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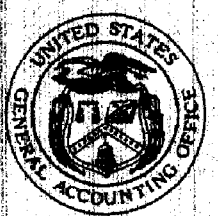
Report to the Chairman, Permanent Subcommittee on Investigations, Committee on Governmental Affairs, U.S. Senate

August 1994

MEDICARE

HCFA's Contracting Authority for Processing Medicare Claims



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Health, Education, and
Human Services Division

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August 2, 1994

The Honorable Sam Nunn
Chairman, Permanent Subcommittee on
Investigations,
Committee on Governmental Affairs
United States Senate

Dear Mr. Chairman:

Your investigation into the activities of four Blue Cross and Blue Shield (BCBS) plans and the oversight role of their national association and our recent report on the financial condition of Blues plans[1] uncovered many examples of wasteful spending and mismanagement. Because many Blues plans also contract with the Health Care Financing Administration (HCFA) to process and review Medicare claims, you were concerned that this kind of waste and mismanagement may result in HCFA overpaying Medicare contractors to pay beneficiaries' medical claims. Accordingly, you asked us to examine (1) how HCFA contracts with insurance companies to process and review Medicare claims, (2) how HCFA contracts with the Blue Cross and Blue Shield Association to subcontract with its member plans to process Medicare Part A claims, (3) how HCFA sets contract prices and seeks to ensure that proper cost controls are in place, (4) how HCFA evaluates contractors' performance, and (5) whether payments for dues that these contractors make to insurance associations are permissible.

Background

Medicare is a federal health insurance program that covers about 33 million people age 65 and over and about 2 million disabled individuals who are under age 65. Medicare provides coverage under two parts. Part A—hospital insurance—covers inpatient hospital services, home health services, skilled nursing facilities, and hospice services. Part B—supplementary insurance—covers physician services, outpatient laboratory services, and a wide array of other health services.

HCFA administers the Medicare program by contracting with insurance companies to process Medicare claims. Section 1816 of the Social Security Act (42 U.S.C. 1395h) authorizes HCFA to contract with entities such as insurance companies, then called fiscal intermediaries, to process Medicare part A claims. HCFA also has a part A contract with the Blue

[1]Blue Cross and Blue Shield: Experiences of Weak Plans Underscore the Role of Effective State Oversight (GAO/HEHS-94-71, Apr. 13, 1994).

Cross and Blue Shield Association, the national trade association for the independent Blues plans, which subcontracts with 41 Blues plans to process Medicare part A claims. Section 1842 of the Social Security Act (42 U.S.C. 1395u) authorizes HCFA to contract directly with entities such as insurance companies, then called carriers, to process Medicare part B claims.

In fiscal year 1993, Medicare contractors processed about 700 million claims and were paid about $1.5 billion—about 2 percent of the total Medicare budget. The remaining 98 percent of the Medicare budget—about $146 billion—was used to pay hospitals, doctors, and other providers.

Scope and Methodology

To determine how HCFA awards and oversees Medicare contracts, we reviewed Medicare part A and B contract and budget documents for fiscal years 1990 through 1992 at BCBS plans in Florida and Kansas, and at Travelers Insurance Company, Hartford, Connecticut. We selected these contractors to obtain a mix of both Blues and commercial insurer plans. We also interviewed HCFA, Medicare contractor, and Blue Cross and Blue Shield Association officials about the Medicare contracting process. (See app. II for our detailed scope and methodology.)

Results in Brief

Since 1966, HCFA has awarded most part A and B Medicare contracts without competition, renewed them annually, and compensated contractors on a cost-reimbursement basis. Periodically the Congress has directed HCFA to experiment with other types of contracts in an effort to reduce administrative costs. Earlier experiments had mixed results, but current experiments indicate that different types of contracts may reduce costs. The Congress is now considering a legislative proposal requiring HCFA to study the feasibility of making the contracting process more competitive. While HCFA's current authority provides opportunities to achieve administrative efficiencies, it may be useful for the Congress to direct HCFA to evaluate new approaches that could lead to a more competitive environment. Any changes, however, should avoid problems that have occurred in past experiments.

The role that the Association plays in coordinating part A contracting activities with the individual Blues plans may limit the need for HCFA resources to perform these activities. However, HCFA has not evaluated the Association's performance since 1989, even though HCFA paid the

Association over $21 million during that period. In our view, HCFA needs to regularly assess the Association's performance, just as it does for other contractors, to ensure that the Medicare program is being managed efficiently.

HCFA's budget process uses payment controls to help ensure that contractors do not exceed their budgets. With one exception, HCFA reduced the per claim funding for each contract we reviewed and limited contractor payments to the agreed upon budget. However, although HCFA has reduced the costs per claim, we are concerned that these reductions could lead to cuts in funding for reviews that ensure that claims are being paid properly and, therefore, make the Medicare program more vulnerable to waste and abuse.

HCFA oversees the Medicare contracting process by evaluating contractor performance against claims processing, customer service, and program efficiency standards. HCFA also reviews the Department of Health and Human Services' (HHS) Office of Inspector General (OIG) audits of Medicare contractors. In the past, however, these audits have found little basis to question contractor financial activities. The Inspector General believes that the OIG's audit resources could better be used in other oversight activities.

Medicare contract provisions, which are consistent with federal procurement regulations, permit contractors to be reimbursed for dues paid to associations if the dues are used to help the contractors provide better service to beneficiaries and providers. Contractors are not allowed to include lobbying costs in dues payments. OIG audits routinely review dues payments to ensure compliance with these regulations and provisions. The OIG audits that we reviewed for both Blues plans and commercial insurers had found no basis to question their dues payments.

How Medicare Contracts for Claims Processing

When Medicare began in 1966, the Congress required HCFA to contract with entities such as insurance companies that already performed in their private business many of the functions that they would perform for Medicare. Generally, contracts for processing Medicare claims could be awarded noncompetitively and on a cost-reimbursed basis to ensure that insurance companies would be willing to participate in the Medicare program.

For Medicare part A, providers nominate a contractor to process their Medicare claims, subject to HCFA approval. These contractors, called fiscal intermediaries, are responsible for processing and reviewing all part A claims and communicating with providers—hospitals, nursing facilities, home health agencies, and hospices—about the program. Most providers nominate local Blues plans as their intermediaries, but commercial insurers, such as Travelers, are also nominated by providers. In fiscal year 1993, HCFA had part A contracts to process claims with five commercial insurers and the Blue Cross Blue Shield Association, which, in turn, subcontracted with 41 local Blues plans. These contractors were paid $475 million in fiscal year 1993.

For Medicare part B, HCFA selects the contractors rather than providers nominating them. These contractors, called carriers, process and review claims from doctors and suppliers in a particular geographic area. In fiscal year 1993, HCFA had 54 contracts with 36 insurance companies that were paid about $1.04 billion to process and review claims.

Since the early 1980s, the Congress has twice authorized HCFA to experiment with different types of contracts to determine whether they would reduce administrative costs. The Deficit Reduction Act of 1984, section 2326, authorized HHS to use a limited number of fixed-price competitions annually. The fixed-price experiments had mixed results. Some fixed price contracts generated savings, but some resulted in payment errors and lost program dollars that more than offset any estimated savings resulting from the change in contracting method.[2] For example, high payment error rates in two experiments resulted in over $130 million in payment errors (both overpayments and underpayments).

In the Omnibus Budget Reconciliation Act of 1989, section 6215, the Congress provided for HCFA to experiment with incentive contracts for processing Medicare claims. Under these experiments, if a contractor's final costs are less than the agreed upon budget, the contractor and HCFA share the savings. This legislation expired on September 30, 1993, but contracts awarded under this legislation are still ongoing. HCFA internal evaluations of these contracts indicate that they result in savings and that they encourage well-performing contractors to remain in the program.

In September 1993, the National Performance Review recommended that HCFA's contracting authority be amended to allow for competitive

[2]Medicare: Existing Contract Authority Can Provide for Effective Program Administration (GAO/HRD-86-40, Apr. 22, 1986).

contracts to reduce costs and eliminate inefficiencies. The Congress is now considering legislation that would require HCFA to study the feasibility of changing the contracting process to a more competitive environment.

HCFA has developed a long-standing practice of contracting with the same entities—typically insurance companies that also process claims for private clients and policyholders. While HCFA officials are working to improve their contracting practices, they perceive many obstacles to changing this practice. As a result, it may be necessary for the Congress to authorize HCFA to evaluate new approaches leading to a more competitive environment and lower claims processing costs. Pending legislative provisions to require that HCFA study the feasibility of making the Medicare contracting process more competitive could eventually lead to improvements in HCFA's contracting practices, but we believe that current Medicare statutes provide HCFA greater flexibility than has been exercised to date. Any changes in HCFA's contracting process should, however, seek to avoid problems that have occurred in past experiments.

Award and Oversight of the Association's Prime Contract

When the Medicare program began, most hospitals nominated the Blue Cross Blue Shield Association as its part A intermediary. HCFA entered into a contract, referred to as the prime contract, with the Association to act as the national coordinating agency to subcontract with individual Blues plans to process Medicare part A claims. HCFA's intent was to reduce its workload by having the Association oversee these contracts because it was familiar with the local Blues plans that most hospitals wanted as their intermediaries.

HCFA payment controls for the prime contract are similar to those for the contractors that process claims in that HCFA sets the total budget limits for the prime contract. In negotiating the prime contract, HCFA proposes a total budget based on the Association's workplan. In addition to the Association's subcontracting activities, the workplan includes tasks such as providing training to subcontractors, serving as an advocate in the appeals process, assisting local Blues plans in their budget process, chairing technical assistance groups for special projects, and interpreting HCFA guidance and providing analysis for individual plans. According to Association officials, the final budget usually does not exceed HCFA's initial proposal. Throughout the year, the Association can request supplemental funds for new work requirements, similar to the other contractors.

From 1990 through 1992, HCFA paid the Association over $21 million to serve as the prime contractor (see app. I). However, HCFA's last evaluation of the Association's performance as the part A prime contractor was in 1988. According to HCFA officials, although they evaluated the 41 Blues plans that the Association subcontracted with, HCFA officials stopped evaluating the Association's performance because contract administration resources were limited and they believed that their daily contact with the Association provided assurance that the prime contract was appropriately administered. In our view, while daily contact is useful for the day-to-day administration of the contract, it is not an acceptable substitute for a periodic, in-depth evaluation of the Association's performance—as is being done for the other contractors. Such evaluations are necessary to measure a contractor's effectiveness and efficiency to decide whether to continue or terminate the Medicare contract.

How HCFA Controls Contract Costs

HCFA determines the amount of funding each contractor will receive using cost per claim data. Using data from a 1989 engineering study that has been updated annually, HCFA calculates the cost per claim based on the mix of claims and each contractor's historical data. According to HCFA officials, this payment control ensures that contractors are not overpaid. HCFA's process has kept the cost per claim low, and for the contractors we visited costs per claim declined for eight of the nine contractors. However, we are concerned that these reductions decrease funding for payment safeguard activities that are critical for protecting Medicare from waste, fraud, and abuse.

HCFA begins the budgeting process by issuing budget performance requirements (BPRs) to each contractor. BPRs identify the particular contractor's tasks to be completed during the annual budget cycles, which vary according to the work involved in processing a contractor's specific workload.[3] BPRs also include HCFA's cost per claim goal, called the bottom line unit cost. The bottom line unit cost, which varies by contractor, is the maximum allowable cost to process a Medicare claim.

Contractors' costs to process Medicare claims are allocated among several line items or processing activities. Each line item includes costs for items such as salaries, computers, facilities, postage, pensions, travel, accounting, and activities that detect fraud and abuse. (App. I contains a

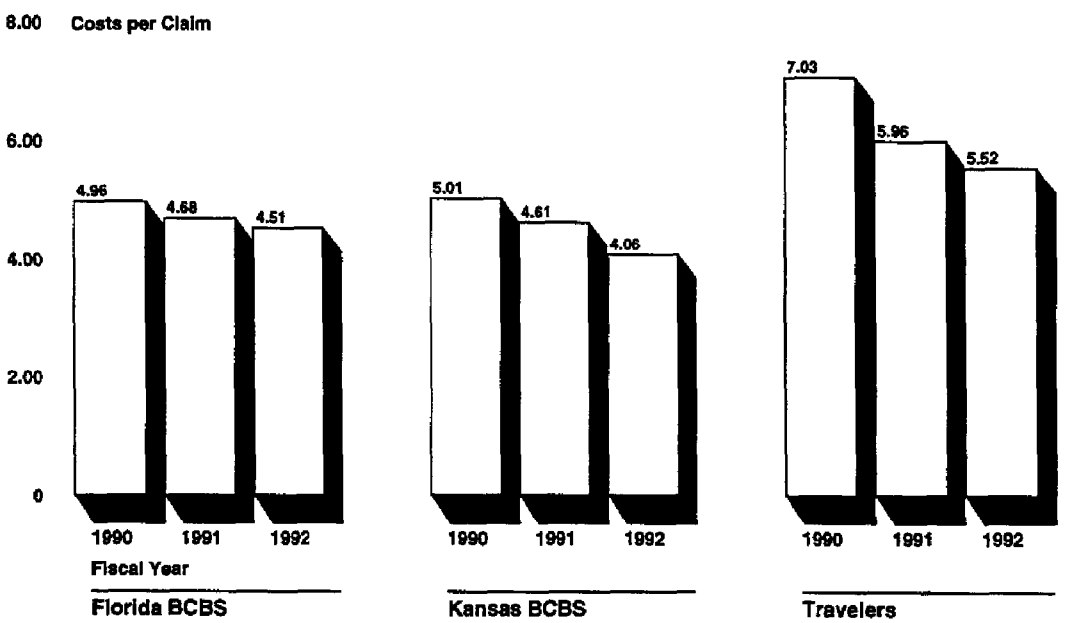
[3]Factors that can affect the amount of work involved in processing claims include such things as the percentage of claims submitted manually rather than electronically. Claims from different types of providers also differ in processing difficulty, so the mix of claims also affects budgeted costs.

summary of budget line items of the contracts for the part A and B contractors in our study.)

After HCFA issues the BPRs, each contractor submits a budget to HCFA that reflects the contractor's estimate of the claims processing workload and costs to perform the work. When HCFA's cost per claim to perform the work is lower than the contractor's estimate, the parties discuss the differences and attempt to resolve them. Contractors may submit supplemental budget requests throughout the year if HCFA requires additional services from the contractor.

For the part A contractors[4] that we reviewed for fiscal years 1990 through 1992, the costs to process a Medicare claim declined (see fig. 1).

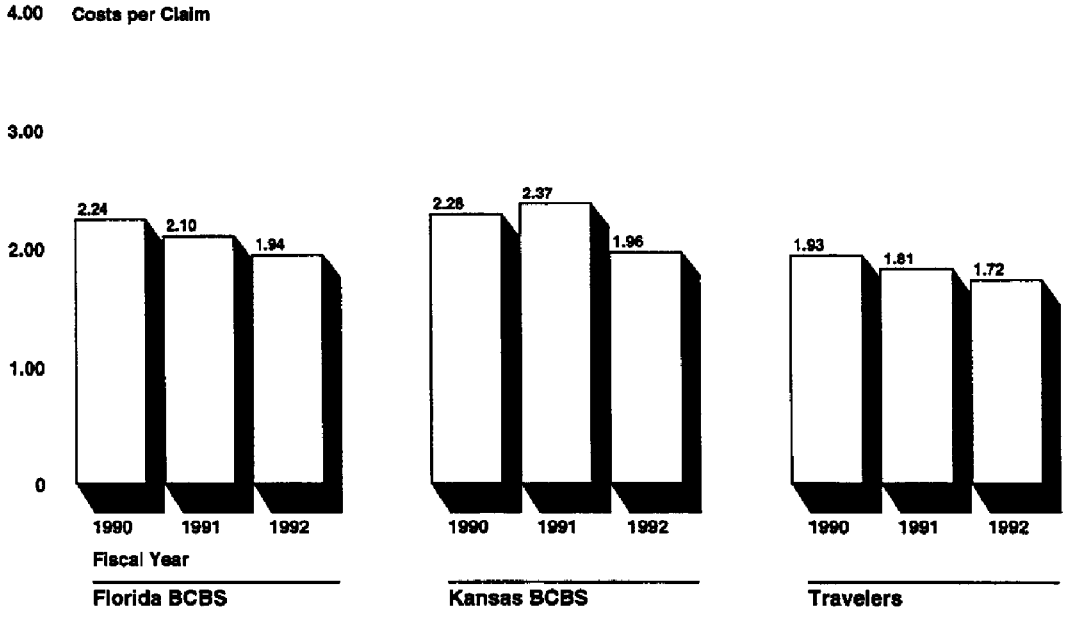
Figure 1: Changes in Medicare Part A Costs per Claim



[4]Travelers' part A costs reflect aggregate costs for three separate contracts it holds in New York, Michigan, and Connecticut.

Costs per claim also declined for eight of the nine part B contractors that we reviewed for fiscal years 1990 through 1992.[5] The contractor whose costs per claim increased attributed the increase to the transition costs and increased workload it assumed when it took over the claims processing activities of another contractor who voluntarily left the Medicare program (see fig. 2).

Figure 2: Changes in Medicare Part B Costs per Claim



Although HCFA has reduced contractors' costs per claim each year, our past studies have shown that contractors have responded by decreasing funding for payment safeguard activities. Such activities are aimed at helping to avoid unnecessary or inappropriate Medicare payments.[6] HCFA contractors have a record of saving about $14 for every $1 spent on payment safeguards.

[5]Travelers' part B costs reflect aggregate costs for the four separate contracts it holds in Michigan, Connecticut, Mississippi, and Virginia.

[6]Medicare: Adequate Funding and Better Oversight Needed to Protect Benefit Dollars (GAO/T-HRD-94-69, Nov. 12, 1993).

Despite the rising volume of Medicare claims, contractors' per claim funding for payment safeguards has declined by over 20 percent since 1989. These cuts have had a significant effect on how well contractors control the billions of dollars of benefit payments. In response to reduced per claim funding, contractors may apply fewer or less stringent payment controls to keep the workload manageable. In our view, HCFA needs to better manage contractor payment safeguard activities to ensure that declining funding for claims processing does not come at the expense of controls that protect Medicare from waste, fraud, and abuse. According to HCFA officials, in 1994, HCFA initiated approaches to better direct the funding to areas with the potential for large dollar savings.

How HCFA Performs Contractor Oversight

HCFA evaluates contractor performance each year through its Contractor Performance Evaluation Program (CPEP), with the exception of the Association's prime contract. CPEP evaluates contractors' performance against a set of standards announced at the beginning of each budget year. The standards emphasize claims processing, service to the provider and the beneficiary, payment safeguards, administrative management, and program efficiency. CPEP results are used to compare contractors' performance, correct inadequate performance, or terminate contracts. Although CPEP is generally accepted as a useful tool in comparing contractor performance, it has focused more on process rather than outcome. Therefore, CPEP does not sufficiently emphasize efforts to save program benefit payments, particularly through its measurement of the effect of payment safeguards.[7]

In addition to CPEP, the OIG audits all costs that the contractors and the Association incur in administering the Medicare program. Each year's contract costs are audited within 5 years of the contract year. According to OIG officials, the audits have questioned relatively few of the costs the contractors have claimed. Because of the low dollar findings in these audits the OIG has proposed to HCFA that it reduce the scope of these audits to only reviewing costs that have been problematic in the past, such as pension funding and space allocation. OIG officials believe that their limited resources can be more effectively used in other audits of the Medicare program, such as fraudulent claims and overpayments, where the dollar findings are much more significant.

For the contracts we reviewed, all passed CPEP requirements, including the criteria to remain within their budget limitations. We also reviewed the

[7]Medicare (GAO/T-HRD-94-59, Nov. 12, 1993).

most current OIG audits and found that overall they questioned a very small dollar amount—less than 2 percent of the claimed costs.

Association Dues Are Permissible

According to provisions of the Medicare contracts, which are consistent with federal acquisition regulations, Medicare contractors may be reimbursed for dues paid to insurance associations. In return for the dues, the associations provide consulting services, training, and interpretation and analysis of HCFA regulations. However, OIG audit guidelines state that dues or contributions are not permissible when their purpose is to influence passage of legislation. In these cases, contractors are to assign all lobbying costs directly to their private lines of business.

Dues are not permissible for Blues part A plans because the services rendered for the dues are provided as part of the prime contract. For Blues plans that are part B contractors, HCFA has developed a formula, called the millage rate, based on the number of Medicare beneficiaries that each plan serves. In fiscal year 1992, HCFA increased the rate of allowable dues paid to the Association, which amounted to $1.4 million. We reviewed the OIG audits for the Blues plans we studied and noted that the OIG found no basis to question dues payments to the Association.

Travelers, the commercial insurer we reviewed, paid dues of over $512,000 for fiscal years 1990 through 1992 to its trade association—the Health Insurance Association of America (HIAA). Commercial insurers can be reimbursed for dues under both part A and B because the services provided in return for the dues are not already provided as they are under the Association's prime contract. Travelers allocates its total dues to either its private or Medicare line of business based on the number of beneficiaries in each program. According to Travelers officials, all costs associated with lobbying are assigned directly to their private line of business. We did not verify Travelers' cost allocations, but we reviewed OIG audits, which found no basis to question costs relating to dues. Table 1 shows the dues allocated to Medicare by the three contractors we visited.

Table 1: Dues Medicare Contractors Paid to Insurance Associations That Were Allocated to Medicare

	Fiscal year 1990	Fiscal year 1991	Fiscal year 1992	Paid to
Kansas part B	$18,937	$19,881	$59,016[a]	BCBSA
Florida part B	39,312	36,929	51,289	BCBSA
Travelers part A	19,130	20,095	22,784	HIAA
Travelers part B	128,968	150,712	170,306	HIAA

[a]In fiscal year 1992, Kansas Blue Cross and Blue Shield took over the Kansas City, Missouri, Blues plan's part B contract, increasing the number of beneficiaries, which the HCFA formula uses to determine the rate of allowable dues.

Conclusions

HCFA's contract process has changed little since the inception of the Medicare program. The Congress is considering requiring HCFA to study the feasibility of changing its contracting process to encourage a more competitive environment. We believe that directing HCFA to explore new contracting methods could be valuable, provided that past problems are avoided.

The Association functions as an extension of HCFA in its role of subcontracting with its individual plans to process Medicare part A claims. However, HCFA needs to routinely evaluate the Association's performance to ensure that the Medicare program is being managed efficiently.

HCFA's budget process has controls to ensure that contractors are not overpaid. While costs declined for all but one of the contractors we reviewed, we are concerned that these reductions could result in fewer payment safeguard activities that are essential for protecting Medicare from waste, fraud, and abuse.

HCFA oversees the Medicare contracting process through its annual CPEP evaluation and through OIG financial audits of contractors' administrative costs. For the contractors we reviewed, all passed the requirements of CPEP, and the OIG audits found little basis to question contractors' costs.

Medicare contract provisions, which are consistent with federal acquisition regulations, permit Medicare contractors to be reimbursed for dues paid to insurance associations provided that the services rendered for the dues benefit the Medicare program. Dues payments used for lobbying are not reimbursable under federal laws and Medicare regulations. For the contractors we reviewed, the OIG reports found no basis to question the dues payments.

Recommendations

We recommend that the Secretary of HHS direct the Administrator of HCFA to develop criteria and evaluate the performance of the Blue Cross and Blue Shield Association in its role as the part A prime contractor to ensure that the Medicare program is being managed efficiently.

We discussed a draft of this report with HCFA officials who generally agreed with its comments. We have incorporated the officials' comments where appropriate. HCFA officials also stated that the contract process should be changed, particularly the nomination process. We believe that the pending legislation requiring HCFA to study its contracting process is called for and, if enacted, could lead to such changes.

We are sending copies of this report to the Secretary of HHS, the Administrator of HCFA, Association officials, and the contractors we visited. Copies also will be made available to others on request. Should you have any questions about this report, please contact John Hansen, Assistant Director, at (202) 512-7105 or Karyn Bell, Senior Evaluator, at (202) 512-7155. Vernette Shaw also contributed to this report.

Sincerely yours,

Leslie G. Aronovitz
Associate Director, Health
Financing Issues

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Abbreviations

BCBS	Blue Cross Blue Shield
BPRs	Budget Performance Requirements
CPEP	Contractor Performance Evaluation Program
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
OIG	Office of Inspector General

Summary of Contract Costs

Table I.1: Florida Blue Cross Blue Shield - Part A

Contract type	Fiscal year 1992 Cost	Fiscal year 1991 Cost	Fiscal year 1990 Cost
(1) Bills payment	$5,452,061	$5,592,001	$5,128,581
(2) Appeals	407,704	389,179	335,389
(3) Medicare secondary payer	1,475,913	1,154,893	1,235,755
(4) Medical review	890,027	744,902	896,523
(5) Desk audit	1,160,018	919,296	1,005,571
(6) Field audit	2,366,766	2,873,274	2,411,730
(7) Provider settlement	955,902	931,342	960,375
(8) Provider reimbursement	1,557,025	1,616,058	1,481,561
(9) Productivity investment	2,216,264	2,049,037	2,648,143
(10) Other	0	550	10,800
Total administrative cost	$16,418,680	$16,270,532	$16,114,428
Benefits paid	$3,988,481,702	$3,380,197,927	$3,389,482,762
Percent of administrative costs	Greater than 1%	Greater than 1%	Greater than 1%
Bottom line unit costs	$4.51	$4.68	$4.96
Number of claims processed	3,640,416	3,477,822	3,249,804

Table I.2: Kansas Blue Cross Blue Shield - Part A

Contract type	Fiscal year 1992 Cost	Fiscal year 1991 Cost	Fiscal year 1990 Cost
(1) Bills payment	$1,346,427	$1,234,872	$1,249,034
(2) Appeals	52,297	69,644	41,196
(3) Medicare secondary payer	393,286	437,955	679,427
(4) Medical review	213,700	227,745	214,300
(5) Desk audit	154,248	264,636	226,741
(6) Field audit	635,818	657,093	619,652
(7) Provider settlement	83,754	139,284	115,502
(8) Provider reimbursement	170,710	205,760	228,615
(9) Productivity investment	162,899	151,080	47,545
(10) Other	3,600	0	0
Total administrative costs	$3,216,739	$3,388,069	$3,422,012
Benefits paid	$543,795,380	$497,391,301	$509,860,178
Percent of administrative costs	Greater than 1%	Greater than 1%	Greater than 1%
Bottom line unit costs	$4.06	$4.61	$5.01
Number of claims processed	792,145	735,043	682,532

Table I.3: Travelers - Part A

Contract type	Fiscal year 1992 Incentive	Fiscal year 1991 Cost	Fiscal year 1990 Cost
(1) Bills payment	$1,466,290	$1,330,378	$1,393,867
(2) Appeals	239,068	239,835	217,438
(3) Medicare secondary Payer	258,160	380,868	530,077
(4) Medical review	381,522	349,062	480,134
(5) Desk audit	915,064	799,100	753,658
(6) Field audit	354,937	513,771	546,945
(7) Provider settlement	394,520	295,091	534,142
(8) Provider reimbursement	607,281	670,785	657,065
(9) Productivity investment	200,400	204,719	299,911
(10) Other	121,786	0	4,561
Total administrative costs	$4,939,028	$4,783,609	$5,417,798
Benefits paid	$627,336,240	$545,687,578	$623,889,326
Percent of administrative costs	Greater than 1%	Greater than 1%	Greater than 1%
Bottom line unit costs	$5.52	$5.96	$7.03
Number of claims processed	894,280	802,668	770,315

Table I.4: Florida Blue Cross Blue Shield - Part B

Contract type	Fiscal year 1992 Cost	Fiscal year 1991 Cost	Fiscal year 1990 Cost
(1) Claims payment	$45,296,390	$45,955,586	$42,865,385
(2) Appeals	7,741,494	9,706,114	8,647,001
(3) Inquiries	10,578,945	11,298,603	12,331,081
(4) Provider education	1,284,078	901,647	509,532
(5) Medical review	7,862,383	7,265,378	7,835,333
(6) Medicare secondary payer	4,130,858	1,757,456	2,458,987
(7) Participating physician	2,369,118	2,361,851	1,968,305
(8) Productivity investment	3,699,808	3,787,021	4,840,884
(9) Other	0	0	4,000
(10) Other	2,229,564	2,194,800	512,800
Total administrative costs	$85,192,638	$85,228,456	$81,973,308
Total benefits paid	$3,085,046,289	$2,968,730,215	$2,955,563,822
Percent of administrative costs	2.8%	2.9%	2.8%
Bottom line unit costs	$1.94	$2.10	$2.24
Number of claims processed	43,997,171	40,653,360	36,652,687

Table I.5: Kansas Blue Cross Blue Shield - Part B

	Fiscal Year 1992	Fiscal Year 1991	Fiscal Year 1990
Contract type	**Cost**	**Cost**	**Cost**
(1) Claims payment	$8,413,481	$4,369,119	$4,236,912
(2) Appeals	596,700	354,689	273,798
(3) Inquiries	2,081,700	879,303	862,805
(4) Provider education	212,500	140,280	91,198
(5) Medical review	1,859,491	1,113,630	935,856
(6) Medicare secondary payer	656,286	458,640	570,768
(7) Participating physician	411,607	315,856	248,291
(8) Productivity investment	936,832	733,795	204,874
(9) Other	105,600	47,900	10,800
(10) Other	0	0	0
Total administrative costs	$15,274,197	$8,413,212	$7,435,302
Total benefits paid	$461,919,686	$206,487,467	$195,720,453
Percent of administrative costs	3%	4%	4%
Bottom line unit costs	$1.96	$2.37	$2.28
Number of claims processed	7,790,261	3,552,129	3,259,163

Table I.6: Travelers - Part B

	Fiscal year 1992	Fiscal year 1991	Fiscal year 1990
Contract type	**Incentive**	**Cost**	**Cost**
(1) Claims payment	$26,512,034	$27,299,305	$25,835,053
(2) Appeals	2,008,501	1,626,352	1,647,515
(3) Inquiries	4,844,757	5,245,474	4,892,627
(4) Provider education	782,470	650,617	457,318
(5) Medical review	3,254,228	3,575,421	3,699,007
(6) Medicare secondary payer	1,554,665	1,458,507	1,212,264
(7) Participating physician	452,328	451,302	522,911
(8) Productivity investment	2,090,579	600,989	2,168,619
(9) Other	0	0	0
(10) Other	3,420,629	1,532,900	255,247
Total administrative costs	$44,920,191	$42,440,867	$40,690,561
Total benefits paid	$1,463,452,888	$1,382,350,179	$1,268,821,785
Percent of administrative costs	3.1%	3.1%	3.2%
Bottom line unit costs	$1.72	$1.81	$1.93
Number of claims processed	26,120,595	23,401,163	21,036,169

Table I.7: Blue Cross Blue Shield Association - Part A Prime Contract

	Fiscal year 1992	Fiscal year 1991	Fiscal year 1990
Contract type	**Cost**	**Cost**	**Cost**
(1) Bills payment	$883,703	$1,075,268	$667,148
(2) Appeals	0	0	0
(3) Medicare secondary payer	140,770	153,044	93,511
(4) Medical review	194,145	155,771	217,885
(5) Desk audit	738,090	855,333	565,483
(6) Field audit	1,253,737	1,464,662	1,556,262
(7) Provider settlement	3,480,579	3,442,264	3,266,806
(8) Provider reimbursement	171,911	286,013	242,327
(9) Productivity investment	147,414	0	0
(10) Other	175,306	13,595	470,585
(11) Other	0	0	62,214
(12) Other	0	0	170,197
Total administrative costs	$7,185,655	$7,445,950	$7,312,418

Scope and Methodology

To determine how the Medicare contract process works, we interviewed HCFA, Medicare contractor, and Blue Cross and Blue Shield Association officials. We reviewed Medicare part A and B contract and budget documents for fiscal years 1990 through 1992 at Blue Cross and Blue Shield (BCBS) of Florida and Kansas, and at Travelers Insurance Company, Hartford, Connecticut. We selected these contractors to obtain a mix of both Blues and commercial insurer plans.

To determine how HCFA contracts with the Association to subcontract with its member plans to process Medicare part A claims, we interviewed HCFA, Association, and BCBS subcontractor officials. We also reviewed contract documents for fiscal years 1990 through 1992.

To determine how HCFA ensures that contractors are not overpaid we interviewed HCFA and contractor officials to determine how HCFA sets budget limits and how contractors adhere to the budget limitations. For three contractors, we analyzed budget documents for a 3-year timeframe and assessed how the budget limitations were enforced and how the budgeted amounts changed over the timeframe reviewed. In reviewing the contracts, we determined how HCFA made budget decisions and distributed funds to the contractors and how each contractor's level of funding changed over the timeframe reviewed. We did not attempt to assess HCFA's methodology of setting budget limits for each contractor, but we did assess whether or not funding increased or decreased for the contracts we reviewed.

To determine how HCFA evaluates the performance of these contracts, we interviewed HCFA officials responsible for CPEP, and OIG officials responsible for the financial audits for the contracts we reviewed. We also reviewed the most recent OIG audit reports for each of the contractors we visited. We discussed with OIG officials the fact that these audits questioned few costs and the officials' planned approach of reducing the scope of these audits because most Medicare contractor audits question few costs and result in few recoveries. Our work focused on the oversight process and did not attempt to assess whether or not these oversight activities were adequate.

To determine the appropriateness of dues paid to associations, we reviewed OIG audit requirements for allocating dues to Medicare and discussed the appropriateness of dues payments with OIG officials. With HCFA officials we discussed the procedures that both Blues plans and commercial insurers use to determine the amount of allowable dues to be

paid to associations. For the Blues plans, we obtained information from HCFA regarding the formula it developed for the individual Blues plans to determine the amount of dues it can pay the Blue Cross Blue Shield Association. From Travelers Insurance Company, we obtained information on how it calculates and allocates allowable dues. We did not verify these calculations for the contract years that we reviewed. However, for both the Blues plans and Travelers we reviewed the most recent OIG audit reports to assess the appropriateness of the dues payments and found that none of the allocations had been questioned.

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