slower payments, and general inefficiency would result.

Beyond the budget considerations, the GAO and the Congress ought to consider what that means in human terms for the elderly beneficiaries on fixed incomes who depend upon timely, effective payment of their claims. Almost uniformly, the nationwide RRB carrier has performed better than the area carriers in terms of timeliness of payment. Both overpayment and underpayment errors by the RRB carrier consistently have been much lower than those on average by the area carriers. Surveys of railroad retirement beneficiaries and providers consistently have shown extremely high satisfaction with the service provided by the RRB carrier. Most of the railroad employees and retirees have no connection at all with the Social Security Administration, the Health Care Financing Administration, or the area carriers. Eliminating the RRB's authority would require the establishment of an entirely new set of relationships and inevitably would cause a deterioration of the service which the railroad beneficiaries are entitled to receive. This is particularly true as claims volume continues to increase annually.

We urge that the GAO and the Congress not discount the public policy considerations at issue and the hardship that would befall railroad retirees as the result of this legislative proposal. Dispassionate budget analysis sometimes overlooks the very real human expense involved in proposals such as this one. For example, the Grace Commission last year proposed that the federal government earn an additional $300,000.00 per year from this program by delaying payments to beneficiaries. The GAO has made a similar argument when it proposed to offset the federal revenue loss attributable to the area carriers' higher overpayment error rate with the area carriers' higher underpayment rate, compared to the overpayment/underpayment rates of the RRB carrier.

A responsible budget analysis should not credit the area carriers for having failed to pay beneficiaries the full amounts to which they are entitled. Such federal budget savings entail a very real--and we submit, an unacceptable--human expense. Underpayments and delayed payments should be corrected, not credited as federal revenue savings.

We have demonstrated consistently that the federal revenue savings attributable to the proposed legislative change would be minimal--if not nonexistent--particularly when compared with the hardship and expense involved for railroad retirees. We urge the GAO and the Congress to reject this legislative proposal as a matter of public policy.

Sincerely,

Fred A. Hardin

Fred A. Hardin

cc: Mr. Richard L. Fogel
Director
Human Resources Division
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APPENDIX V

MEDICARE

June 6, 1984

Mr. Richard L. Fogel
Director
Human Resources Division
United States General Accounting Office
Washington, D.C. 20548

Re: Draft Report Entitled "Use of a Separate Nationwide Carrier to Process Medicare Part B Claims for Eligible Beneficiaries of the Railroad Retirement Board

Dear Mr. Fogel:

This letter analyzes the findings and conclusions of the draft report entitled "Use of a Separate Nationwide Carrier to Process Medicare Part B Claims for Eligible Beneficiaries of the Railroad Retirement Board."

Briefly, The Travelers takes issue with GAO's recommendation that Congress should enact legislation that would terminate RRB's authority to select a carrier(s) for railroad Part B beneficiaries and turn over the responsibility for processing their claims to the HCFA area carriers. Sound public policy reasons counsel against the legislation recommended by GAO and, contrary to GAO's findings, the federal government would realize little or no savings as a result of the legislation.

I. Summary of Conclusions

In the draft report, GAO updates the findings and conclusions that it reached in a report submitted to Congress in June 1979. GAO recommends, as it did in 1979, that Congress enact the aforementioned legislation based on its finding that, as a result of this legislation, Medicare's annual administrative costs would have been reduced by approximately $6.5 million in 1983.

1. Public policy dictates against enactment of the legislative proposal. The conclusion in the draft report fails to credit several important public policy considerations that

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counsel in favor of retaining RRB's current contracting authority:

- Congress delegated Part B claims processing authority to RRB in order to ensure effective service for 860,000 elderly railroad beneficiaries.

- The uniqueness of the railroad retirement system requires a separate nationwide carrier for railroad Part B beneficiaries. Unless Congress modifies the current overall RRB authority, RRB's authority to contract for Part B claims processing should not be modified.

- The RRB carrier has achieved a significantly higher level of satisfaction among beneficiaries and providers than have the HCFA area carriers.

- In terms of accuracy and timeliness of claims processing, the RRB carrier has performed substantially better than the HCFA area carriers.

- Railroad labor and management have concluded that the superior service provided by the RRB carrier to railroad Part B beneficiaries cannot effectively be supplanted by over 40 area carriers. Therefore, railroad labor and management have consistently opposed the type of legislation proposed by GAO.

2. Purported federal budget savings would not materialize. The $6.5 million annual savings estimated by GAO have two components. First, $5.5 million in savings from lower administrative costs that purportedly would be incurred by HCFA area carriers in processing railroad Part B beneficiary claims. Second, $1.0 million in purported savings from the elimination of misrouted claims. GAO's estimates, however, are overstated and, in any event, do not outweigh the public policy reasons for retaining a separate nationwide RRB carrier:

- GAO's estimate that the federal government could have realized savings of $5.5 million in 1983 from lower administrative costs is mistaken. GAO should not have based its federal budget savings estimate for 1983 on an incremental cost methodology, and thus the federal budget savings for 1983 should have been no more than $1.1 million. However, even using an incremental cost methodology, federal budget savings would have been, at most, $2.8 million in 1983.

- GAO's finding that the federal government would have realized savings in 1982 of $1.0 million resulting from the elimination of misrouted RRB claims is based on

inflated estimates and fails to offset for misrouted area carrier claims. The costs associated with misrouted RRB claims are rapidly declining and, in any event, can be reduced substantially by methods other than transferring the responsibility for processing railroad Part B beneficiary claims to the HCFA area carriers.

3. Substantial budget losses would result from the legislative proposal. GAO does not consider substantial losses that would be incurred by the federal government:

- The federal government would incur losses amounting to $1.5 million per year due to the HCFA area carriers higher overpayment rate.
- The federal government would incur losses amounting to $1.0 million per year due to a shift in overhead and fixed costs to The Travelers in its capacities as a Part A intermediary and a Part B HCFA area carrier in several states.
- The federal government would incur losses ranging between $3.9 million and $13.1 million per year because the HCFA area carriers on average devote fewer resources to carrier administration and thus, through inefficiency, pay more in benefits per enrollee than does the RRB carrier.
- The federal government would incur substantial annual losses because the HCFA area carriers would not be able to implement Section 116 of TEFRA as effectively and efficiently as the RRB carrier.
- The federal government would incur considerably more than $1.0 million in termination costs and $4.9 million in costs attributable to systems conversion and to the conversion of RRB histories, provider files and other data essential for detecting the duplication of benefits and overutilization.

4. Conclusion. Congress delegated Part B claims processing authority to RRB for compelling public policy reasons. That authority should not be terminated unless those public policy considerations are superceded by truly significant budget savings for the federal government. Not only would the savings estimated by GAO fail to materialize as a result of the proposed legislative proposal, but also a net budget loss to the federal government likely would occur. Thus, the legislative proposal is ill-advised.

GAO note: The following is a word-for-word copy of Travelers Insurance detailed comments except that the page numbers have been changed to reflect the page numbers in this report. Our analysis follows its comments.

II. Discussion

TRAVELERS COMMENT:

A. Public Policy Considerations.

From a public policy perspective, neither GAO nor any other observer has endeavored to criticize the RRB's decisions to utilize a separate nationwide carrier for railroad Part B beneficiaries and to select The Travelers as the separate nationwide carrier. Sound reasons support the use of a separate nationwide carrier, and The Travelers has provided an exceedingly responsive service for the 860,000 elderly beneficiaries whom it serves.

GAO ANALYSIS:

Our June 1979 report and the Grace Commission's May 1983 report included recommendations to the Congress that the RRB beneficiaries be placed under the HCFA area carrier system. In discussing the various justifications for the existing arrangement, the latter report also stated that "The conclusion of the Task Force is that these purported benefits do not outweigh the extra costs to the taxpayer of the existing arrangement." These recommendations and related language seem to us incompatible with Travelers' contention that "From a public policy perspective neither GAO nor any other observer has endeavored to criticize the RRB's decisions to utilize a separate nationwide carrier for railroad Part B beneficiaries . . ."

TRAVELERS' COMMENT:

In 1966, the Secretary of HEW delegated to RRB the authority to select a carrier(s) to process Part B Medicare claims for qualified railroad retirement beneficiaries. RRB's authority to select a carrier(s) was later formalized by legislation. The impetus behind this delegation of authority, which still exists today, was "the uniqueness of the railroad retirement system, a centralized, federally-administered social insurance program for a single industry."[1]

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[1]See letter dated May 15, 1979, from RRB to Gregory J. Ahart, Director, Human Resources Division, U.S. General Accounting Office (included as Appendix VIII in GAO's 1979 report).

In exercising its authority, RRB decided to select a single nationwide carrier, particularly because railroad labor and management fully supported a single nationwide carrier. The support of railroad labor and management was, and still is, important because the railroad retirement system, throughout its 44-year history, has been based on collective bargaining agreements negotiated by railroad labor and management.[2]

In practice, the use of a single nationwide carrier has worked extremely well. As RRB commented to GAO in 1979,[3] and as remains true today, The Travelers has performed very well in its capacity as the single nationwide RRB carrier. For example, The Travelers payment/deductible error rate consistently has been lower than that of the HCFA area carriers,[4] and The Travelers average claims processing time consistently has been lower than

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[2]Of course, this type of arrangement, under which one carrier processes Part B claims for a distinct group of beneficiaries, is not restricted to the railroad industry. HCFA has this type of arrangement with the United Mine Workers, Home Health Agencies, Hospices and other groups. GAO note: These arrangements are not similar to the Travelers-RRB arrangement. The HCFA arrangement with the United Mine Workers Health and Retirement Funds primarily involves people who are eligible for both Medicare benefits and health benefits under the United Mine Workers Health and Retirement Funds, which covers about 120,000 beneficiaries. Its purpose was to prevent duplicate payments for individuals with dual eligibility. In contrast, the Travelers-RRB arrangement is not limited to individuals with dual eligibility. Further, Home Health Agencies and hospices are providers of service not groups of beneficiaries.

[3]See note 1 supra.

[4]The RRB carrier's rate of underpayment errors also has been consistently lower than that of the HCFA area carriers. This difference in rate of underpayment errors, at least from the railroad Part B beneficiaries' perspective, should be highly relevant to any decision to turn over the responsibility for processing railroad Part B beneficiary claims to the HCFA area carriers.

that of the HCFA area carriers.[5] The Travelers also has achieved a significantly higher level of satisfaction among beneficiaries and providers than have the HCFA area carriers. GAO acknowledges that the use of The Travelers as the single nationwide RRB carrier is extremely advantageous to railroad Part B beneficiaries.[6]

Although GAO's recommendation runs counter to these considerations, they nevertheless are precisely the considerations that were weighed by HEW and Congress when they initially delegated to RRB the authority in question. These considerations still should be conclusive if Congress considers the legislative proposal.

GAO ANALYSIS:

Our June 1979 report pointed out that about 78 percent of the beneficiaries and 65 percent of the providers we sampled were satisfied with Travelers' claim processing services. However, these data would not support Travelers' statement that these levels of satisfaction were "significantly higher" than those achieved by the HCFA area carriers. In fact, the 1983 study commissioned by HCFA and referred to by Travelers on page 30 of this appendix included interviews with samples of Medicare beneficiaries served by six HCFA area carriers and with samples of providers served by five of the six carriers. The study showed that overall, 82 percent of the beneficiaries said that they were satisfied with the way the area carriers handled their Medicare claims and from 60 to 90 percent of the providers said they were "very satisfied" or "somewhat satisfied" with the area carriers' performance.

Further, nowhere have we acknowledged that the use of Travelers is "extremely advantageous" to railroad Part B beneficiaries.

With respect to Travelers' arguments for maintaining the status quo from a public policy perspective, we believe that it is generally recognized that at the inception of Medicare, concessions were made to various special interest groups to gain

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[5]In 1983, for the first time in recent years, the RRB carrier's average claims processing time was higher than that of the HCFA area carriers. The RRB carrier substantially improved its average claims processing time in 1984, however. For the first six months of 1984, the RRB carrier's average claims processing time was 8.4 days, which compares favorably to the HCFA area carriers' average claims processing time of 9.9 days in 1983.

[6]See Draft Report at 8.

acceptance of the program and to facilitate its implementation. However, as questions are being raised about the increasing cost of Medicare and the financial soundness of the trust funds, the appropriateness of such concessions is being reevaluated.

TRAVELERS COMMENT:

B. Purported Federal Budget Savings Will Not Materialize.

1. Lower Administrative Costs Purported to be Incurred by HCFA Area Carriers.

GAO estimated that federal budget savings of $5.5 million would have occurred under the legislative proposal in 1983. GAO based this estimate on an incremental cost methodology, calculating the difference, in 1983, between the RRB carrier's average cost per claim ($2.51) and the HCFA area carriers' average incremental cost per claim ($1.52) multiplied by the railroad Part B beneficiary claims volume. GAO determined the HCFA area carriers' average incremental cost per claim by accepting the undocumented and unverified estimates provided in 1979 by 14 HCFA area carriers, who compete with the RRB carrier and who stood to gain additional business by undercutting the RRB carrier's position. Those area carriers estimated that it would cost them 66% of their average cost per claim (0.66 x $2.31 in 1983) to absorb the responsibility for processing railroad Part B beneficiary claims. In 1984, GAO incorrectly concluded that the original estimates of the 14 HCFA area carriers, fatally flawed from the outset, remain valid. Hence, GAO based its current budget estimates on those unverified projections.

GAO ANALYSIS:

It is not accurate to characterize the 14 area carriers' estimates as "undocumented" because the carriers did provide us with written responses showing by each functional type of cost how much such costs would change in 1979 by adding the relatively small RRB workload to the projected 1979 claims volumes. In fact, the "additional business" was so small, we believe Travelers has very questionable grounds to challenge the motives and veracity of these organizations. Further, because the added workload on a carrier-by-carrier basis was so small (generally less than 5 percent), the only practical way to "verify" the estimates would be for the HCFA carriers to actually process the RRB claims.

APPENDIX V

TRAVELERS COMMENT:

Use of the 66% figure in determining the HCFA area carriers' average incremental cost per claim was inappropriate in 1979 and is even more inappropriate in 1984. The 66% figure has subsequently been proven by GAO's own statistics to have been inaccurate. The savings to the federal government more accurately may be measured by comparing the RRB carrier's average cost per claim with the HCFA area carriers' average cost per claim as several studies commissioned by HCFA have confirmed.[7]

GAO ANALYSIS:

Travelers' decision to cite this particular study to support its comments seems inconsistent with its previous position on the study particularly with regard to the issue of "economies of scale." In a July 5, 1983, letter to the HCFA Administrator, as Chairman of the Medicare Administration Committee of the Health Insurance Association of America, the same individual that signed Travelers' comments on our report had the following to say about the Abt Associates, Inc., study:

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[7]A recent study by Abt Associates, Inc., which had been commissioned by HCFA, see note 15 infra, explains that several studies have tried to test whether economies of scale exist in the Medicare claims processing industry or stated differently, whether there is any validity to an incremental cost theory like that espoused by GAO. According to the Abt study, all except one of those studies found no evidence of economies of scale in Medicare claims processing. Id. at 2-16 - 2-18. The single study that purported to find evidence of economies of scale was GAO's own 1979 report concerning the use of a separate nationwide RRB carrier. Id. at 2-18.

The Abt study itself reconsidered whether economies of scale exist in Medicare claims processing. Using far more sophisticated methods than those employed by GAO in 1979, the Abt study found only a "hint" of economies of scale. Id. at 2-19. As the study explained, the HCFA area carriers with very small claims volumes perhaps could process additional claims at a cost slightly less than their average cost per claim, while the HCFA area carriers with larger claims volumes could process additional claims only at approximately the same cost as (or even at a cost greater than) their average cost per claim. Id. at 2-52.

"We are extremely concerned that the report prepared by Abt Associates, Inc. is replete with findings and recommendations that are misleading and erroneous."

. . . . .

"Findings and recommendations are justified by regression analysis as though the Medicare contractor community is a collection of like objects. Each contractor is faced with different problems in the administration of the program in its area . . ..

"It is wrong, therefore, to draw conclusions based purely on statistical analysis . . .

"We do not agree with the conclusions reached in the report under the subject 'Economies of Scale'. . .. Certainly, the regression analysis is inconclusive and we do not agree that diseconomies appear at an annual volume of 14 million claims. Although the report states that no carrier currently processes this level of claims volume, this is no longer true. Two carriers currently are above that volume level and there is no evidence of any diseconomy of scale."

Further, on the page 2-52 cited by Travelers, the Abt study was discussing the potential savings from consolidating small carriers processing less than 2 million claims per year. The added volume in absorbing the RRB workload at most of the larger carriers would be less than one-tenth of that amount.

TRAVELERS COMMENT:

In the years since 1979 for which probative statistics are available,[8] the HCFA area carriers' actual average incremental

[8]The years for which probative statistics are available are 1979, 1980 and 1981. The years 1982 and 1983 do not provide probative statistics because the incremental cost estimate relied upon by GAO in 1979 could validly be tested only in a marketplace unfettered by the artificial budget constraints imposed in 1982. As GAO recognizes, 1982 was not a typical year in that HCFA's cost type carriers absorbed their increased claims volumes at no increased total costs. We believe that this occurred because the appropriation or budget level for all contractor activities . . . increased from 1981 to 1982 by $10.4 million or only about 1.5 percent of the fiscal year 1981 funding levels which necessitated the carriers to cut back on various activities and services. Draft Report, Appendix I at 5. The following year, 1983, also was not a typical year because the area carriers were in the process of recovering from the cut backs necessitated by the budgetary constraints imposed on them in 1982. The area carriers were beginning to resume the activities and services that had been curtailed and to re-hire personnel that had been released. In 1983, therefore, the area carriers' average incremental cost per claim was only $0.98, or 42% of their average cost per claim ($2.31). GAO note: We do not agree that fiscal year 1983, which is the most recent full year for which data are available, should be completely disregarded as Travelers suggests. As indicated on the table on page 4 of appendix I, the carriers had sufficient funds in 1983 to make over $17 million in prepayments for 1984 expenses. These prepayments were made in the last quarter of fiscal year 1983, which partially explains the difference in the reported average unit costs for the first three quarters and the last quarter which is shown in the following table.

	Claims processed (millions)	Average cost per claim
October 1982 - June 1983	138.5	$2.20
July 1983 - September 1983	47.9	2.84

Thus, while fiscal year 1982 was atypical in that cost increases were constrained by budget limitations, available evidence suggests that the area carriers were not under comparable constraints in fiscal year 1983 and that the 1983 incremental cost experience should not be disregarded.

cost per claim never approached an amount as low as 66% of the HCFA area carriers' average cost per claim. The HCFA area carriers' actual average incremental cost per claim was 87% for those years.[9] In the most recent year for which probative statistics are available, 1981, the HCFA area carriers' actual average incremental cost per claim equalled 100% of the HCFA area carriers' average cost per claim, substantiating that the incremental cost methodology should not be used.

GAO ANALYSIS:

The incremental cost estimates provided by HCFA carriers and the incremental cost data on page 5 of appendix I were computed based on different periods of time and thus are not comparable. The incremental costs obtained from the area carriers involved estimated increases in cost for the same or "current" year (1979) where the projected effects of inflation were already built into the amounts. In contrast, the incremental cost data on page 5 compare one year's cost to the previous year's and as noted in the report do not take into account the effects of inflation. In effect, Travelers' computations of "actual" incremental cost for comparison with the HCFA carriers' estimates assume there was no inflation during the period 1978 through 1981, which in our opinion, is unrealistic. For example, according to HCFA's analysis of administrative costs, the carriers' average hourly personal services cost (salaries and wages plus fringe benefits), which represents about 60 percent of total costs, increased at the following rates.

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[9]In 1979, the HCFA area carriers' average incremental cost per claim was $2.42, which equals 87% of the HCFA area carriers' average cost per claim in 1979 ($2.77). In 1980, the HCFA area carriers' average incremental cost per claim was $1.98, which equals 74% of the HCFA area carriers' average cost per claim in 1980 ($2.68). In 1981, the HCFA area carriers' average incremental cost per claim was $2.66, which equals 100% of the HCFA area carriers' average cost per claim in 1981 ($2.67). See Draft Report, Appendix I at 5.

Fiscal year	Average personal service cost per productive hour	Percent increase from previous year
1978	$ 7.78	-
1979	8.45	8.6
1980	9.17	8.5
1981	10.09	10.0
1982	11.39	12.9
1983	12.26	7.6

Notwithstanding these increases in wages, the carriers' average unit costs per claim decreased during the 5-year period primarily due to offsetting increases in productivity. Using the rate of increase in the carriers' personal service costs as a measure of the effects of inflation, we recomputed the incremental cost from one year to the next by increasing the prior year's personal services cost by the percentage increase in personal service costs per hour and compared the adjusted total costs with the following years. We limited our inflation adjustment to personal service costs because the increases were readily determinable from HCFA's analysis of carriers' administrative cost reports. A comparison of the unadjusted and adjusted incremental unit costs is shown in the following table.

Fiscal year	Unit cost	Incremental unit cost unadjusted for inflation	Percent of unit cost	Incremental unit cost adjusted for wage increases	Percent of unit cost
1979	$2.77	$2.42	87.4	$1.05	37.9
1980	2.68	1.98	73.9	0.96	35.8
1981	2.67	2.66	99.6	1.29	48.3
1982	2.44	-	-	-	-
1983	2.31	.98	42.4	-	-

In our opinion, the incremental unit costs adjusted for wage increases are more comparable to the HCFA area carriers' estimates than the Travelers' computation of 87 percent because the former reflects incremental unit cost on the basis of the "current" year's costs instead of on the basis of the previous year's costs.

TRAVELERS COMMENT:

Comparing the average costs per claim of the RRB carrier and the HCFA area carriers, the budget savings would have been no more than $1.1 million in 1983.

Even using the incremental cost methodology with the correct 87% figure, the annual savings to the federal government would have been substantially lower than those projected by GAO. The HCFA area carriers' average incremental cost per claim for 1983 should be $2.01 (0.87 x $2.31), and not $1.52 as GAO had determined. The savings for 1983 therefore would have been only $2.8 million (($2.51-$2.01) x 5,600,000), or approximately one-half of the amount estimated by GAO.

GAO ANALYSIS:

As discussed on the previous page, the "correct 87% figure" disregards the impact and effects of inflation, which for the period being considered is unrealistic.

TRAVELERS COMMENT:

2. Purported Savings from Elimination of Misrouted RRB Claims Are Inflated

GAO arrived at the $1.0 million figure for misrouted RRB claims by relying on two estimates obtained from several HCFA area carriers. These area carriers estimated that 20% of RRB claims in 1982 were misrouted (0.20 x 5,100,000) and that, as a result, the area carriers incurred administrative costs of approximately $1.00 per claim.

Reliance on the HCFA area carriers' estimates is inappropriate for several reasons. First of all, it is unclear how the HCFA area carriers estimated the number of RRB claims that were misrouted. HCFA requires the area carriers to report the number of misrouted claims that they handle, including not only misrouted RRB claims but also misrouted area carrier claims and "crossover" Medicaid claims. HCFA apparently does not, however, require the area carriers to identify the type of misrouted claim. In addition, it is unclear how the HCFA area carriers estimated the cost per claim involved in handling the misrouted RRB claims. In light of these uncertainties, and especially in light of the HCFA area carriers' grossly inaccurate estimate of their average incremental

cost per claim,[10] the two estimates here should not be credited.[11]

GAO ANALYSIS:

We obtained estimates from individuals at the area carriers whose duties involved handling the misrouted claims and who were presumably the most knowledgeable as to what proportion was attributable to RRB claims. We have no reason for assuming they were not telling us the truth and that their estimates were not reasonable. Further, as pointed out on the previous page, Travelers' assertion that the HCFA area carriers had "grossly inaccurate estimates of their average incremental cost per claim" is based on an unrealistic assumption and faulty comparisons.

Finally, if Travelers wanted to provide some objective evidence to dispute the area carriers' estimates of misrouted claims, it would merely have to check with its field offices to determine the percentage of incoming claims that come from the area carriers.

Although we believe the estimate of the number of misrouted claims to be reasonable, we acknowledge in the report that the estimate of the area carriers' current costs of identifying and rerouting them was "probable."

TRAVELERS COMMENT:

Another factor also reduces the federal budget savings somewhat. If the responsibility for processing railroad Part B beneficiary claims is turned over to the HCFA area carriers, then a percentage of those claims would be misrouted in approximately the same percentage that area carrier claims ordinarily are misrouted. Consequently, the percentage of misrouted area carrier

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[10]As is discussed above, the HCFA area carriers underestimated their average incremental cost per claim by at least 21%. The HCFA area carriers estimated their average incremental cost per claim as 66% of their average cost per claim, while in fact their average incremental cost per claim turned out to be 87% -- and 100% in the most recent year for which probative statistics are available -- of their average cost per claim.

[11]In its letter to GAO commenting on the 1979 report, RRB itself questioned the accuracy of the two estimates. RRB, from its experience, considered the two estimates to be inflated. See note 1 supra.

claims should be subtracted from the percentage of misrouted RRB claims before multiplying by the cost per claim.

GAO ANALYSIS:

Although Travelers' comments may be theoretically correct, the effect of its impact on the estimate of the number of misrouted claims is minimal. The HCFA carriers for the area surveyed processed about 96 million claims in fiscal year 1982. The misrouted claims of all types were about 1.2 million, or about 1.25 percent. About half (45 percent) involved RRB claims; thus about half, or 0.7 percent (55 percent of 1.25 percent), were other types of claims which were misrouted. As we understand Travelers' comment, if the 5.1 million in RRB claims it processed in 1982 had been processed by the area carriers, then 0.7 percent, or about 35,000, would have been misrouted and should be deducted from the 1,020,000 misrouted claims, leaving an adjusted amount of 985,000 claims, which in our view is still "about 1 million."

TRAVELERS COMMENT:

Finally, in addition to the foregoing observations, the problem of misrouted RRB claims should become increasingly insignificant over the next few years. As the draft report acknowledges, the percentage of misrouted RRB claims has steadily declined since 1978, and most of these claims originate from providers rather than beneficiaries, a circumstance which will allow the problem to be more easily corrected. Two other factors should further accelerate the correction of the problem. First, the movement toward electronically submitted claims should decrease routing errors. Second, HCFA itself could substantially reduce the administrative costs associated with the handling of misrouted RRB claims by instructing the area carriers to transfer those claims to the RRB carrier at the front end of the claims process.

GAO ANALYSIS:

We cannot speculate as to when the problem of misrouted RRB claims will be eliminated. As previously discussed, the volume of RRB claims since 1970 has increased from 8 to 12 percent a year with the Travelers-RRB fiscal year 1984 budget estimates projecting about 6.2 million claims for the current year, or an increase of about 10 percent over 1983. Thus, over the next 3 or 4 years, if the incidence of misrouted claims is reduced from 20 to about 10 percent, the number of such claims would still be about 750,000 to 850,000.

Further, in its comments on our June 1979 report, Travelers provided similar optimistic predictions as to the solution of the problem which did not fully materialize. For example, as Travelers pointed out at that time, the Medicare identification numbers for RRB beneficiaries were provided with unique prefixes to facilitate their identification. Given this change, we had expected the improvement in misrouted claims to be even greater than it was.

TRAVELERS COMMENT:

C. Substantial Federal Budget Losses Not Contemplated by GAO Would Result From the Proposed Legislation.

1. HCFA Area Carriers' Higher Overpayment Rate.

The federal government would incur substantial annual losses because the HCFA area carriers have a higher overpayment rate than the RRB carrier. In 1983, these losses would have equalled more than $1.5 million.[12]

GAO has rejected the methodology suggested by The Travelers for determining these revenue losses. GAO argues that the HCFA area carriers' higher overpayment rate is offset by the HCFA area carriers' underpayment rate, which is also higher than the RRB carrier's underpayment rate. GAO suggests that "the true impact on outlays for benefit payments would be the net difference between overpayments and underpayments not just gross overpayment errors."[13]

This suggestion is astonishing as a matter of public policy. The underpayment error rate which GAO credits as an offset to the overpayment error rate by HCFA area carriers depicts payments which have been improperly denied to elderly beneficiaries. GAO should not propose that the Congress seek, or institutionalize, purported federal budget savings attributable to monies withheld from these elderly claimants. In the current system, as underpayment errors are discovered, they are corrected with a payment. Similar attempts to collect overpayments which are detected often prove to be unsuccessful.

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[12]This $1.5 million estimate is arrived at by multiplying the difference between the HCFA area carriers' overpayment rate and the RRB carrier's overpayment rate times the dollar amount of submitted charges ((.8% - .6%) x $774,638,738 = $1,549,277).

[13]Draft Report, Appendix I at 10.

It is inappropriate as a matter of public policy to suggest that the Congress reap budget savings from underpayments; and it is inappropriate as a matter of simple fact to discount overpayments as budget losses. The federal government would incur budget losses of $1.5 million per year from the higher overpayment error rate among HCFA area carriers.

Even using the methodology improperly suggested by GAO, the federal government would incur significant annual losses. The differences between the underpayment and overpayment error rates of the HCFA area carriers and the RRB carrier in 1982 did not tend to offset each other, as GAO suggests. There was a net difference of 0.1%. Even under the GAO methodology, therefore, the federal government would have incurred net losses in 1982 of $644,000.[14]

GAO ANALYSIS:

We believe the $1.5 million cited by Travelers needs to be clarified. The $1.5 million in "losses" cited by Travelers for fiscal year 1983 are similar to the $2,657,118 in "savings" for 1982 cited by Travelers and discussed on page 8 of appendix I. The principal reason for the lower amount for 1983 is that the differences between the national average payment deductible error rate and the Travelers-RRB payment deductible error rate as shown by Medicare quality assurance statistics have grown much smaller as shown below.

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[14]The amount of net federal losses or savings is computed by multiplying the dollar amount of charges submitted by railroad Part B beneficiaries ($644,000,000) times the difference between the HCFA area carriers' net overpayment rate and the RRB carrier's net overpayment rate (.3% - .2%). The net overpayment rate equals the difference between the overpayment rate and the underpayment rate.

APPENDIX V

	Total payment deductible error rate		Overpayment error rate		Underpayment error rate		Deductible error rate	
	1982	1983	1982	1983	1982	1983	1982	1983
National average	1.7*	1.5	0.9	0.8	0.6	0.6	0.1	0.1
Travelers-RRB	0.8	1.1	0.5	0.6	0.3	0.4	0	0.1
Difference	0.9*	0.4	0.4	0.2	0.3	0.2	0.1	0

* Does not add due to rounding.

As previously discussed on page 8 of appendix I, it is our basic position that Medicare's quality assurance statistics cannot be used to compute "savings" or "losses" in the manner Travelers suggests.

We are not suggesting that the Congress reap budgetary savings from underpayments to elderly or disabled beneficiaries. We are merely pointing out that the Medicare quality assurance statistics used by Travelers to compute "savings" or "losses" include overpayments and underpayments and it seems unrealistic to consider only one and not the other in the context of using the HCFA area carriers to pay the RRB-related claims. With regard to underpayments, in two prior reports (see note a) we were critical of Medicare's quality assurance program because it did not adequately identify situations where beneficiaries have been underpaid due to errors that were not necessarily the fault of the carrier but rather of the provider.

Finally, we believe it is important to reiterate that because Travelers paid different amounts than the HCFA area carriers would have paid for the same service by the same provider for about 80 percent of the claims we sampled, there is no assurance that RRB beneficiaries would have received any more or any less money if the HCFA area carriers had processed their claims.

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[a]More Action Needed to Reduce Beneficiary Underpayments (HRD-81-126, Sept. 3, 1981).

Reasonable Charge Reductions Under Part B of Medicare (HRD-81-12, Oct. 22, 1980).

TRAVELERS COMMENT:

2. Increased Administrative Costs for The Travelers in Its Capacities as HCFA Part A Intermediary and Part B Area Carrier.

The Travelers now processes both railroad and HCFA Part B beneficiary claims through the same claims processing system. The number of railroad Part B beneficiary claims is approximately equal to the number of HCFA Part B beneficiary claims. (The Travelers is also a HCFA Part A intermediary.) The efficiencies that The Travelers has been able to achieve by utilizing the same claims processing system for both railroad and HCFA Part B beneficiary claims inevitably would be reduced significantly by GAO's proposal. In the event that the responsibility for processing RRB Part B beneficiary claims is turned over to the HCFA area carriers, The Travelers in its capacities as a HCFA Part A intermediary and a Part B area carrier would incur increased administrative costs of at least $1.0 million per year. These costs would necessarily accrue to the federal government.

GAO ANALYSIS:

Travelers apparently recognizes the validity of our incremental cost approach by pointing out that if there are adjustments to claims volumes, there will be corresponding adjustments in the fixed costs applied to the remaining workload. We do not agree, however, that "these costs would necessarily accrue to the federal government." This is because Travelers is already one of the most costly Part A intermediaries (ranking 55th out of 63 intermediary locations in terms of adjusted unit cost per bill processed in 1983) and as a HCFA Part B area carrier in 1983 was about $0.15 a claim, or about $1.0 million, more costly than the average cost for the carriers in its peer group. (For comparison purposes, HCFA groups its carriers into four peer groups based on claims volume.)

Therefore, it is uncertain as to how much additional costs HCFA would accept during its annual budget negotiations without requiring some offsetting savings. Further, we believe HCFA's authority to limit contractor administrative costs to those of its peers was strengthened by the enactment of section 2326(d) of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369), which provides that in determining the necessary and proper administrative costs of intermediaries and carriers, HCFA shall "take into account the amount that is reasonable and adequate to meet the costs which must be incurred by an efficiently and economically operated" intermediary or carrier.

TRAVELERS COMMENT:

3. Higher Payments in Medicare Benefits per Enrollee

A recent study by Abt Associates, Inc., which had been commissioned by HCFA, found that among carriers processing Part B Medicare claims, a higher cost per claim generally is associated with a lower level of benefit payments per enrollee. Specifically, the study determined that in 1981 an increase of $0.04 in a carrier's cost per claim was associated with a reduction in benefit payments per enrollee of either $0.58 or $1.96, depending on the methodology used.[15]

Importantly, the study did not attribute the reduction in benefit payments to the underpayment of beneficiaries or to any other improper withholding of deserved benefits. The study attributed the reduction to the commitment of more resources to carrier administration, including "more effort in the areas of utilization review, audit, detection of duplicate claims, verification that providers have used the correct procedure codes in billing for services, and similar functions."[16]

In 1981, the year analyzed by the study, the RRB carrier's average cost per claim ($2.97) was $0.30 higher than the HCFA area carriers' average cost per claim ($2.67). As the study suggests, the RRB carrier's higher average cost per claim probably was attributable to the commitment of more resources to carrier administration. Indeed, the RRB carrier consistently has performed its claims processing functions more accurately than the HCFA area carriers, as GAO acknowledges.

Thus, in 1981, the RRB carrier seems to have saved the federal government between $3,871,500 ((($2.97 - $2.67) - $0.04) x $0.58 x 890,000) and $13,083,000 ((($2.97 - $2.67) - $0.04) x $1.96 x 890,000) by paying less in benefit payments per enrollee than the average HCFA area carrier as a result of greater administrative efficiency. The federal government would have lost these savings if the responsibility for processing railroad Part B beneficiary claims had been turned over to the HCFA area carriers.

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[15]See "Final Report for the Evaluation of the Medicare Part B Fixed Price Experiments in Maine, Upstate New York and Illinois," by Abt Associates, Inc. (commissioned by HCFA) (1983) at 2-70.

[16]See id. at 2-72 (footnote omitted).

GAO ANALYSIS:

We discussed Travelers' gross projections of $3,871,500 to $13,083,000 in lower benefit payments with the project director of the subject study, who advised us that:

"It would be a serious misinterpretation of the analysis to assume that a carrier must inevitably be saving the Medicare program money on benefit payments simply because its costs are higher than some benchmark, such as the national average of claims processing costs. A more correct rendering of the analysis is that some carriers have justifiably high costs--because they are doing a better job or because they are located in a costly business area--and these higher costs are necessary in order to assure good control over Medicare benefit payments. However, all instances of higher costs are by no means justified." He added, however, that for the period 1979 to 1981 Travelers-RRB administrative costs were lower than predicted by a statistical model which would indicate that the carrier "appears to be more efficient than would be most carriers under similar circumstances," but that "RRB's benefit payments were in line with those of other carriers under similar circumstances."

In fiscal year 1981, Travelers-RRB made benefit payments of $273.4 million, or about $307 per enrollee. Under Travelers' calculations, the $0.04 per claim cited in the Abt study was divided into $0.30 to produce a multiplier of 7.5. This multiplier was applied to the benefits per enrollee of $0.58 and $1.96 to produce a reduction in benefit payments of $4.35 and $14.70 per enrollee, respectively. We do not believe that such gross projections are supportable. If the Travelers' approach is carried to the extreme and if its administrative costs per claim had reached $6 more than the national average, then Travelers-RRB would not have made any benefit payments at all which, of course, would never have happened.

Although, as mentioned in the Abt study, our prior work had shown a positive cost-to-benefit relationship to the Medicare carriers' utilization review function (see note b) the Travelers-RRB unit cost in 1981 of $0.13 a claim for this function was exactly the same as the national average so that no savings in benefit payments resulting from higher administrative costs could be attributable to this activity.

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[b]Improving Medicare and Medicaid Systems to Control Payments for Unnecessary Physicians' Services (GAO/HRD-83-16, Feb. 8, 1983).

TRAVELERS COMMENTS:

4. Losses From HCFA Area Carriers' Less Effective and Efficient Implementation of Section 116 of TEFRA.

GAO acknowledges that the Travelers current arrangement with RRB will facilitate the effective and efficient implementation of Section 116 of TEFRA, which provides that, effective January 1, 1983, Medicare payments will be secondary for workers and their dependent spouses aged 65 through 69 who are covered under employee group health plans, if the workers elect to make their group health plans primary to Medicare.

GAO adds that, in contrast, the Travelers "implementation of section 116 of TEFRA under its RRB contract is likely to be more effective and efficient than the implementation of this provision by the area carriers" because of the Travelers long-term relationship with the railroad industry and, more importantly, because of the computer edits used by the Travelers. The Travelers, unlike the HCFA area carriers, uses computer edits in order to identify claims that should be paid first under the private health plans and therefore eliminate erroneous payments to beneficiaries out of Medicare funds.

Nevertheless, when it recommends that the Congress enact legislation that would turn over the responsibility for processing railroad Part B beneficiary claim to the HCFA area carriers, GAO fails to consider the losses that the federal government would incur in connection with Section 116 of TEFRA. GAO was unable to quantify these losses, but it is clear that the federal government would incur substantial losses.

GAO ANALYSIS:

As pointed out in OMB's comments on this report, we may have placed too much emphasis on this purported advantage to the existing Travelers-RRB arrangement because the more effective administration of the working aged provision of section 116 of TEFRA applies to only 10,000 RRB beneficiaries (those who are employed by the railroads and who are not receiving railroad retirement) or only about 1 percent of the RRB beneficiary population. Travelers' payment safeguards would not extend to RRB Medicare beneficiaries who may be in nonrailroad employment and thus not covered by Travelers' private Group Policy contract for the nation's railroads and railway labor organizations.

Because available data show that about 10 percent of the aged Medicare beneficiaries are employed, Travelers is probably in no better position than the HCFA area carriers with regard to the effective implementation of section 116 of TEFRA for the vast majority of its working aged.

This situation seems to be confirmed by Travelers' June 30, 1983, letter to RRB concerning its 1984 budget, in which it estimated a cost of $387,000 for implementing this provision. This cost would duplicate the additional payment safeguards and system changes being established by the HCFA area carriers.

TRAVELERS COMMENTS:

5. Termination and Other Costs

In the event that the responsibility for processing railroad Part B beneficiary claims were turned over to the HCFA area carriers, the federal government also would incur substantial nonrecurring losses. These losses would include not only more than $1.0 million in termination costs, as GAO recognizes, but also considerable additional termination costs and more than $4.9 million in costs attributable to systems conversion and the conversion of RRB histories, provider files and other data essential for detecting the duplication of benefits and overutilization.[17]

GAO ANALYSIS:

We believe that Travelers' assessment of the problem and the related estimates of $4.9 million in systems conversion costs are overstated. According to HCFA officials, the HCFA area carriers

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[17]The $4.9 million estimate is used here to illustrate that conversion costs would be substantial. The estimate is not precise, however, because it was arrived at by referring to, as an example, similar conversions done by area carriers in converting to Standardized Procedural Coding (HCPCS). As explained at the National HCPCS Conference on April 26 and 27, 1983, the conversion cost is equal to the average man years times the average personal service cost times the number of carriers (5-2/3 x $20,151 x 43 = $4,910,416). In this equation, the average man years is based on the following estimates made at the National HCPCS Conference: 6-1/2 man years (Arkansas Blue Cross/Blue Shield); 2-1/2 man years (Medical Mutual Insurance of Indiana); and 8 man years (Washington Physicians Service). The average personal service cost is based on an analysis of the HCFA area carriers' administrative costs in 1983.

would only have to convert the RRB beneficiary history files and the Travelers' pending claims files if they were to absorb the RRB workload. Because the Travelers-RRB claims volume is so small in relation to the HCFA area carriers, its provider files would be of little or no use to them to identify overutilization. The conversion cited by Travelers in the footnote involves a Standardized Procedural Coding System (HCPCS). Carriers use procedure codes to identify the medical services such as office visits being provided. Historically carriers have had different coding systems, and one of HCFA's objectives is to have all carriers converted to HCPCS by June 1985 with almost all converted by January 1985. According to Travelers, it also plans to have converted its RRB system to HCPCS by the beginning of the year. If this is the case then there will be no need to do any extensive conversion of the procedure codes in the beneficiary history or pending claims files. Thus the file conversion would not involve similar conversions cited by Travelers in developing its estimate of $4.9 million.

TRAVELERS COMMENTS:

III. Conclusion

The draft report does not credit (1) important public policy considerations which support continuation of the current RRB authority and (2) substantial budget losses that would befall the federal government under GAO's proposal. The federal budget savings purported within the draft report would not materialize. Simply stated, the draft report insufficiently supports a recommendation that Congress should enact legislation that would terminate RRB's authority to select a carrier for railroad

APPENDIX V

Part B beneficiaries and turn over the responsibility for processing railroad Part B beneficiary claims to the HCFA area carriers.

Thank you for the opportunity to comment on the draft report. Please do not hesitate to contact me if you have any questions.

Very truly yours,

L. E. Carter

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