EFFICIENCY AND EFFECTIVENESS OF THE PART B SECTION OF THE MEDICARE PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON FEDERAL SPENDING PRACTICES, EFFICIENCY, AND OPEN GOVERNMENT

OF THE

COMMITTEE ON GOVERNMENT OPERATIONS UNITED STATES SENATE

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FRIDAY, JUNE 13, 1975

U.S. SENATE,
SUBCOMMITTEE ON FEDERAL SPENDING PRACTICES,
EFFICIENCY, AND OPEN GOVERNMENT,
COMMITTEE ON GOVERNMENT OPERATIONS,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10 a.m., in room 5110, Dirksen Senate Office Building, Hon. Lawton Chiles (chairman of the subcommittee) presiding.

Members present: Senators Chiles, Metcalf, Glenn, Weicker, and Brock.

Staff members present: Lester A. Fettig, chief counsel and staff director; Claudia Ingram, minority counsel; Douglas Cutler, minority counsel; and Robert F. Harris, chief clerk.

OPENING STATEMENT OF SENATOR CHILES

Senator CHILES. Today we will begin to look at the efficiency and effectiveness of the part B section of the medicare program [1] which pertains to reimbursement for physician services.

The impact of the entire situation is magnified in Florida. The delays are longer, the snafus are more pronounced but I think to some extent what we say and hear today has national ramification.

The congressional intent on efficient operation of the system is spelled out in the legislative history of Public Law 89–97:

> Overall responsibility for administration of the hospital insurance and voluntary supplementary health insurance programs rest with the Secretary of Health, Education and Welfare, but State agencies and private organizations operating under agreements with the Secretary and private carriers or public organizations operating under contracts with the Secretary would have a major administrative role.

That major administrative role should not and does not supersede the ultimate role of the Secretary of Health, Education, and Welfare. However, as I understand the intent of Congress, carriers and fiscal intermediaries act on the behalf of the Secretary and the Government.

I recognize that the carriers and intermediaries have detailed and varied responsibilities such as being involved in the review and investigation of potentially fraudulent claims, being involved in the review of claims process, and in the coordination of many program activities at the State level which implicate medicare.

[1] See copy of sec. 302, subsec. (b), ch. 7, Social Security, title 42, U.S.C., p. 70.

The fact remains, however, that the major responsibility of carriers involves the prompt determination and the prompt payment of medicare benefits under part B.

It was with a feeling of deep concern that this function was not being properly carried out that caused this Senator to request a General Accounting Office investigation and initiate a congressional inquiry.

The Congress felt, and perhaps rightly so, that private carriers would offer special advantages that a rigid Government bureaucracy could not provide. Almost every member of the committee felt the same way and certainly the Florida delegation felt this same way.

Yet, some of the letters I have here seem to come right out of the files of Government agencies and look like typical examples of Government run-around.

There is little doubt that somewhere along the delicate steps that lead from physician or beneficiaries to and through the carriers calculations, back to the beneficiary, things have gone awry. And badly so.

I am aware, just as other committee members are, that simple delays are to be expected. We are tremendously concerned though about the many instances of uncommon delays that have become all too familiar to us.

Nine months is an uncommon delay to wait to be informed that insufficient information has been provided on the form for a legitimate reimbursable item.

Seven and a half months is an uncommon delay to wait in suspense because a check has been laying on someone's desk—forgotten or misplaced.

These occurrences are far too many in number to be lightly brushed aside. But because they involve the elderly who are often living on fixed incomes during these inflation-ridden times, the tragedy is unduly compounded.

The aim of this committee is to improve the efficiency of the system. By using Florida as a focal point, it is our hope that reforms will be instituted that will eliminate costly and cruel delays that are too often purely unnecessary.

This is one system, one program where every error, every delay, every inefficient action is immediately translated into human misery.

In requesting the General Accounting Office investigation of Florida's carrier problems, I carefully considered the timeliness of the request.

It is time to demand an investigation when less than 40 percent of the doctors in a State accept assignment for medicare benefits.

It is time to demand an investigation when a State that's in the top eight in population is in the bottom two of average claim processing time.

It is past time for demanding an investigation when your office staff spends three times as much time on claims benefits as any other single item.

The many reasons for unreasonable delays cannot erase the justifiable concern of those who suffer the hardships that are caused by such delays.

There is no question that part B of medicare is so uniquely sensitive an area of Government involvement, that carriers should be the best representative of the Government in dealing with the elderly.

Again, I feel that while the General Accounting Office's report deals in specifics with Florida, the general applications are probably nationwide.

This committee is interested not only in exposing problems but also in providing solutions.

Senator Weicker?

OPENING STATEMENT OF SENATOR WEICKER

Senator WEICKER. Thank you, Mr. Chairman.

We are here today to take a look at the problems in the delivery of benefits under part B of medicare. I understand that we will hear testimony from the GAO, Social Security Administration and Blue Shield of Florida, regarding the delays primarily in the reimbursement for physician services in the State of Florida.

Throughout these hearings we must keep in mind that what is involved here is an extremely compelling human element. The beneficiaries eligible under part B of medicare are the aged, many of whom live on social security alone. For these people who pay their $60 deductible, and request reimbursement for physician services from medicare, or its designated carrier, in this case Blue Shield, the prompt payment from the carrier is of critical importance. These people cannot afford any delay whatsoever. What may be viewed as an ordinary administrative tieup, or computer reject, can result in a real hardship for the beneficiary.

The status of our Social Security program and our health program for the aged are a matter of extreme public concern. Older Americans have expected efficiency in the delivery of benefits for which they are eligible. It is the responsibility of the Congress, the Social Security Administration and its carriers to insure that they receive these benefits expeditiously.

The case we look at today is not an enigma to the State of Florida alone; but has larger implications across the country. According to the GAO, 74 million part B claims were processed by medicare carriers in 1974 alone, if only 1 percent of these claims are lost or result in administrative delays of 60 days or longer, 740,000 cases would be affected. Indeed, from the Florida case, we shall hear that 6 percent of the claims filed take more than 60 days to process.

The questions which I have today center around the answers to these problems of delays. I will want to know what is being done to correct these delays and what more can be done. If legislation is necessary, I want to know what the Congress can do to expedite the claims process.

Mr. Chairman, I know of your standing interest in this matter. I unfortunately have to go to the floor of the Senate at this time because we are opening up early but I hope we get to this. Make no mistake about it, it is one of the areas since I have the senior citizens of my State coming down to Washington for a 2-week intern program for our senior citizens. In the midwinter, I ask them to raise problems—

this is one of the primary ones raised by them so I apologize for having to leave but I certainly hope we can evolve something from this.

Senator CHILES. I know of your interest and I thank you for your statement. The record will stay open for a few days for the submission of written questions.

Our first witness today will be Mr. Gregory J. Ahart, Director, Manpower and Welfare Division, General Accounting Office.

TESTIMONY OF GREGORY J. AHART, DIRECTOR, MANPOWER AND WELFARE DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY EUGENE E. TAYLOR, SUPERVISORY AUDITOR, ATLANTA OFFICE, GAO, AND ARNOLD G. RIFFE, SUPERVISORY AUDITOR, MANPOWER AND WELFARE DIVISION, GAO

Mr. AHART. To my immediate right is Mr. Eugene E. Taylor, a supervisory auditor from our Atlanta office in direct charge of the work in Florida. To his right is Mr. Arnold G. Riffe, supervisory auditor, Manpower and Welfare Division, who has duties and responsibilities at the Social Security Administration.

We are pleased to be here today to discuss the status of our review of the time required to pay claims under part B of medicare in Florida.

We reviewed the time required to process medicare part B claims and identified factors which contribute to a lengthy processing time. In addition, we reviewed the processing of certain claims which were provided to us by members of the Florida delegation. The discussion of those specific claims, Mr. Chairman, is covered in an appendix [1] to my statement.

We have not completed our analysis of the entire claims processing procedure or of the appeals process; but we have substantially completed our work on the length of time required to process claims to the point of initial rejection or payment, and our analysis of where and why delays occur during the processing cycle.

Today we will highlight the results of our review to date.

GENERAL BACKGROUND

The Department of Health, Education, and Welfare [HEW], through the Bureau of Health Insurance [BHI], of the Social Security Administration [SSA] administers the medicare program. Section 1842(a) of the Social Security Act authorizes the Secretary of HEW to enter into agreements with public and private organizations and agencies to act as medicare part B carriers in administering the medicare program. These carriers are responsible for receiving, processing and paying claims submitted for medicare part B benefits.

As of December 1974, HEW had contracts with 48 organizations to perform as medicare part B carriers in 63 areas throughout the United States and its territories. Carriers are reimbursed by SSA for administrative costs incurred in performing their functions. During calendar year 1974, the carriers incurred administrative costs of about $240 million, processed about 74 million claims, and paid benefits totaling about $2.76 billion.

Blue Shield of Florida has been the medicare part B carrier for the State of Florida since inception of the medicare program in 1966. In

[1] See p. 14.

calendar year 1974, Blue Shield of Florida received 4.1 million claims, processed 3.9 million claims, paid $194.4 million in benefits, and incurred administrative costs of $15.3 million. The average cost for processing claims during the last 6 months of calendar year 1974 was $4.57 for Blue Shield of Florida and $3.36 for all carriers. The claims processed per 100 man-hours during this period were 155 for Blue Shield of Florida and 256 for all carriers.

We have prepared a chart, which is attachment 2 [1] to my statement, showing the volume of claims processed in calendar year 1974 by the 10 largest medicare part B carriers and the average claim processing time reported by those carriers. Blue Shield of Florida ranked eighth in this group in average processing time.

In 1974, Florida ranked eighth in the Nation in population, but fourth in the number of medicare part B claims processed. This disparity reflects both the large number of retired persons who live in Florida—18 percent of the State's population is age 65 and over as compared to 10 percent in the Nation as a whole—and the annual influx of large numbers of elderly tourists. Under medicare rules, beneficiaries are required to submit claims to the carrier for the area in which medical expenses are incurred, even though that may not be the area in which they reside.

These factors have significantly affected the medicare part B workload of Blue Shield of Florida in two ways. First, the carrier has experienced a dramatic increase in the number of claims received each year—nearly doubling from 2,127,450 in calendar year 1970 to 4,130,628 in calendar year 1974. Second, there is a large seasonal variation in the number of claims received. For example, in 1974, the number of claims received each month varied from a low of 258,821 in September to a high of 526,642 in December.

In addition to the problems caused by a rapidly expanding workload and high seasonal fluctuations in workload, Blue Shield of Florida has been plagued with a high personnel turnover rate. During calendar year 1974, Blue Cross and Blue Shield of Florida experienced a corporate annualized turnover rate of 48.4 percent, while the organizational units directly associated with medicare part B experienced a turnover rate of 65.1 percent. Even more disturbing, the turnover rate for medicare part B claims examining sections was 77 percent.

One apparent reason for the high turnover of medicare part B claims examiners has been the fact that they have been paid at a lower rate than have claims examiners in other parts of the carrier's operations. In May 1975, the carrier approved raising the pay of medicare part B claims examiners to that of other claims examiners in the organization, but this raise has not yet been put into effect.

One result of the high turnover rate is an excessively high error rate being experienced by Blue Shield of Florida in its processing of medicare part B claims.

At the direction of SSA, medicare part B carriers each week perform an end-of-line review of a sample of claims processed that week to identify errors which remain uncorrected at completion of initial processing. The results of the end-of-line review provide an indication of the quality of work being done during the routine manual processing portion of claims processing.

[1] See attachment 2 on p. 18.

The end-of-line review was initiated on January 1, 1974. Results are expressed as the ratio between the number of errors detected and the number of line items examined. For the period February 1974—first reporting month—through December 1974, the error ratio reported by Blue Shield of Florida ranged from a low of 0.20 in February to a high of 0.42 in July. In other words, for every 100 line items processed during July, 42 errors were made and remained undetected throughout the claims processing cycle.

The most recent report showed an error rate of 0.33 for the month of April, during which the average claim reviewed contained about 1.5 errors. Blue Shield of Florida's error rate was among the highest of all the carriers.

This error rate affects the program in three ways. First, errors cause significant processing delays. Second, errors which slip through the processing cycle undetected may result in underpayments to claimants who must write in to request a review of their claim and who will experience another long delay before resolution of their complaint and ultimate payment of amounts to which they are entitled. Finally, they may result in overpayments which in all probability will remain undetected.

CLAIMS PROCESSING PROCEDURES

To facilitiate understanding of the claims processing cycle, Mr. Chairman, we have prepared a chart which depicts the flow of medicare part B claims from receipt to initial rejection or payment. This chart is also included as attachment 1[1] to my statement. The major portion of our audit effort to date has involved the areas illustrated on this chart.

Upon receipt in the mailroom, claims are sorted and batched according to the nature of the claim—such as routine claims by physicians or other suppliers of health services, called assigned claims; routine claims by beneficiaries, called unassigned claims; claims for the cost of purchase or rental of durable medical equipment, or claims submitted on behalf of deceased beneficiaries. At the present time there are 18 categories being used to group claims into batches.

After the claims are sorted and batched, each claim is stamped with a control number which includes the year, Julian date, batch number and the number of the claim within that batch.

Next, certain information from each claim is entered into the computer and compared with information relating to the particular beneficiary which is already in the computer's address file.

The claims are then delivered to claims examiners who have responsibility for the particular type of claims included in each batch. About 80 percent of the claims go to the routine claims examining section with the remainder going to the special claims examining section.

Information from the simpler claims reviewed is entered directly into the computer by the claims examiners. For the more complicated claims, the examiners prepare worksheets from which information is entered into the computer.

[1] See p. 17.

If the claims examiner finds that all information necessary to process a claim has not been submitted, he notes on the claim that additional information is required.

During processing by the computer, each claim is subjected to five screens. Failure to pass any one of the screens will cause an error suspense sheet to be generated and the claim to be placed in suspense until the question is satisfactorily resolved.

The first screen, which is really two screens in one, tests for edit errors and reasonable charges. In addition, any claims previously identified by the claims examiners as being in need of additional information will kick out during the first screen and be held in suspense until the additional information is obtained—either through telephone calls or correspondence with the beneficiary or provider. Other computer screens test the claim for correctness of basic data. Claims failing to pass this series are called transaction rejects. Possible duplicate payments and cases of suspected overutilization are called prepayment screens. We will discuss these screens in greater detail as we go on.

When these computer screens have been successfully passed, SSA records in Baltimore must be queried, for certain claims to ascertain the eligibility of the beneficiary and/or the status of his deductible. This is needed because beneficiaries might be filing claims with two or more carriers. Thus, information concerning charges incurred and applied against the $60 annual deductible must be accumulated at a central location.

After the claim has been fully developed, all computer screens have been satisfied, and the necessary information obtained from Baltimore, an explanation of medicare benefits—EOMB—and a payment check, if appropriate, are generated to be mailed to the claimant.

After the initial rejection or payment of his claim, a beneficiary dissatisfied with the determination may request that Blue Shield of Florida review the claim. If the beneficiary is still dissatisfied and the amount in dispute is $100 or more he may request a hearing.

FINDINGS—REPORTED PROCESSING TIME

Reports prepared by Blue Shield of Florida show that in calendar year 1974 the carrier processed 3,858,535 medicare part B claims; and that 80 percent of these were processed in 30 days or less; 14 percent in 31 days to 60 days; 3 percent in 61 to 90 days, and 3 percent in more than 90 days. Thus, although serious delays occurred in the processing of a small percentage of total claims—94 percent were processed within 60 days—the number of claims encountering long delays involves thousands of people—236,613 claims took over 60 days to process, and 103,766 of these took over 90 days.

Fifty-nine percent of the claims were unassigned—that is, the claim was submitted by the medicare beneficiary. Thirty-five percent were assigned claims submitted by providers, and 6 percent were for the services of hospital-based physicians. Using information in monthly reports prepared by the carrier, we computed the average processing time for each of these types of claims.

Our analysis showed that claims for hospital-based physicians were processed in an average of 12.5 days, more quickly than were the other

two types. The average processing time fluctuated from a low of 9 days during August when 19,814 claims were processed to a high of 16 days during February when 20,403 claims were processed.

Assigned claims took a little longer, averaging 17.8 days. Again there was a fluctuation in the average processing time from month to month, ranging from a low of 11 days during August when 115,760 assigned claims were processed to a high of 26 days in December when 118,695 claims were processed.

Unassigned claims have the longest average processing time, averaging 25.6 days. Monthly averages ranged from a low of 17.5 days during March when 185,149 unassigned claims were processed to a high of 37 days during October when 157,519 claims were processed.

The cumulative totals for calendar year 1974 show that Blue Shield of Florida experienced an average processing time of 22.1 days per claim while processing a total of 3,858,535 claims to initial rejection or payment.

VERIFICATION OF REPORTED PROCESSING TIME

The processing time reported by Blue Shield of Florida to SSA appears to have been computed in accordance with SSA instructions, and includes the number of calendar days between the Julian date incorporated into the control number assigned to a claim upon receipt and the date of the check and/or explanation of medicare benefits form issued at completion of the processing cycle.

We noted, however, that claims normally are in the carrier's office for some period before control numbers are assigned and that some period elapses between preparation of checks and EOMB forms and their mailing to claimants. Based on our tests and information available at the carrier, we estimate that a total of about 7 days elapse at these two stages.

Senator CHILES. Do you mean you could add 7 days onto all of these times?

Mr. AHART. Approximately 7 days, Mr. Chairman, based on our studies.

We also found that two types of claims processed through the payment cycle distorted the computation of processing time to some degree. These are referred to as setups and deletions.

A setup occurs when a single claim is divided into two or more claims for processing purposes. The following situations necessitate setups:

The claim includes services performed in more than one calendar year;

The claim includes charges incurred by both husband and wife;

The claim contains more than 32 line items; or

The claim contains both routine items and complicated procedures such as multiple surgery.

Setups are not prepared until the original claim reaches a claims examiner. They are then sent back through the front-end control procedures and routed to the proper claims examiner for processing. The distortion occurs because a new control number—including Julian date—is stamped on the setup and is used in computing processing time when in fact the original claim will have been on hand for some time.

In calendar year 1974, Blue Shield of Florida processed 247,600 setups.

A deletion occurs when a claim is initially received, stamped, and routed to a claims examining section that does not have responsibility for that type of claim. In these instances, the claim is returned to the mailroom, deleted from the computer, re-sorted, given a new control number and started through the system again.

As in the case of setups, these claims will have been on hand for some period before they are routed to the correct claims examining area.

The carrier could provide us with records showing number of deletions only for a 1½-month period from December 23, 1974, to February 8, 1975. During that period, there were 10,094 deletions. It should be noted, however, that the volume of deletions may not have been as high before October 1974, when current procedures for sorting and batching claims were put into effect.

Our verification of the processing time reported by Blue Shield of Florida was based upon analysis of a random sample of 1,961 medicare part B claims processed during calendar year 1974 which was extracted for us by the carrier's electronic data processing department. We are satisfied that the program used in extracting the sample produced a random sample, and Blue Shield of Florida officials agreed that the sample is representative of claims processed in calendar year 1974.

We verified that the data on the computer printout of the claims in the sample represented the number of days elapsed between the Julian data in the control number and the date on the check issued. In addition, we verified on a test basis the control numbers shown on the printout to those shown on the original copy of the claims.

DETAILED ANALYSIS OF SELECTED CLAIMS

In our sample of 1,961 claims, there were 377 which required over 30 days to process. In order to learn where and why the delays in processing occurred, we selected one-half of the claims—or 189 for detailed analysis. We were unable to obtain sufficient data on three of the claims to permit meaningful analysis and the analysis of three other claims showed that they had been delayed for extended periods at the direction of SSA. Because these extended periods were such as to distort the results of our sample, we disregarded them. The 183 remaining claims required a total of 9,925 days to process; an average of about 54 days. About 76 percent were processed in 31 to 60 days; and an additional 16 percent were processed in 61 to 90 days.

Processing time was as follows:

Forty-one percent in routine manual processing which includes receiving, sorting, stamping, microfilming, and examining and entering the claim into the computer for further processing;

Sixteen percent in additional development which involves obtaining from the beneficiary or the provider additional information required to properly process the claim;

Twenty-eight percent in edit kickouts resulting from computer screens of such items as reasonable charges, possible duplicate charges, and the accuracy of the data entered; and

Fifteen percent in queries of SSA central files to determine the beneficiary's eligibility and the status of the deductible.

ADDITIONAL WORK IN SELECTED AREAS WHERE DELAYS OCCUR

Since the procedures followed during routine manual processing have been altered recently as a result of the installation of direct data entry equipment, we did no additional review work in that area. Also, since queries to the central files are necessary and required, and delays in this area generally are outside the control of Blue Shield of Florida, we did no additional work in that area.

ADDITIONAL DEVELOPMENT

Reports prepared by Bureau of Health Insurance show that in calendar year 1974 about 19.7 percent of all medicare part B claims handled by Blue Shield of Florida required additional information before they could be processed. This is almost double the national average of 10.2 percent.

SSA guidelines prohibit a carrier from returning claims to the claimants, in most instances, requiring instead that the carrier develop the needed information. The carrier attempts to develop the required information by telephone whenever feasible. Otherwise, it is requested by mail.

Within our sample of 183 claims which took over 30 days to process, 69 claims, or 38 percent, required additional information—obtaining the information took an average of about 23 days.

For these 69 claims, an average of nearly 15 days elapsed between the date the claims examiner requested the additional information and the date the telephone call was made or a request letter was sent. Based on observations made during May 1975, we believe that a similar delay is still being experienced at this point in the claims processing cycle.

To gain a better understanding of the type of information being requested when claims are forwarded to the additional development section, we sampled an additional 250 claims which were being processed during our review and which needed additional information. Our analysis of the 250 claims and the 69 claims discussed above showed that the additional information requested in about 60 percent of these 319 cases was either an itemized breakdown of the services performed and the charges for the services, or a statement of the diagnosis of the medical condition which necessitated the services.

We believe that the additional information requested by the claims examiners was needed to properly adjudicate the claims in accordance with SSA instructions and requirements.

EDIT KICKOUTS

According to Blue Shield of Florida officials, about 35 to 40 percent of all claims processed kick out of the normal processing flow because they do not pass one or more of the five computer screens or because additional information is needed.

In our analysis of the 183 claims, we found that 125, or 68 percent, had been kicked out of the processing cycle because they did not pass a computer screen. These 125 claims were out of the processing cycle an average of 22.3 days because of this action.

A total of 2,788 days delay was associated with the 125 claims. Forty-six percent of this time was associated with edit error kickouts,

23.5 percent with reasonable charge kickouts, 14 percent with prepayment screen kickouts, 9 percent with transaction rejects, and 7.5 percent with possible duplicate payments.

The 125 claims kicked out of the normal processing flow a total of 200 times. There were 35 reasons for the 200 kickouts. We analyzed the circumstances surrounding kickouts for the most frequently occurring reasons in an attempt to identify changes which could reduce the number of kickouts and thereby reduce the processing time.

About 12.5 percent of all claims processed kick out as a result of the edit error screen. We reviewed 225 such kickouts which had been corrected and reentered into the computer on June 3, 1975, and found that they had been out of the processing cycle an average of about 10 days.

Edit error kickouts are classified into about 90 categories. Our analysis of the classification of 320,575 edit errors, which caused 220,299 claims to kick out during the period April 14 through May 30, 1975, showed that 57 percent were attributed to errors made by the claims examiners or the persons who process the claims before they are sent to the claims examiners.

We believe that some of these errors could be eliminated by minor changes in the procedures for initially entering claim information in the computer—changes which would permit persons entering information to verify the accuracy of their work and to correct their errors. Any substantial improvement in the rate of edit error kickouts is, in our opinion, dependent upon a reasonably stable work force.

We believe that the reviews associated with prepayment screen kickouts and certain transaction reject screen kickouts are necessary to insure integrity of the program. Claims disallowed as a result of these screens totaled almost $3 million in calendar year 1974, and more than $750,000 during the first quarter of calendar year 1975.

However, the claims in our sample which were kicked out by the prepayment screen were delayed an average of about 33 days and those which were kicked out by the transaction reject screen were delayed an average of about 27 days. Our preliminary observations are that the time taken to review these types of kickouts can be significantly reduced by improving physical document flow, but we have not completed our review in this area.

Our analysis of the kickouts for reasonable charges indicated that by raising the screen from 75 percent to 125 percent of the allowable charge, the number of reasonable charge kickouts could be reduced by about 50 percent and still permit detection of 80 percent of the errors being detected by the present screen. Personnel of the edit department had made a similar analysis and had drawn similar conclusions.

As a result of our joint recommendation to program management, the reasonable charge screen was raised to 125 percent of the allowable charge on May 1, 1975. We believe this change should reduce total kickouts by about 20 percent.

When information in a line item of a claim being processed matches information relating to a service previously allowed and paid, the claim is kicked out by the duplicate charge screen to permit a determination as to whether the line item in question is a duplicate charge. Carrier personnel told us that about 35 percent of such kickouts occur because only the last two digits of the procedure code differ from those of the code for a service previously allowed, and that in

almost 99 percent of these cases the item in question is a duplicate charge and payment is denied.

We suggested to carrier officials that the computer program be revised to automatically deny payment when all items match except the last two digits of the procedure code. Such a change should reduce the number of duplicate charge kickouts by about 35 percent without a material change in the number of erroneous rejections. Carrier officials advised us that this change was made effective on June 2, 1975.

PROGRAM MANAGEMENT

Although we have not completed our work, it appears to us that the most significant problem facing Blue Shield of Florida with regard to the time required to process medicare part B claims is the lack of adequate management attention at all levels to obtaining a satisfactory resolution of those claims which cannot be routinely processed in a reasonable time. Management's attention has been focused on processing the mass of claims which can be routinely handled with a minimum of problems, perhaps because claims which take longer than 60 days to process represent a relatively small percentage of the total claims processed.

We are not suggesting that management's attention to processing the mass of claims should be lessened. But we believe that Blue Shield management personnel should devote greater attention to the problem cases—the quarter of a million claims which took longer than 60 days to process last year.

It also appears to us that management has not acted to alleviate backlogs until they have reached crisis proportions, even though routinely prepared reports have shown the development of backlogs at various locations in the process. In addition, we believe that management attention to improved document flow is necessary to improve the processing time.

BHI reviews the medicare part B operations of Florida Blue Shield. In addition, the carrier's medicare part B operations were reviewed in July 1974 by a private consulting firm and in January 1975 by a team of representatives of other Blue Shield plans. All of these reviews identified the lack of effective management as the basic problem affecting Blue Shield of Florida's administration of medicare part B.

In April 1975, the board of directors of Florida Blue Shield established the position of vice president for medicare part B, and in May 1975, the vice president initiated a reorganization of medicare part B operations. This reorganization could help in bringing about the management action and control which we believe is needed to improve the administration of the carrier's medicare part B operations. Another factor which could favorably affect Florida Blue Shield's medicare part B operations was the decision of BHI to obtain the services of another carrier—Group Health Incorporated—to service Dade and Monroe Counties beginning July 1, 1975. Claims from these two counties represent about 30 percent of the medicare part B claims being processed by Blue Shield of Florida.

Mr. Chairman, that concludes the summary of our work to date. We will be pleased to try to respond to any questions that you or other members of the subcommittee may have. Of course, we are continuing our work and we will furnish a complete report for your review.

[Attachments to the statement of Mr. Ahart follow:]

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APPENDIX

REVIEW OF SELECTED CASES

Several members of the Florida congressional delegation provided us with examples of the complaints they were receiving from Medicare Part B beneficiaries throughout the State. Although time did not permit a detailed, in-depth analysis of each case, we did review 12 cases to ascertain the time required to process claims to initial rejection or payment. We reviewed all data available and analyzed the problems involved in each of these cases which actually involved 19 claims.

Seven of the 19 claims were delayed from 90 to 182 days because they involved payments for chiropractic services. Claims for chiropractic services were suspended from processing during the period October 28, 1974 to December 16, 1974, by direction of the Board of Directors of Blue Shield of Florida. It appears, based upon the dates of receipt of the claims reviewed, that a slow-up in the processing of this type of claim began in July 1974. This slow-up and ultimate suspension of processing resulted in a substantial backlog of chiropractic claims being carried into 1975 and in long delays in payments to thousands of beneficiaries.

Blue Shield of Florida attributed the suspension to a lack of sufficient guidance from SSA concerning the definition of a subluxation in chiropractic terms. Also the carrier was reluctant to hire a consultant chiropractor because of positions stated by both the American Medical Association and the Florida Medical Association to the effect that willing professional association of doctors of medicine with chiropractors was unethical.

In one case, the claimant implied that he had submitted his claim in January 1974 when in fact the carrier did not receive the claim until January 15, 1975. This claim was paid on May 19, 1975--requiring 124 days to process. The claim was in the Special Claims Examining Section until April 3, when it was sent to the Additional Development Section. It was returned to Special Claims Examining on April 29, entered into the computer on May 1, and kicked out on that same date by the edit error screen. Six of the 19 claims were delayed for long periods awaiting development of additional information. Five of the six claims stayed in the additional development section over 45 days.

One of the 19 claims took over nine months to process (281 days). This claim was in Special Claims Examining from late May 1974 to early February 1975, with no indication of the reasons for its being there for that length of time. Personnel of the section speculated that it had been lost or misfiled. The claimant had telephoned Blue Shield of Florida on two occasions but apparently no action was taken to resolve the claim until a Congressman interceded on her behalf. The claim was paid one month after receipt of the Congressman's letter.

One case involved two claims which the beneficiary said had been submitted in July 1974 and for which she said that she had not been paid as of January 1975. However, one of these claims had been rejected because it was for noncovered services and the beneficiary had been so notified in October 1974. The other claim was for chiropractic services.

APPENDIX

It was paid February 7, 1975, after being subjected to the slow-up and suspension of chiropractic claims already discussed. We noted that this claim required additional development and that it was kicked out by the prepayment screen because the claimant had claimed reimbursement for 35 chiropractic visits between August 1973 and June 1974.

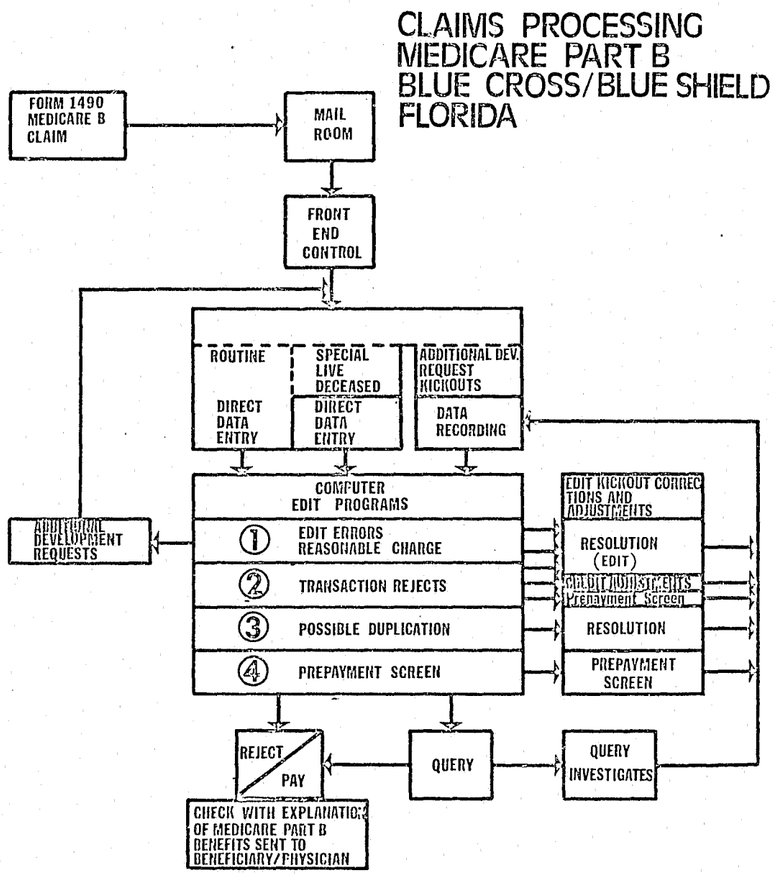
One case reviewed took over 7 months to process because of Blue Shield's inability to obtain the necessary additional information. Blue Shield requested the information four times but apparently only the last request reached the physician.

One case involved four claims, two of which were for chiropractic services. The remaining two claims were processed in 34 and 15 days respectively.

In the course of our review we examined data sheets for most of the beneficiaries involved in the 12 cases. In one case, the beneficiary had submitted 24 claims over a 15-month period, and the great majority of these had been paid within 15 to 30 days. This fact was not mentioned in the beneficiary's letter to the Congressman.

Another beneficiary failed to mention in his complaint that Blue Shield of Florida had processed 15 claims for him during the past 15 months and that most were paid within 15 to 30 days.

ATTACHMENT I



ATTACHMENT II

TEN LARGEST CARRIERS BASED ON VOLUME OF CLAIMS PROCESSED

IN CALENDAR YEAR 1974

POSITION	CARRIER	CLAIMS[1] PROCESSED	AVERAGE PROCESSING TIME
1	Blue Shield of California	6,100,048	16.1
2	Blue Cross-Blue Shield of Greater New York	5,511,034	16.0
3	Group Medical and Surgical Service (Texas)	3,796,921	19.0
4	Blue Shield of Florida, Inc.	3,628,551	22.7
5	Pennsylvania Blue Shield	3,256,325	16.3
6	Blue Shield of Michigan	3,092,170	13.0
7	Occidental Life Insurance Co. of California	2,948,503	23.1
8	Blue Shield of Massachusetts, Inc.	2,391,294	11.4
9	Nationwide Mutual Insurance Co. (Ohio)	2,263,981	17.9
10	The Prudential Insurance Co. of America (New Jersey)	2,227,963	22.9

[1]Excludes claims for services provided by Hospital Based Physicians.

Senator CHILES. Mr. Ahart, I want to thank you for your statement and the work that GAO has done in this instance. I think it is a very comprehensive statement. It certainly seems to cover the main areas, the problem areas and point out very graphically what some of those problem areas are. I would like to go through and ask you a few questions so that I can understand this a little bit better.

I see the average cost for processing claims in Florida is $4.57; $3.36 for all other carriers. Can you tell me why the Blue Shield gets a higher cost and who determines that? Does BHI set that forth?

Mr. AHART. I think our source is a statistical report comparing the average cost as well as the productivity of different carriers, which BHI pulls together. I think the explanation for the difference can be found in the productivity indicator, which shows the Florida Blue Shield processing only 155 claims per 100 man-hours.

Senator CHILES. I am trying to find out the difference between the cost.

Mr. AHART. It would be the amount of labor going into it as well as other factors, but the major factor would be the man-hours, which for Florida was 155 claims per 100 man-hours, as compared to 256 processed nationally.

Senator CHILES. So it is because they are producing fewer cases per man-hour that the average cost per case is higher?

Mr. AHART. I think that we can relate this to the fact their personnel turnover is so high, 77 percent in the claims examining function and with so many new examiners coming in it will be less efficient than the typical operation.

Senator CHILES. Would you concur, then, judging from the error rate in the processing time for claims that Blue Shield of Florida because of its inefficiency is the reason for its costs being 30 percent higher than average?

Mr. AHART. Yes; it would be a matter of inefficiency in its operations.

Senator CHILES. The 10 largest medicare B carriers in Florida is eight from the bottom of that, 10 States?

Mr. AHART. That is right.

Senator CHILES. Florida has been receiving a doubling of cases from the year 1970?

Mr. AHART. That is correct.

Senator CHILES. And also has been receiving a seasonal variation. Those are factors that I should understand by now if it has been happening since 1970. It is not a surprise it just happened in 1974.

Mr. AHART. There has been a lot of growth and the seasonal fluctuation would be an annual occurrence during the tourist season and one that should be anticipated.

Senator CHILES. Did you determine anything about the high turnover rate, this 77 percent; do you think that was primarily because of wages paid or were there other factors, or did you go into this?

Mr. AHART. We are still looking at that, Mr. Chairman. Certainly we think the wages paid in the examining functions in other parts of the Blue Shield operation would be a factor in the turnover rate. We are going to do additional work to see if there are other factors we can identify as reasons.

Senator CHILES. What reasons were given for paying the part B examiners less than the other examiners?

Mr. AHART. They have a system which evaluates and classifies each job on different factors, the complexity of it and so on. It is

really the matter of points assigned by the classification people in the personnel department to the difficulty and the complexity of the part B examining function. We have not gone behind those factors to see if they are reasonable. The carrier has approved an increase in their pay, which has not yet gone into effect, to bring them up to the pay of the other claims examiners.

Senator CHILES. What are they actually paid?

Mr. AHART. It is a fairly low range of $107 a week to some other figure. I believe we have that in our backup material. The range for these examiners is from $107 a week to $145 a week, in comparison with the regular examiners which was $114 to $157 a week. So there is something less than a 10 percent differential.

Senator CHILES. Ten percent differential. What was their turnover in their regular examiners?

Mr. AHART. We don't have that figure. The overall turnover is about 48 percent and with the part B examiners, it was about 77 percent, so it is a fairly large differential there.

Senator CHILES. Can you explain to me how this reimbursement claims figure that the Government pays to Blue Cross-Blue Shield is figured? In other words, they certainly put in the wages and salaries that they pay their employees and they had their other costs and expenses and overhead added to that by virtue of profit or what they work on? How is that figured? Can you break that down for me?

Mr. AHART. The contract provides for a total reimbursement by the Government for the part B. This would include the salaries, computer processing, all the costs associated with that and an appropriate share of the overhead of the overall organization.

The contract itself is presumably a no-fee contract in the sense that it is cost reimbursement only with no allowance for profit to Blue Shield as the carrier. I don't know how more specific we can get than that. We could give you a breakdown of what is included in the $15.3 million in administrative costs for calendar year 1974, if you would like to have that.

Senator CHILES. I would like to have that but I am trying to understand why it is to Blue Cross-Blue Shield's advantage to pay less to an examiner, especially to a claims B examiner, as opposed to another examiner.

Mr. AHART. To the best of our knowledge at this point, it was simply a matter of personnel judgment on the difficulty associated with the claims examining functions in part B as opposed to other parts of their operation. This is an area we are going into in more depth as our review continues to see if we can get a better understanding of the reasons why this would occur and why the turnover rates would be so excessive in the part B examiners' section, but we don't have any further answer on that today.

Senator CHILES. Is it your feeling based on the high turnover rate this was the major reason for this fact that there were 42 errors per 100 line items processed during July?

Mr. AHART. We think this is a very significant factor. We have all the new examiners there and new people in the operation so their error rate would be higher than if you had a stable work force where you have people learning their job and learning how to avoid the errors.

Senator CHILES. How can we determine whether these errors did result in other payments that have been undertaken?

Mr. AHART. I think the only way that could be done—and I don't know if we have any information on that today—would be sampling the claims and testing that sample and determine how many were overpayment or underpayment errors or other types of errors. I don't think we have done that. I don't know if that information is or is not available from what we refer to as the end of the line review. Mr. Taylor may have some additional information on it.

Mr. Taylor says it is available but we don't have that information with us today.

Senator CHILES. It would seem if you said 42 percent of 100 line items had an error, if I was one of those claimants, I would like to know if that error was in my favor or against me, and I think the Government would like to know if the error was an overpayment or not; because if you have that percentage of errors, I don't think it is going to average out, maybe it does. It seems to me the people are being rooked or the Government is being rooked. In any event, that is not what the process is supposed to do, I think we ought to try to get some figures on that.

Looking at the monthly averages ranging from a low of 17.5 days during March, 185,000 unassigned claims for process to a high of 37 days during October when 157,000 were processed does not seem to be indicative that the number of claims were influencing the average days because it was a month when they had less claims that they had a much higher average day.

Mr. AHART. There is no correlation between the volume of claims and the average length of processing time.

Senator CHILES. Then it is not just the seasonal variation where the problem results?

Mr. AHART. It is not all attributable to the seasonal variation. Mr. Taylor might comment on this. If they do need to bring in additional claims examiners to handle the higher workload during the winter months, that might increase the processing time and the error rates. That is a hypothetical assumption on my part. There is no direct correlation for different types of claims and the numbers and the average processing time.

Senator CHILES. The time is greatly reduced if it is an assigned claim or done by a hospital physician. So the fact that we have fewer doctors receiving assignments in Florida, does influence the time his claim would take?

Mr. AHART. Yes; it is certainly a big influence.

Senator CHILES. What is the rule in regard to how long a claim should be in the office before it has a control number placed on it? You were saying you had about 7 days' time elapsing between the time it came in and the time you issued the checks.

Mr. AHART. Actually, the 7 days was the total of two different time periods.

Senator CHILES. The front end and the back end?

Mr. AHART. Yes, and I don't have any specific information personally on what would be reasonable. There would be some time before you get it into the system. Mr. Taylor may have some criteria as to

what it would be. I guess at this point we would say as short as possible to get it under control and into the system but I don't think we have any criteria on just what that would be.

Senator CHILES. If you don't have some criteria, you would not get a true date figure. As you noted in all the time periods you have given us you said you ought to add 7 days to it because of this delay.

Mr. AHART. Yes.

Senator CHILES. What kind of reason did you get for the fact that when you were sampling for additional development that the 69 claims set an average of 15 days between the time the claims examiner requested the additional information and the time that the telephone call or request was made?

Mr. AHART. Perhaps Mr. Taylor can comment on that. I don't know if we have specific information or whether we asked the right kind of questions.

Senator CHILES. Did you get any excuse or reason, or is it just sitting there?

Mr. TAYLOR. No, sir, the error suspense sheet that comes out saying it needs additional development must be matched up with the additional supporting documentation therewith so the information goes in a package to the girls who make the telephone calls or to the other group that would request the information by mail. It does seem to take them between 10 and 15 days to get all of the documentation gathered together and presented to the girl who will make the telephone call.

Senator CHILES. They don't have any control time on that or any time that you would say this ought to be done within a certain number of days?

Mr. TAYLOR. I don't believe so, sir.

Senator CHILES. Did you examine their training program, what kind of training program they had for these people? I guess they don't have very long if they are turning over 77 percent. They don't sit around very long after they have been trained. What kind of training program?

Mr. TAYLOR. Sir, we have not looked into it. I understand they do have a 4- or 5-week training program for these claims examiners but we have not done any work in that area.

Senator CHILES. In addition to wages, what other factors does Blue Cross-Blue Shield have in the way of work incentives, for morale incentives? Did you check into their vacation pay and their vacation time, their benefits?

Mr. TAYLOR. We have not done much work in that area, sir.

Senator CHILES. It was your determination, then, that prior to the time of the hiring of this new vice president or the creation of this new vice president that their management attention was just to the fact that in percentage numbers, the percentage numbers were that most of the claims were being handled in a routine fashion and they were concentrating on that. There was no attention to the fact that they had these quarter of a million cases a year that were taking this unreasonable period of time?

Mr. AHART. I think we would say certainly not adequate attention to the ones that were problem cases. I think probably there would be a tendency to take some comfort in the fact that a small percentage of them go over 60 days and not enough attention given to the fact that

thousands of people are having claims delays. Wtih the appointment of a vice president to take care of this area and with the kind of emphasis that should be given to these problems, things should improve, but it was our view and the view of other people who reviewed it that there was not adequate management attention being given to these kinds of problems.

Senator CHILES. Thank you very much. We look forward to the other development and we will continue to be in touch with you in following up on this and we appreciate the work you have done.

Our next witness will be Mr. Thomas M. Tierney, who is the Director of the Bureau of Health Insurance for the Social Security Administration.

TESTIMONY OF THOMAS M. TIERNEY, DIRECTOR, BUREAU OF HEALTH INSURANCE, SOCIAL SECURITY ADMINISTRATION, ACCOMPANIED BY DOUGLAS RICHARDS, DIRECTOR, ATLANTA REGIONAL OFFICE

Mr. TIERNEY. I am delighted to be here this morning, Mr. Chairman. I have with me on my right, Mr. Douglas Richards, who is the head of our regional office in Atlanta, in whose region is encompassed this operation. I have prepared a statement which has been filed with the committee.

Senator CHILES. Your statement will be included entirely in the record at the conclusion of your testimony.

Mr. TIERNEY. There is so little that I can add to what has been said, there would not be much point in my reading the statement, so I would like to ask that it be put in the record and I will make a couple of comments.

Senator CHILES. It has been.

Mr. TIERNEY. I will comment on a couple of the problems we have seen in Florida and then I would be glad to respond to any questions you might have.

Let me start out by saying, Mr. Chairman, from what you have already heard and I know from your own interest and background in the past, medicare is a very complicated program. I think it has been a tremendously successful program in many ways, but it was probably the first massive effort to enter into whole new areas of health care and the mechanisms of paying for health care that had ever been undertaken in this country, and certainly in the beginning there were a lot of headaches. Things are improving and things I would dare say even in Florida are improving.

Senator CHILES. No, sir, don't dare say that. Don't dare say that because I don't believe you can dare say that in Florida yet.

Mr. TIERNEY. I would say that I think things in Florida, and I think Mr. Ahart would agree, have for the first time the potential for improving, and that is because of the things he stressed but the one factor perhaps he did not put sufficient stress on is that 30 percent of the entire Florida part B medicare claim load will be transferred to a new carrier on July 1. That is about a million claims in perhaps the most difficult area of Florida from the standpoint of securing assignment and this type of thing; so if I said improved I misspoke myself. I think there is a real promise that things will improve in Florida.

Let me make it clear, Mr. Chairman, we have been probably the greatest critics Blue Shield has had and I am not here in any way to defend them.

I think there are one or two things you would want to know about their performance and costs and particular problems as we have viewed them.

You raised a question for example about the hospital claim. I think the one element left out of the GAO response to that was this assignment situation. Assigned claims are very much easier, as the figures indicate, to process. They are prepared by doctors' secretaries and they are well done with few errors and they go through fairly well. Those prepared by hospital bookkeeping departments are perhaps the best and they go through very well. An unassigned claim is usually one prepared by the patient himself or herself. Usually it contains a large number of errors so there is a correlation between the overall figure of claims processing and the assignment ratio.

I want to make one further thing clear to you which maybe was not clear to you. You first indicated there was a payment by the Government of all of the costs of the operation and then some plus for profit; there isn't any plus for profit. It is a pure cost operation subject to audit not only by the HEW audit agency but subject to audit by GAO. So there is not a profit in the situation.

Other than that, I think what the General Accounting Office found is what we have found and what Mr. Richards' people found and what his representatives have found. That, of course, led up to the Secretary's acceptance of our suggestion that a very significant change be made.

Senator CHILES. Tell me for my information, then, how you do determine what costs you will pay to any carrier?

Mr. TIERNEY. In the first place, it is not on a prospective basis or bid basis or prenegotiated rate. It is a retroactive cost. At the end of each year they file a very detailed line item cost report which we then review, audit, and they are reimbursed to the extent their costs are reasonable. If there are any costs which are unreasonable or any allocations which are inappropriate, they are not paid; but it is a resultant figure, Mr. Chairman, rather than a negotiated figure, a prospective figure.

Senator CHILES. Then the costs that they pay their examiners are part of the cost that they then pass over or that they report to you?

Mr. TIERNEY. Yes, sir.

Senator CHILES. And in turn are reimbursed for?

Mr. TIERNEY. Right.

Senator CHILES. Do you set any rate as to how much they can pay their examiners?

Mr. TIERNEY. No, sir. We do not set a rate. If there is an excessive amount, an unreasonable amount, it would be subject to question and reasonable for any other portions of their expense but we don't set any minimum amounts that they must pay. This has been in keeping, Senator, with the philosophy of the Congress and the whole production of medicare—to the extent possible the Government is to look to the private sector to do this administrative processing job for it and the Government's responsibility is to see to it that it be done well and that the costs be reasonable but that it not try to interpose

its managerial judgment on the judgment of the organizations involved. So we have not set minimum wage or anything like that.

Senator CHILES. You say that you think benefits are going to result by the fact that you have taken approximately 30 percent of their claims and given them to another carrier. Why, primarily?

Mr. TIERNEY. Primarily, Senator, because Florida simply has never been able to get on top of its claims load. It has had this kind of backlog of claims almost from the inception of the program. We have had very similar situations in other States. California produces the most claims of any State in the Nation. It was carrying a load that would seem simply impossible to ever get on top of. There were 14 counties in California that turned from Blue Shield to Occidental. That reduction of a load to a manageable amount vastly improved the operation out there. The same thing is true in seven or eight other contract areas. We think in reducing the load, maybe at last they will get on top of it.

Senator CHILES. I see Blue Shield of California is handling 6,100,000 claims with an average time of 16.1 and Blue Shield of Florida has 3,628,000 with an average time of 22.7. So, here you have double the number of claims being handled by a carrier, Blue Shield of California, and they are doing it in 16.1 days, and I look at the figures that GAO has developed for us and they don't show any correlation between the seasonal variation. They do better the more claims they have and in a shorter number of days. It seems to me once the seasonal variant is a known factor, the first year, yes, but the seasonal variation in Florida as well as the growth is a known factor. That has been a management variant that should be compensated for.

Mr. TIERNEY. There is no question about it that management varies from very good to perhaps acceptable in the intermediaries across the country. You can't look just at time, Senator. California, I believe, and I would like to correct this if I am wrong, has the highest assignment rate in the Nation. They, therefore, have very good clean claims coming in that are quite easier to process than Florida who have among the two or three lowest assignment rates in the Nation. That is not an excuse but it is something you can't ignore either. It makes a tremendous difference.

Senator CHILES. Under the recent report of the Secretary of HEW, the Advisory Committee on Medicare Administration did not recommend any changes in the Government's policy as to the use of private carriers. Among the reasons given for that was, one of which the part B in medicare is uniquely sensitive as an area of Government involvement in the practice of medicine and if private carriers which were long accustomed to working with physicians were more likely to enlist the physicians' cooperation in support than a Federal agency. According to the Office of Research and Statistics in the Social Security Administration in the December 1974 report, the assignment rate fell from 64.6 percent in 1970 to 56.9 percent in 1973, and in Florida at the end of 1973, the assignment rate was only 35.9, way below the national average.

It does not look like the private carriers are doing the job we anticipated they were going to do.

Mr. TIERNEY. I don't think we can attribute it solely to them. The most important thing about the assignment rate going down is the constant restriction of what was at one time almost an open

check—pay whatever the doctor sent in. The Congress said let's pay customary and prevailing fees, whatever the doctor's customary fee was so long as it was not higher than other customary fees and I understand they are quite high in some areas.

Every year since the program started, there has been some restriction brought into that picture and understandably so because it was just running out of hand. There were some years when fees for physicians were frozen under the Economic Stabilization Act. This year we will be putting in a fee adjustment but based solely on a new index. I think the lowering of the assignment rate, if you were to inquire of professional medicine, at least that is what they tell us, is that they just find the payments increasingly unacceptable. As you know, when they take an assignment they have to agree that that is it. They take that fee and they can't collect anything from the patient, so that is the real background of why the assignment rate has gone down.

Senator CHILES. Has the Social Security Administration established a ratio between the delays and delivery of benefits and the assignment rate?

Mr. TIERNEY. I am sorry I don't understand you.

Senator CHILES. Have you set a ratio between the fact of where there is an assignment and where there is not and what should be a reasonable timespan between the two?

Mr. TIERNEY. We have figures on what they are, Senator. We have not set what they must be.

Senator CHILES. Do you have any kind of range that you would consider to be the norm or what you would then look at a carrier if they were not meeting, but if there is a physician in-house in a hospital it ought to be done with an average claim being handled with x number days and if assignment it should be handled within x number of days and if there is no assignment, it ought to be handled in x number of days.

Mr. TIERNEY. We have those figures, Senator. I am not trying to quibble. We have them as a result of the improvement and enhancement of the program, computerization of the program and therefore established goals. I don't want to say to you that we have said that a hospital-based physician claim on an assignment must be handled in 3 days. We have not said that.

Senator CHILES. I am just asking if you have something in your shop when you say the State of Florida or the State of Connecticut or some other State that they are coming up within certain days that you have some guideline to send somebody out there to find out what in the hell is happening.

Mr. TIERNEY. We have that on a monthly and quarterly basis on assignment rate, unassigned, cases received, how many queries, how many rejects, average processing time, how many over 15 days, how many over 30 days. We have a mass of data I would be happy to supply the committee, Mr. Chairman, and from it we can certainly detect here is a situation where something is wrong.

Senator CHILES. I am not exactly looking for the massive data. I am looking for the guidelines or average things.

Mr. TIERNEY. I think if I were to supply you with one of our quarterly standard reports you would find virtually every aspect of their operation, each area's operation is reflected in those reports

and it is obviously from those, Senator, that you make judgments that this is a good carrier, this is a bad carrier, this is a proven carrier, and so forth.

Senator CHILES. We have tons of reports in the Government and we have a lot of them in the Congress, even, and reports can be a lot of paperwork or they can be used as a means of really getting into something. I want you to kind of understand from where I sit this GAO report does not just reflect on Blue Cross-Blue Shield now showing what we have kind of realized in Florida—not the exact numbers but just from the cries of the people, a quarter of a million people. I think it also reflects that we have not been policing Blue Cross-Blue Shield the way we should. It is interesting to note now they have put a vice president in charge of management as of June. Maybe that is the result of your taking 33 percent of the things away from them, but I wonder if it is as a result of GAO going in there.

It seems to me again the prime responsibility under the mandate of the Congress is the operation of this program rests with the Government. We have set up the carrier. We seem to think that is the best way of delivering the services. But I don't think we can sit back and say to those people, to our citizens, "Well, it is the carrier's fault and it is all their fault." They are looking to the Government. So, I think part of the fault really is perhaps with the Congress, that we have not moved quicker to determine, to oversight, to determine whether it is being carried out and certainly with social security that they have allowed this to happen and go on as long as they have.

Mr. TIERNEY. I would agree with you. Let me give you one thought, Senator. We have, since the beginning of this program, I believe, done more to improve the health care processing in this country than anything that ever happened in the last 30 years. I believe if you brought Blue Cross and Blue Shield in here they would tell you they have done a better job since medicare and I think the insurance companies would say the same thing but there are still weaknesses. One of the imponderables you run into, Senator, is when do you cut the string? Here is an outfit you spend a lot of money on. They have a full staff, they have a computer, they are giving a promise that maybe in another 6 months things are going to be better, so the inclination, frankly, is let's try, let's push, let's push, let's push. When you finally cut the string, it is quite traumatic. We moved Blue Shield, for example, out of Cleveland and turned it over to Nationwide. In the long run it worked out well. For 6 months there was chaos. There has been reluctance to change, but there is hope that you can improve.

Senator CHILES. I think that might be where you had to do the ultimate thing and cut the string. But what I want to know is what are we doing so that we don't have to do that, to get them in line and say, look, you are not paying attention to this and you are not paying these claims examiners enough. It is intolerable to have a 77 percent turnover and it is just not acceptable and the money is being passed on, so why don't you pay these people decently and put in management in charge of these kinds of things. Maybe if we say we don't involve ourselves at all with these private carriers, I would hope Blue Cross-Blue Shield is doing a better job with their claims and I would suspect they are. If I use the figure profit, that is because of my failure to understand the program. But if we are talking about over-

head when they get $15 million into their operation, certainly you ought to help them in what their other operation is going to be in reducing that overhead, and that has to be the same thing as profit because Blue Cross-Blue Shield, like any other carrier, Prudential, or the rest, they are not taking it on just to be taking it on. That is not the way things work in this country, I don't think. We don't want them to work that way. I think there has to be some reason they are doing that. Maybe we don't use the term "profit" but I am sure it helps the other side of their operation.

Mr. TIERNEY. No question about it.

Senator CHILES. That is the feature in helping the other side of the operation that has an incentive and that is why others are doing it.

Mr. TIERNEY. Blue Cross and Blue Shield have a unique situation. They have to be in the business—they have to be in the business. Nevertheless, there is because of the ability to have a larger computer capacity, for example, to allocate portions thereof appropriately to medicare, there are, if you want to call them profits, there are good features which accrue to a medicare carrier or intermediary.

Senator CHILES. Again, I think part of our problems at all times is I am sure we are delivering services better. I don't take issue with that, but if you look at those figures, if you look at them from where we were, sooner or later though somebody has to face this quarter of a million people in Florida who are facing these delays. You listen to them and they become a little different thing from a 0.00 statistic. They become a human being who many times have no other source of income, sitting there waiting every day for that check to come in.

Now, a person with pride, he does not want to be dunned or become unable to pay his bills. That is all they have to think about and it just drives them wild. To them they don't think the system is working better. It is just kind of the worst affair that can happen in their lives.

Mr. TIERNEY. I totally agree, Senator. The Social Security Administration of all agencies of Government has demonstrated an interest throughout its existence in providing people with what they are entitled to. Our goal is to pay every time as fast as it can be done, obviously. We have come some of the way and we have a way to go to getting that done.

There is one other feature that is so obvious that I hesitate to bring it up and that is processing time alone is not a criteria that the Government can stand by. If you go to an extreme, if you take every bill that comes in and send out a check that afternoon, you have a problem, and that would be a totally irresponsible operation.

Senator CHILES. I agree with that.

Mr. TIERNEY. There are all of these fool things and it is very difficult, and you have to remember the doctor has a very big thing going in this. If we had a 75 percent assignment rate in Florida, I think you would find there would be many more satisfied medicare beneficiaries in Florida. There is no way to force that.

Senator CHILES. I think we still have to work within the realities of what we do have in Florida or California or any of these other States. The realities are even though we don't have that, we are not getting the kind of time we should be getting. You are right in processing time alone but what that information tells us on just processing time, and that tells us 40 errors in 120 items, that is not just processing time—that scares me to death.

Mr. TIERNEY. I don't want to sound defensive on every point. Those 42 errors are part of the system we set up which now counts any error as a reportable error. For example, if one of the numbers in the zip code is wrong, it is an error. If one of the middle initials of the person is wrong, it is an error. Up in New York we got into a ridiculous situation where if people sent a claim to New York City instead of the Bronx—that was counted as an error. We are now perfecting that system so that those errors which do have a dollar impact, which do show there is a mistake that has been made, that the case should or should not have been paid and should or should not have been paid in this amount will be reflected and you get a much better picture. Forty is still too many. There are those who say if you have a good system you should catch every error, but the 42 does not mean there are that many significant errors. Everything that is wrong is counted as an error.

Senator CHILES. In evaluating carrier performance, the committee was concerned that private utilization might discourage efficiencies and cost savings. In essence, the committee said monopolies were created contrary to the spirit of free enterprise. Would you comment on that?

Mr. TIERNEY. I think that was really not a recommendation of the committee report that any change be made in that. There was one member of the committee who felt strongly that a doctor should send his bills to any carrier in the country and that that would somehow create competition. If he wanted to send it to one in Washington, he would send it there. We don't think that is administratively possible and we think the only incentive for sending claims elsewhere would be to get a higher fee or get it paid faster but it would be administratively unfeasible.

Senator CHILES. Has HEW or SSA taken internally or through outside consultants to consider possible removal of this?

Mr. TIERNEY. We are turning Dade County, Fla. over to a whole new carrier. That means the doctors.

Senator CHILES. You are splitting the territory.

Have you developed or considered developing a plan to encourage open competition among the carriers?

Mr. TIERNEY. You can't have open competition as long as the law says it will be done on a no-profit, no loss basis—in other words, we can't take bids. One of the things we have labored on for a long time——

Senator CHILES. You could compete on efficiency. You can compete as to the original charge as against efficiency.

Mr. TIERNEY. Not ahead of time, you can't. You can take a look afterwards and say this outfit did a much better job than you and, therefore, we are going to replace you with that outfit and that has happened in eight or nine places. But you can't get a bid ahead of time from someone that they will process all claims in 6 days.

Senator CHILES. You have two or three companies submitting proposals to take over Dade and Monroe Counties.

Mr. TIERNEY. That is right, and they gave us their best estimates as to how they would operate and whether they would bring in a computer and do it right there or do it on their home office computer. As I recall, Prudential, Equitable, Travelers, Blue Cross—we had to make an educated evaluation of which seemed to have the greatest

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promise for doing the job both on the basis of what they proposed to do and their past record as carriers. There was no bid.

Senator CHILES. In a way you would say you competed with that agreement or that contract?

Mr. TIERNEY. I don't think they would agree we competed it. Those who did not get it would not agree we competed. We sure tried to make our best judgment of which one of these organizations had the greatest promise of relieving the Florida situation.

Senator CHILES. Maybe I don't understand it then, but I would think if it were one of those companies I would consider myself to be in competition with the other companies to get that agreement.

Mr. TIERNEY. That is right, but they did not say we could process these at 12 cents, and so forth. Prudential proposed to operate—all the claims would go up to their computer center in New Jersey. That kind of thing went back and forth and our systems people had to try to come to some judgment as to which one had the best promise of success.

Senator CHILES. I appreciate your being here and indulging us. We are trying to learn something about this. I hope to learn a little bit more about it. I do know that it is not something that is easy and simple or something for which anyone has perfect answers, but I continue to reiterate when you see the hew and cry that goes up from these people and you see the real plight that they are in, I think it has to dictate that we all have to do a better job to try to see that they all get better service on their claims.

Mr. TIERNEY. I could not agree more, Senator, and we certainly welcome your interest and we are well aware of your concern and I would want you to know that any and every bit of information that we have is totally available to you and we would be glad to help you in any way we can. I know you are sincerely concerned and want to improve the program. I hope you feel that we want to do the same thing.

Senator CHILES. Thank you.

[The prepared statement of Mr. Tierney follows:]

Statement of Thomas M. Tierney
Director of the Bureau of Health Insurance
Social Security Administration, DHEW
before the
Subcommittee on Federal Spending Practices,
Efficiency, and Open Government
Committee on Government Operations
United States Senate

Mr. Chairman and Members of the Subcommittee:

I appreciate the opportunity to discuss with you the administration of the Part B Medicare program, particularly with respect to the Subcommittee's interest in the problems in the State of Florida. These are problems which have been created in part by the unique characteristic of the Medicare beneficiary population and suppliers of health services in the State of Florida.

I am aware of the request of the Subcommittee to the General Accounting Office to make a review of the Florida situation. However, I have not yet received a copy of the GAO interim report and, therefore, may not be able to respond to any specific findings of the study in my meeting with you today.

As you know, in the administration of the Part B program the day-to-day operational work of the program is performed by carriers, such as Florida Blue Shield, which has administered the program in Florida since the beginning of the program in 1966. The carriers have the administrative responsibility for

receiving and reviewing claims for covered health services and making payments to the beneficiary or, in the case of assigned claims, to the supplier of the service. In its role of monitoring the administration of the Part B program, the Bureau of Health Insurance of the Social Security Administration maintains a comprehensive Contractor Inspection and Evaluation Program which is the responsibility of its regional representatives. This program consists of a continuing surveillance and assessment of the effectiveness of a contractor's operations.

In addition to the inspection and evaluation program, we have other measures to monitor the performance of carriers in three basic areas: cost, timeliness, and quality. Administrative cost and timeliness of workload processing are reported and analyzed on a periodic basis. A quality assurance program to determine the extent and type of errors in claims processing has recently been implemented. Through these measures, we try to identify problem areas and to work with the carrier to correct any deficiencies which may develop before considering transfer of jurisdiction or nonrenewal of the contract.

The administration of the program in Florida has long been of special concern to us as a number of problems manifested themselves.

A very large number of SMI enrollees reside in the State: some 1.1 million aged and 66 thousand disabled as of October 1, 1973.

Florida Blue Shield, as sole Medicare carrier in the State, has been handling a continually increasing claims load as the Medicare beneficiary group grows with more retirees moving into the State.

As an illustration of the claims workload processed by Florida Blue Shield during FY 1974, this carrier processed over 3.5 million claims--the fifth largest workload in the nation. This represented a 23 percent increase in claims workload over FY 1973. A 16 percent increase is projected in FY 1975 over 1974.

The problem of claims volume is further augmented by elderly vacationers, many of whom are in Florida for extended periods during the winter months.

Under the Medicare law, a beneficiary requiring a doctor's care in an area away from his home State must file for his benefits in the State where he receives care. This regulation places a heavy burden on the carrier in coping with the seasonal fluctuations which occur in Florida. Four counties in the State of Florida, for example, have over one million visitors each during the year. This produces a claims increase during the winter months experienced by few other Medicare carriers. The increasing workload and the seasonal nature of the claims submission to a single carrier have created problems in the State resulting in claims processing delays. As the pending

claims workload increased, beneficiary dissatisfaction grew until in July 1974, Florida Blue Shield reached a peak of 55,000 inquiries from beneficiaries awaiting reply.

In view of this situation, and the predicted future growth of Florida population, the Secretary concurred in our recommendation to transfer approximately 30 percent of the workload of Florida Blue Shield to a second carrier. Accordingly, on March 4, 1975, the decision was announced that effective July 1, 1975, responsibility for administering the Part B Medicare program in Dade and Monroe Counties of Southern Florida would be transferred from Florida Blue Shield to Group Health Incorporated (GHI) for services received on and after that date. It is estimated that Dade and Monroe Counties presently account for about 30 percent of the total Part B claims volume in Florida, and about 25 percent of the State's age 65 and over population. This area is probably the most complex and difficult area presently administered by Florida Blue Shield.

Group Health Incorporated, which currently administers the Part B Medicare program in Queens County, New York, will establish a claims processing operation within this jurisdiction.

In making the selection of Group Health Incorporated as the replacement carrier, the Bureau carefully reviewed both written and oral proposals from Equitable, Group Health Incorporated,

Metropolitan, Prudential, and Travelers, all of whom it was felt, from their past performance record, had the potential to assume the additional responsibility.

Group Health Incorporated was selected as the replacement carrier because of its highly favorable ranking on elements of past performance, unit cost, and ADP capabilities, as well as on the merits of the proposal submitted.

The preparations for transfer of jurisdiction have been proceeding smoothly to date and it is anticipated that Group Health Incorporated will be able to assume its responsibilities on July 1, 1975, as scheduled. Both carriers have been making every effort to assure the success of the transfer and have been cooperating to the fullest extent in exchanging data and meeting deadlines.

It is anticipated that by shifting this significant portion of the workload to Group Health Incorporated, Medicare beneficiaries will receive faster and more efficient service. We will, however, continue to watch the situation closely and be prepared to take whatever actions are necessary to improve service to the Medicare beneficiaries in Florida. Essentially, the provision of adequate service to the beneficiary is the principal objective of our administration of the Medicare program--not only in Florida but throughout the country.

Our next witness will be Mr. W. J. Stansell, senior vice president, Blue Shield, Inc. of Florida.

TESTIMONY OF W. J. STANSELL, SENIOR VICE PRESIDENT, BLUE SHIELD, INC., OF FLORIDA; ACCOMPANIED BY MESSRS. DAN LEWIS AND NATHAN E. OPLINGER

Mr. STANSELL. Mr. Chairman, thank you for this opportunity to appear to testify.

On my right is Dan Lewis who is in charge of all claims operations in Florida and Blue Cross plans that pay over a billion dollars in benefits each year.

Also with me is the now famous, at this hearing at least, the new vice president of medicare part B claims, an operation which pays about $200 million a year.

Senator CHILES. I did not hear the gentleman's name.

Mr. OPLINGER. Oplinger.

Mr. STANSELL. We are from Blue Shield of Florida, organized not for profit under a special enabling act under the 1944 Florida Legislature. Our governing board consists of 21 business and professional men from all geographic areas of Florida. On behalf of them and our 3,700 employees, I can assure you we are involved in all medicare needs for the single purpose of providing a high level of service to all Floridians and Florida's visitors for whom we have a contractual obligation to provide health care benefits.

At the invitation of the Department of HEW and upon the urgings of the Florida Medical Association we entered into a contract in 1966, the beginning of the program, to administer medicare part B for all beneficiaries receiving care in Florida.

As has been previously mentioned, our volumes are varied. Our medicare receipts were about 40,000 claims each. In 1975 it has more than doubled to about 100,000 claims per peak.

As has also been mentioned, of course, there are seasonal fluctuations in volume, recognizing Florida as the fastest growing State in the Nation and our over-65 citizens are increasing at even greater rates than we projected, 10 million population by 1982, with another 2 million eligible for medicare. In view of this, we expect similar rises in claims volumes in the next few years.

Today, because we only received our formal invitation on Monday of this week and, too, since we have not reviewed in detail the testimony today, we have listened carefully, noted specific concerns expressed by you and your colleagues on the committee and the previous witnesses today and, with your permission, Mr. Chairman, it is our desire to prepare a full response for later entry into the record.

[The material referred to follows:]

STATEMENT OF BLUE SHIELD OF FLORIDA, INC., submitted by W. J. Stansell, senior vice president

Blue Shield of Florida, Inc., appreciates the opportunity to submit for the record comments on the testimony presented on June 13, 1975, before the Senate Subcommittee on Federal Spending Practices, Efficiency, and Open Government, Committee on Government Operations, regarding operation of the Medicare Part B program in the State of Florida. Our comments are in three sections. Part I discusses some of the significant general points raised during the course of the hearing. Part II responds briefly to some technical points raised during testimony by the General Accounting Office. Part III consists of recommendations for improvements regarding the Part B program itself, as requested by Senator Chiles.

Part I

In our testimony before the Subcommittee, we stated our high regard for the competence and objectivity of the GAO Audit Team investigating Medicare Part B claims processing by Blue Shield of Florida, Inc. It is not our intention to rebut or correct the testimony by GAO, but to add additional information and, where the current situation differs materially from that which existed during the 1974 period that was studied, to present more recent information. We have no intention of evading responsibility for problems which may exist or have existed in the past, but we think it is considerably more important to focus our attention on the present and future than to dwell on what is behind us.

Management and Organization

The problems on which GAO reported have concerned the management of Florida Blue Shield for some time, and we have initiated several reviews of our operations by consultants and outside groups with experience in the processing of Medicare Part B claims. As a result of their recommendations Medicare Part B operations have undergone a major reorganization within the past several months.

---A Vice-President has been appointed for Medicare Part B, in order to ensure that Medicare Part B matters receive full-time attention at the corporate officer level.

---Virtually every manager within the operation has been reassigned, in order to make better use of available talent, and new managers have been or are being brought in from other departments.

---New managerial positions have been created and staffed, in order to assure a sufficient depth of management that planning and control functions are not shunted aside due to the press of everyday problems that large and rapidly increasing volumes generate.

---Preliminary goals have been established that commit the Part B management team to a level of performance, by the end of FY 1976, that is as good as the national average on available indices. (Our ability to match the national average cost per claim, however, will depend to a rather large extent on the

assignment rate and the percentage of claims requiring additional development.)

---In order to achieve those goals, detailed management planning, incorporating significant accountabilities for and measurements of results, is currently underway.

The goal-setting and planning process just described will encompass plans and goals not only in the areas of claims processing times and quality of performance, but also in those areas of personnel utilization that are the keys to improved performance: employee turnover, quality of supervision, working conditions, job design.

Delayed Claims

While the GAO testimony recognized that 94% of the nearly 4 million claims we processed in 1974 were paid within 60 days, the auditors were critical of the number of claims---237,000, or about 6%---that required more than 60 days to process. We recognize this as a key concern. By way of explanation, though not excuse, we would point out that extraordinarily large yearly increases in claims volumes (which have regularly exceeded both our estimates and the estimates made by the Bureau of Health Insurance), and seasonal fluctuations in claims volumes, have both led Florida Blue Shield to stress timely payment of the vast bulk of claims and have diverted management attention from those claims that are delayed an excessive length of time.

Recognizing the validity of the comments by GAO, and the problems created for beneficiaries whose payments are delayed, we will deal more effectively with those claims that are delayed either through error or because of missing or incorrect information on the claim. Procedures now being developed will, when implemented, identify every claim that has not completed processing within 50 days of receipt. Once identified, these claims will receive whatever attention is needed to ensure that processing is completed as rapidly as possible---generally in less than 10 days after they are identified.

One of the elements that leads to delayed payment of claims is the number of claims pending at any given time. Obviously, when there is a heavy inventory of claims to be processed, newly-received claims may be delayed. Due to the very large seasonal fluctuation in claims received by Florida Blue Shield (GAO noted that the 1974 monthly low was 258,821 in September and monthly high 526,642 in December), the inventory typically rises during the winter months and is reduced gradually thereafter. It is possible to increase staff in order to deal with the larger volume of claims that ordinarily begins in about November; but since personnel must be added sufficiently far ahead to permit training and some on-the-job experience, cost per claim is inflated above the level necessary simply to process the relatively stable volume of claims that is received in August, September, and October.

Since December 1, 1974, however, Florida Blue Shield has steadily reduced its pending claims count, even though this has been the season when claims

volumes historically are highest. Moreover, during this period the number of employees in the Medicare Part B operation has been reduced from approximately 930 to 850, a reduction of over 8%.

Error Rates

One of the GAO findings that gravely concerns officials of Florida Blue Shield concerns error rates. We agree that the error rates cited are not acceptable, and that retention of employees is among the crucial elements in reducing the number of errors. Among the specific goals set by management for the upcoming fiscal year is the reduction of error rates to no higher than the national average.

At the same time, it should be pointed out that the method used to assess and state error rates is highly technical and that the resultant error rates are not necessarily related to the number of payments that may be inaccurate. For example, the omission of an apartment number from a beneficiary's address, the use of an initial rather than a first name, and the omission of a middle initial are all counted as errors. Yet the payment made to the beneficiary on such a claim may have been both prompt and correct. Similarly, if a claims examiner fails to document the reason for a payment that differs from the usual payment for a given service, an error is assessed even though investigation may determine that the payment amount was correct.

Moreover, we have strong reason to believe, first, that our post-processing claims audit, through which error rates are determined, is more effective than that performed by other carriers, and, second that the assessment of errors is not uniform throughout the country. We note that the correlation

coefficient between our audit, performed by our personnel, and the sub-sample audit performed by a BHI representative is among the highest in the country. In other words, we apparently do a particularly good job of auditing.

As an example of the inconsistency that we believe exists in the assessment of errors, we would cite the large number of errors assessed against us for acceptance of the terms "hospital care" and "intensive care" rather than the term "hospital visit" to describe in-hospital medical care rendered by a physician. On the grounds that the law contemplates payment only for specific services rendered patients, and that the terms "hospital care" and "intensive care" do not specifically indicate that a patient visit has taken place, BHI directed that claims describing care in such fashion should be denied and that errors would be assessed if they were not. Communication with other carriers around the country, however, leads us to believe that this directive is not being followed by many of them and that errors are not being assessed for failure to follow it. Such inconsistencies, if as we believe they do exist, tend to inflate our error rates in relation to other carriers.

In view of the foregoing points, we believe that press reports emphasizing an "excessively high error rate" by Blue Shield of Florida are highly misleading, though technically correct. They unfortunately suggest to Medicare beneficiaries that a large proportion of payments is incorrect, which is not true.

Despite these comments regarding error rates, however, we reiterate what we said previously: that the number of errors cited in the GAO testimony is unacceptable to Florida Blue Shield and will be reduced.

Salaries and Turnover

Both in GAO's testimony and during subsequent questioning, it was noted that Medicare B claims examiners have been in a lower salary classification than other claims examiners. At the request of Part B management, the relative classifications have been reviewed on a number of occasions by a company-wide salary administration committee. As a result of the most recent such review, in May 1975, the classification of Medicare Part B claims examiners was raised to parity with other claims examiners. Resulting salary increases will be received by the examiners shortly, and will be retroactive to May. (It should be noted that actual salaries, as opposed to salary ranges, for all personnel will depend on performance and length of service.)

It was felt by GAO that salary considerations may have played a large role in the high turnover rate within Medicare B as a whole and particularly in the claims examining area. During 1974, however, Florida Blue Shield made two general salary increases, which applied to all employees. Careful monitoring of the results of those increases -- which would have come earlier had it not been for the Economic Stabilization Program -- did not reveal any significant effect on turnover.

At present, however, turnover has been sharply reduced throughout Florida Blue Shield. Specifically, turnover among Medicare B claims examiners from January through May 1975 was at an annualized rate of 28% -- well under one-half the 77% rate that existed in 1974. While some of this reduction is unquestionably due to general economic conditions, we are convinced that a large part of it is attributable to improvements in supervision and management practices, and to the fact that in the past six

months claims examiners have been achieving a higher level of performance than in the past, which in itself increases job satisfaction.

Another factor impacting on turnover in 1974 and previous years has been the historically low unemployment rate in Jacksonville, Florida. While comparative figures from other large employers with similar types of operations are not easily obtained, our contacts with such employers have indicated to us that they, too, have experienced a relatively high rate of turnover. Where there is little unemployment, job mobility is high; and a workforce composed largely of younger persons is peculiarly subject to turnover for many reasons.

Costs and Productivity

In connection with the improved performance level of Medicare Part B employees, the productivity figures for 1974 cited by GAO may be compared to current productivity figures. Figures for the last half of 1974 showed that the number of claims processed per 100 man-hours was 155 for Florida Blue Shield and 256 for all carriers. Our most recent data from the Bureau of Health Insurance indicate that Florida Blue Shield's productivity per 100 man-hours in April 1975 was 196. While this is not yet the level of performance we expect or desire to reach, it does represent a 26.5% increase.

A similar improvement has occurred as regards cost per claim processed. The figures for the last half of 1974 showed a cost per claim of $4.57 for Florida Blue Shield, as compared to $3.36 for all carriers. For the period July 1974 to April 1975, however, the cost per claim at Florida Blue Shield was down to $4.13, and for April 1975 alone the cost per

claim was $3.60 as compared to a national average (as of December 1974) of $3.36. Again, this is not satisfactory to Florida Blue Shield management, but it does indicate a trend that we are committed to seeing continue.

In regard to the cost of processing claims, one significant measurement has, so far as we know, escaped notice. This is known,technically, as the cost per payment record. Usually, when physicians submit Medicare claims on an assigned basis (meaning that the physician accepts payment directly from Medicare), the claims involve one service and/or one physician, and therefore one payment record is involved. When beneficiaries themselves submit claims on an unassigned basis, they generally accumulate several bills and submit them as part of a single claim. (One claim may include as many as 32 separate items under our processing system; others do not allow this many items on a single claim.) Processing a claim that involves several different services and suppliers obviously requires more time than processing one that involves a single service or single physician.

Because Florida has a low rate of assigned claims, the majority of claims processed by Florida Blue Shield involve more than one service and more than one physician or supplier. Most other carriers generally have a higher assignment rate, and therefore a higher number of claims for only a single service and physician. When costs of processing are allocated, not on a per-claim basis but on the basis of the number of different doctors or suppliers or bills paid (i.e., on a payment record basis), the gap between the cost at Florida Blue Shield and the cost at other major carriers is considerably smaller than the difference in cost per claim. For the last six months of 1974, the national average cost per payment record was $3.92. For Florida Blue Shield

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the cost per payment record was $4.38. This $0.46 difference is considerably less than the $1.11 difference when cost per claim is compared.

Unassigned Claims

As noted by GAO, 59% of the claims processed by Florida Blue Shield in 1974 were unassigned. GAO also noted that unassigned claims require significantly longer to process, on the average, than assigned claims or claims from hospital-based physicians: 25.6 days for unassigned claims, as compared to 17.8 days for assigned claims and 12.5 days for hospital-based physician claims. The relatively high rate of unassigned claims, and the longer time required to process them, are related to another statistic cited by GAO: that 19.7% of all Medicare Part B claims processed by Florida Blue Shield in 1974 required that additional information be obtained before processing could be completed. This is almost twice the national average of 10.2%.

The number of claims requiring additional information is a direct result of the high rate of unassigned claims in this state. An internal study made in 1974 showed that during a three-month period over 90% of the claims on which additional information was requested by telephone were unassigned claims, and that over 80% of the claims requiring correspondence prior to processing were unassigned claims. The cost of processing unassigned claims, during calendar 1973, was also found to be significantly higher than the cost of processing assigned claims: $3.492 as opposed to $3.043.

It should be obvious that any claims that require additional information before they can be processed will be delayed. Where the number of claims requiring such information is as high as it is in Florida, there will be a

significant effect on the total average time required to process claims.

Our experience shows that unassigned claims and claims requiring additional development of information contribute significantly to a higher average cost per claim and to slower average processing times. There are several reasons for this. Obviously, unassigned claims that include more than one bill or service take longer to process than assigned claims, which generally reflect a single service. There are both time and cost factors attached to obtaining additional information, which as just noted is necessary far more frequently with unassigned claims than with assigned.

In view of this, some comparisons between Florida Blue Shield and the four other largest Medicare Part B carriers may put the Florida situation in perspective. (The figures are for calendar year 1974.)

Carrier	% Assigned Claims	% Claims Needing Information
Florida Blue Shield	40.81	19.4
California Blue Shield	74.5	8.48
Greater New York Blue Cross & Blue Shield	50.29	6.1
Texas Blue Shield	63.43	11.18
Pennsylvania Blue Shield	66.76	9.81

We believe these figures suggest, as we have stated before, that the Florida situation is unusual, and that the Medicare Part B carrier in this state faces some unique challenges. In so saying, we are not retreating from our previously stated goals for the next fiscal year; we expect, regardless of the unusual

factors in the Florida situation, demonstrable improvement in processing times and error rates. We do believe that those judging our operation, however, should be aware of such factors as these.

Communications Program

Recognizing that one key to improving claims processing time was an improvement in the condition of the claims being received, Florida Blue Shield began during the summer of 1974 an intensive program to teach beneficiaries how to file complete, correct claim forms and to encourage physicians to assist beneficiaries by completing claim forms for them on unassigned claims. In cooperation with local organizations, over 60 workshops have been presented for beneficiaries, particularly in those portions of the state with heavy concentrations of older citizens. Presentations have been made to over thirty medical societies and over 50 groups of medical assistants. Well over a million brochures detailing the correct procedure for filing a Medicare claim have been distributed through direct mail, at workshops, and through physicians' offices. A taped television presentation is also in preparation.

We are not yet sure whether this communications effort has been successful. We are sure that if the condition of the claims we receive cannot be improved, a certain number of claims will continue to be delayed. We also recognize that the beneficiary who files his or her own claim incorrectly is almost never made aware of the error or omission involved, in an educational way, and we think that if carriers were allowed to return such claims to beneficiaries or physicians, along with a statement of the problem, the educational effect would be highly beneficial to all concerned. As a simple example of a common error that leads to delay, we receive thousands of claims that include receipted bills

from medical groups of two or more doctors, and that do not indicate which specific doctor performed each service. Every one of these must be held in suspense while we determine the name of the doctor. As GAO noted, about 60% of the claims that require additional information are missing either an itemized statement of services and charges, or a diagnosis of the condition that made medical treatment necessary.

Part II

At this point we should like to turn our attention briefly to several of the more technical observations made by GAO.

1. Validity of Reported Data Concerning Processing Cycle Time

   GAO noted that Florida Blue Shield computes claims processing times in accordance with SSA instructions. It was, however, noted that the period between receipt of a claim and assignment of control numbers, and the period between preparation and mailing of checks, are not required to be counted. GAO estimated "that a total of about 7 days elapse at these two stages."

   As regards the time that elapses between receipt of a claim and assignment of a control number, it is currently estimated at less than half a day. Some claims which require research before they can be entered may require longer. If a heavier

volume of claims than anticipated is received, overtime is instituted to ensure prompt entry into the system.

Elapsed time between printing and mailing of checks and Explanations of Medicare Benefits averaged 4.2 days during the first five months of calendar 1975, according to an internal study. This calculation involves calendar days, and thus includes weekends and holidays.

The time required between check printing and mailing involves procedures necessary to verify the integrity of the check run, the condition of the checks, and the correlation between the checks and the check register, as well as check signing. These procedures have been reviewed by both BHI and HEW in the past, and the only criticism noted related to the possible need for additional physical check security.

2. Delays in Transmittal of Additional Development Requests

GAO noted that nearly 15 days elapse between the time a claims examiner requests additional information and the time a telephone call is made or letter written seeking that information.

This delay is a function of the processing system currently in use, which involves the direct entry of claims data into the computer system. It should be noted that part of the average 15 days delay is not actually lost time: during this period certain edit functions are performed that, if not done at this point, would have to be done later. In other words, we could shorten the 15 day delay in transmittal of claims to

the Additional Development area, but time saved at this point would have to be used later.

Because we recognize, however, that the 15 day average might be reduced, we are studying a number of alternatives to the present system. Before implementing any changes, we wish to be sure that they will contribute to better overall processing times for those claims that require additional development of information, and to ensure that an improvement in this one area will not be offset by a deterioration in some other area.

Attention is also being paid to the length of time that a claim requiring additional development remains in the Additional Development area, once it has reached there, before action is taken on it. Currently, this period is no more than three days.

3. Reduction of Edit Error Kickouts

GAO suggested that some edit error kickouts could be eliminated by "minor changes in the procedures for initially entering claim information in the computer". We will discuss with the GAO Audit Team the changes they may have in mind. Our initial reaction, however, is that procedure changes that would accomplish this goal would not be minor, and would include conversion to an "on-line" computer system---which we have under active consideration. We agree that one of the two most important keys to a substantial reduction in edit error kickouts is retention and training of employees; the other is the immediate edit capability that an "on-line" system would provide.

4. Possible Changes in Document Flow in Pre-Payment Screening and Transaction Reject Areas

GAO suggested that the time required to review Pre-Payment Screening and Transaction Reject kickouts could be materially reduced through improved physical document flow. We have had a full-scale methods and procedures study underway in the Transaction Reject area for some time, and this study is nearly complete. In the Pre-Payment Screening Area, there have been delays in obtaining copies of claims from the files. We are contemplating establishment of a night crew in the Microfilm Retrieval area in order to speed the process of getting these necessary copies.

5. Reduction of Reasonable Charge and Duplicate Payment Kickouts

As noted in GAO's testimony, we have implemented changes in the Reasonable Charge and potential duplicate claim computer screens, with the aim of reducing kickouts for these reasons. The changes made will reduce Reasonable Charge kickouts significantly, though there may be a slight increase in inappropriate payments as a result. The change in the potential duplicate screen has not been of much help in reducing kickouts, primarily because a recent change in procedure coding has increased the possibility of such kickouts to a level that roughly balances the improvement that would otherwise have resulted from the change recommended by GAO. In a sense, however, we have gained from implementation of the recommendation, since otherwise the coding change would have increased the total number of potential duplicate kickouts.

6. Management Attention to Delayed Claims, Backlogs, and Document Flow

We have commented on this general subject earlier in our submission. In the area of improving document flow and claims control, we do wish to note that we are considering a variety of alternatives. Chief among them is conversion of our computer system to an on-line system, which would substantially reduce paper-handling and would have certain built-in edits and feedback systems that would provide claims examiners with constant information on their performance.

In addition, we are and have been actively reviewing job design and work distribution, primarily with the aim of improving employee motivation and of providing employees with effective feedback on performance. Moreover, the formal management accountability process noted earlier will not in fact be limited to managers, but will have an impact also at the clerical level: results will be expected, performance measured, and accomplishment rewarded accordingly.

Part III

In response to the Subcommittee's request, we have prepared a number of recommendations for improvement of the Medicare Part B program. They range from relatively simple steps concerning administration to an overarching recommendation regarding the philosophy of program management; but even those that seem minor would, we believe, result in significant improvements in carrier administration or in the program's usefulness to beneficiaries, or would eliminate or prevent problems in the program. None, in short, are trivial suggestions.

To begin with, we wish to suggest a number of rather technical adjustments that we believe would be beneficial.

1. We recommend that carriers be permitted to return claims with incomplete information on them to the beneficiaries or physicians who submit them, along with a notation indicating the information that is needed, and that these claims be deleted from the carrier's inventory.

The reason for this recommendation is simple: when carriers are not permitted to return such claims, those who submitted them never learn how to submit correct and complete claims. Carriers may obtain the necessary information through letters or telephone calls, of course, but this accomplishes little toward the end of correcting the problem at its source.

There will obviously be some claims that should not and would not be returned: multiple surgery claims, for example, would best be completed through obtaining a copy of the operative report. Claims that have been returned once and that again come in in incomplete fashion would probably best be developed by the carrier. But in most cases, we believe that beneficiaries and physicians would be best served by being asked to assume some responsibility for the submission of claims that can be processed without additional work on the carrier's part.

We are, in Florida, especially sensitive to this problem because of the exceptionally high rate of claims needing additional information in this state. We would note that such claims are inevitably delayed in processing, to the beneficiary's disadvantage. On the basis of our public workshops at which we seek to show beneficiaries how to file claims correctly, we believe beneficiaries would welcome the opportunity to learn how claims should be submitted in view of the potential for improved claims service.

It has on occasion been indicated to us that claims cannot be returned because, once submitted, they become Federal documents. If this is true, we recommend a statutory change to enable carriers to return them.

2. We recommend a time limit of 15 months from the date of service for the filing of claims.

The fact that beneficiaries may now file claims for up to 27 months after the date services were received complicates claims processing. It often confuses the deductible status; it may complicate the obtaining of additional information; and it results in the filing of many duplicate claims since, with time, beneficiaries forget whether they have filed claims previously. We see no disadvantages to a reduction in the time limit for filing of claims, and several advantages.

3. We recommend that the Medicare handbook given to beneficiaries be revised to include among other things, a discussion of the prepayment screening process through which carriers may deny claims because the services rendered are judged to be medically unnecessary.

Although the present handbook does mention that services must have been necessary for the diagnosis or treatment of an illness or injury, we believe beneficiaries are often unaware that the denial of claims on the grounds of lack of medical necessity is not the work of arbitrary carriers but is envisioned in the Medicare law and is essential to a fiscally sound program. The result of not explaining the medical necessity requirement is dissatisfaction with the program and with the carrier, and an increase in requests for reviews and Fair Hearings.

4. We recommend several changes in the approach to payment for durable medical equipment.

At present, durable medical equipment for which payment may be made under the program may either be rented or purchased. It happens on occasion that equipment is rented for such an extended period of time that its purchase price is paid by the program several times over. This is not necessarily the result of carelessness or thoughtlessness on anyone's part; it may be that the need for such equipment is of longer duration than anticipated.

Nevertheless, this creates an unnecessary cost to the program. While the rental option would be preserved, we recommend consideration of a statutory change that would require suppliers of such equipment to agree that after Medicare has paid a certain amount over and above the actual purchase price in rental charges, the equipment shall be deemed to have been purchased and no further rental charges will be made. A study should be done in order to ascertain the appropriate factor that would fairly reimburse suppliers for overhead and other costs in such cases.

In order to assist beneficiaries, we suggest a further change in the payment arrangement for durable medical equipment that is purchased outright. At present, Medicare can reimburse beneficiaries for items that cost over $50.00 only by monthly payments equal to the monthly rental charge for the same item. As a result, a beneficiary may pay a sizeable sum for an item of durable medical equipment and receive his reimbursement only over a period of months. For the beneficiary on a fixed income, this works a genuine hardship. It also increases a carrier's work load, since a claim for the same item must be processed a number of times.

We therefore recommend that where there are reasonable grounds to believe that a beneficiary will need an item of durable medical equipment for a long enough period of time to justify purchase rather than rental, carriers be allowed to pay the Medicare allowance in a single payment.

5. We recommend elimination of the annual Part B deductible, with the resulting increased cost to be partially offset by a change in the co-insurance factor to 75%-25%.

We believe that implementation of this proposal would be beneficial in a number of respects:

(1) Medicare at present imposes two deductibles, an annual Part B deductible and a Part A deductible that is applied each time a beneficiary is hospitalized. The potential burden on persons living on fixed income is considerable.

(2) The Part B deductible may discourage lower-income beneficiaries from seeking treatment in the early stages of an illness. This can ultimately lead to higher costs to both the beneficiary and the program, since a delay in treatment may well lead to worsening the condition and consequently to expensive hospitalization or other treatment. We note that a recent study of the Medicaid program in California ("Medi-Cal") by the UCLA School of Public Health concluded that beneficiary cost-sharing for physiciar charges in that program ultimately resulted in higher hospitalization rates and overall public expenditures.

(3) The deductible complicates claims administration, since it requires that every claim for every beneficiary be checked against the central file in Baltimore until the deductible is met and this information entered on the carrier's own files.

(4) The deductible is difficult for benefiaries to understand. Moreover, if claims are filed out of chronological sequence an underpayment may result or correspondence may be necessary in order to achieve a correct payment. This is because of the "carryover" provision whereby any amounts applied to the deductible during October, November, and December are also applied to the deductible for the following calendar year.

For example, let us take the case of a beneficiary who incurs no expenses during the first nine months of 1974. In the last three months of the year, he incurs $60.00 worth of expenses, and in January of 1975 an additional $60.00. If the January claim is submitted first (as could easily happen, for a number of reasons), it will be applied to the 1975 deductible. The 1974 bills will be applied to the 1974 deductible when they are filed later. But had these claims been filed prior to the January claim, they would have satisfied both the 1974 and 1975 deductibles, under the carryover provision---and the beneficiary would then have received payment for the 1975 claim.

In summary, elimination of the deductible would, we believe, improve the program for the beneficiaries and reduce the cost and complexity of program administration.

6. We recommend that no additional benefits or categories of beneficiaries be included in the Medicare program without thoughtful consideration of benefit design and adequate lead time for implementation.

The value of additional benefits should be weighed against the administrative complications and costs of including them in the program. The addition of new classes of beneficiaries should be undertaken only if adequate lead time is provided for the development of regulations and any necessary

modifications in processing systems. The point we would stress is that, in any program as large and complicated as Medicare, seemingly minor changes may in fact require major administrative adjustments.

7. We recommend a thorough revision of the approach to reimbursement under Medicare Part B.

Reimbursement is, in our experience, the leading single cause of dissatisfaction with the program among doctors and beneficiaries alike. The present approach to reimbursement, the so-called "reasonable charge" based on individual and community charge profiles, is difficult to explain to beneficiaries and doctors; is administratively expensive; generates considerable correspondence; and---in its present state---leads to significant differences between actual charges and Medicare allowances. It does tend to control costs from the government's point of view, but in areas with high proportions of older citizens it discourages physicians from taking assignment and therefore shifts costs from the program to the aged beneficiaries.

We recommend one of two courses in this area:

(1) Instruct carriers to allow the same Usual, Customary, and Reasonable amounts under Medicare Part B that they would allow in their private business programs. In Florida this would change the allowable charge level for individual physicians from the 50th percentile to the 90th percentile, and the community charge level from the 75th percentile to the 90th percentile. (N.B. These are not percentages; the 90th percentile is that amount that would pay in full the lowest 90% of charges for a given service.)

This would require that Congress repeal that portion of P.L. 92-603 that will soon require physician charge increases under Medicare to be tied to an economic index, and would also require that the Social Security

Administration be instructed to require carriers to use their private business profiles for Medicare. We think it important to point out, in this connection, that to the extent that the requirement of P.L. 92-603 concerning physician fees results in decreasing Medicare allowances beneficiary and physician dissatisfaction with the program will be increased.

(2) If (1) above is not practicable, adopt either nationwide or areawide fee schedules that would clearly state how much Medicare would pay for every service. (Some services, such as multiple surgery, would require individual consideration and could not have pre-determined fees.) This would have the advantages of simplified administration, clarity to beneficiaries and doctors alike, and predictable costs. Such schedules must, however, be realistic and subject to regular updates: i.e., they should reasonably reflect the actual charges of physicians.

8. We recommend conversion to a plastic Medicare I.D. card, similar to a credit card, which could be used by physicians and hospitals to imprint beneficiary names and Health Insurance Claim numbers on the claim forms.

This recommendation arises because of the surprisingly large number of claims we receive with incorrect names and/or Medicare numbers. The omission of, or an error in, the single letter suffix to the Medicare identification number can result in delays, claim rejections, and payment errors. The same is true if there are errors in the beneficiary's name.

We would also note that a plastic I.D. card would be more permanent than paper cards.

9. Our last and most important recommendation is best couched in the words of two recent studies of the administration of Medicare. We recommend that "SSA should reduce its role in carrier decision-making and rely on its capacity to test carrier performance by results," and that "SSA and its contractors (should) develop a relationship which will enable the private sector to add its full capability to the administration of the Medicare program."

The first of these quotations is from The Administration of Medicare: A Shared Responsibility, the Final Report of the Medicare Project Panel of the National Academy of Public Administration. The second is from the Perkins Committee's Report on Medicare Administration, Contracting and Subcontracting. We have quoted these two documents, and have appended them to our submission, because we believe their recommendations are valid and will be of great interest to the Subcommittee.

As is suggested in these two studies, the time is ripe to reassess the relationship that should properly exist between the government and its contractors. Both these studies lay heavy emphasis on the importance of leaving private contractors free to manage flexibly and creatively. Both also stress the importance of measuring carriers by the results they obtain, and of holding them accountable for good performance. Although Florida Blue Shield has been criticized for its performance, we endorse the idea that carriers must be measured by results . . . provided that they have sufficient management authority to produce the desired results. We stress that the issue here involves the strategy of program management, not the competence or

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integrity of SSA nor the responsibility of the government to establish the general policy which should guide the administration of the program.

We would be happy to discuss at greater length any or all of these suggestions with the members and staff of the Subcommittee. We appreciate the opportunity to submit the foregoing material for the record. We trust that it states our response to the issues raised during testimony and questioning without evasion or omission of any significant points.

Mr. STANSELL. In response to the subcommittee's interest in improvement in our written comments, we will address some possibilities for your consideration drawn from our 9 years of experience with the program in Florida.

We would be remiss if we did not pass along to you our high regard for the professional work done by the GAO auditors prior to 1975.

We thank you again for this opportunity. Of course, Mr. Lewis, Mr. Oplinger and I will be happy to answer any questions you have now.

Senator CHILES. We regret that you did not have more information on the material. We were waiting to find out as soon as we could when GAO would have some findings that would be available to us, and this was the earliest period of time we could get those findings. I think we tried to say a number of times as soon as those findings were available, we wanted to go into this area.

I want to say right now that if you wish additional time before we go any further in our discussion today, I certainly want to honor that request and provide additional time. We can recess our hearings and come back, because it certainly is not our purpose here to bring you up here under any kind of surprise.

Mr. STANSELL. I did not mean it was a surprise. We have been in touch with the GAO and the nice folks sitting next to you about our concerns, but without looking at it in detail as presented, we did not feel we were in a position—obviously, we have answers to many questions you might ask this morning, and I believe the GAO and Mr. Tierney both have answered some of the questions that you would naturally ask of us.

Senator CHILES. I just wanted to say we would be happy to have your detailed statement, and we will take your detailed statement, but if you needed any additional time, we would be happy to give you that, too.

Mr. STANSELL. We would like to have 10 days or so to put together some information which we think would be helpful to you and the previous witnesses and your expressed concern.

Senator CHILES. Part of the questions that I did ask GAO you might be better able to answer than they were because there might be areas they could not fall into. Of course, the first one I was asking was on the basis of why it is costing $4.57 for Florida to process a claim as opposed to $3.36 for other carriers.

Their answer, of course, was on the basis that we were processing fewer claims, that probably related to turnover, but I would like to have your best answer.

Mr. STANSELL. I think their answer is fairly complete, Senator. As they said, they wanted to look into that further, and we stand ready to cooperate with them on that.

I think of significance to you though is what the current figure is, the April figure. Mr. Tierney indicated some improvement that he saw coming, and I believe if I give you the figure of $3.60 per claim for the month of April 1975, that would indicate a considerable improvement over the $4.50 figure that resulted from the winter's works.

Mr. LEWIS. We should comment that the figure fluctuates by season, any cost figures.

Senator CHILES. I am sure the monthly cost figures certainly would operate by season.

On the high personnel turnover rate, what is the company's feeling as to why there is this high turnover rate?

Mr. STANSELL. The higher turnover rate has lessened considerably this year, not necessarily due to any action on our part but the economic recession, backing into the fact that during the previous 2 to 3 years in Jacksonville, an area in which we operate with more than 3,000 of our employees has had at times a less than 2 percent unemployment rate. I believe if we would get believable figures from other large employers of this type of personnel, you would see that this figure may be high, but it is not inordinately high. The labor movement is pretty much depleted. We do think there were some problems with salary levels generally within the company.

In 1971, within 2 weeks of the freezing of wages, we had delayed plans to raise our level of pay across the board, and we were frozen as was everybody else for a period of time. In the year 1974, we made two general adjustments throughout the company to bring ourselves to the competitive level that our labor competitors, if you will, in the Jacksonville market had reached. Then the economic recession helped considerably to bring that figure down to something like 28 percent currently.

Senator CHILES. A 28-percent turnover currently?

Mr. STANSELL. Yes, sir.

Senator CHILES. Again, as a management decision, it seems to me when you are experiencing a 77 percent turnover, it would be pretty obvious that you were not competitive, and here you are in a business where you are really reporting costs and then being reimbursed for them, so you are not really in a situation where you could not raise the salaries, or were you?

Mr. STANSELL. We are in the peculiar position of being taxpayers as well as managers of a business, and we did not feel, based on government money, that we should pay a higher rate. We made the decision to pay them at the rate they were being paid and the current decision is based on internal equity in a salary program.

If you have certain people doing easier jobs and being paid more money, you have more problems across the board with a group of employees.

The nature of the medicare B program versus a singular type of program, a single set of benefits, one in which many of the decisions are made by the Government and the regulations versus private programs, where you have variations that could go into the hundreds, and the nature of handling the claims for the two, we saw them as being different; easier, if you will, in the medicare part B side. Because of the other complications, we changed our mind through the restudy and will upgrade the level of salaries and are in the process now of upgrading the salaries of these people. We tried to carefully track after the two raises made in 1974. Of all of our employees, there was not a ripple. Pay is not the only reason why you have turnover, obviously.

Senator CHILES. I am sure that is true, but I would point out knowing you have to have some basis, I would think maybe you spent a little too much time on internal equity and not enough on external equity, because the 77 percent is the external equity that I am concerned about. But you are right; salary is not the only factor.

What is Blue Shield doing in other areas to see that you don't have this turnover? People could not be too happy in the job there if you were turning over at the rate of 77 percent.

Mr. STANSELL. I don't want to appear philosophical, but I think it is a general trend among people who do routine jobs to change as fast as they can, and I think that has a good deal to do with it.

Secondly, in the medicare B operation, because the best estimates of BHI and Florida Blue Shield have been lower on intake of claims on a prospective basis, we have had these people under severe strain in terms of overtime, Saturday and Sunday work to get the work out.

Senator CHILES. Why is that?

Mr. STANSELL. For the simple reason, if you set up for a 15 percent increase in volume and that increase turns out to be 25 percent and you set up in August and September your training of, say, another 100 or 150 claims examiners, and you get 150 and it turns out you need 200, the only recovery you can make is overtime to get the work out, and that contributes to someone seeking another job.

Senator CHILES. Tell me, if you will, sir, about your decision to put on Mr. Oplinger.

Mr. STANSELL. Mr. Oplinger has been an employee of ours for almost 10 years. He has worked in the medicare B operation for most of those years in various capacities. The latest, before his promotion to vice president, was as the director of the operation since, I believe, April of last year. Our decision was based on two or three studies that we had made of our management structure to zero in more closely, as has been suggested by the GAO study, on the specific problem areas of the business but also related to the size of the operation.

To give you some perspective on this, Mr. Oplinger in his shop has almost 1,000 employees. I believe there are about 900 now in the medicare B operation. It pays $200 million a year. These two items bore heavily on our decision to put in an officer-level person to direct his management attention to the program.

Obviously, a part of that was due a recognition on our part of some 18 months ago that we were getting into more problems than we had anticipated.

Senator CHILES. Mr. Oplinger, how do you see your new position? Tell me something about your plans.

Mr. OPLINGER. Plans have already been made in outline for a total reorganization of the med B operation. I believe this was referred to in the GAO testimony.

We have spent many, many hours, determining where there might be understaffing of important jobs. We have detected those, selected people whom we are relatively sure can correct the problems that have been there. I am talking primarily about the delays we spoke about this morning.

We have effectively moved within the last month-and-a-half every management person within that department. We are adding managers to cut down on the type of control they have so they can put more time on the things that cause the most problems. We have added numbers to that. We are currently undergoing quite an extensive long-range planning process, and by long-range, I don't mean this to sound like something which is a year's wait but something which will start July 1 of this year, which is effectively 2 weeks away,

where we are setting very stringent goals for each of the managers and the supervisors working under those managers. We will be tracking those goals at least on a monthly basis. If we find that we are getting off our preestablished goal, we will find out why and make corrections. In my opinion, we can do it in the next 6 years but projected over the next 12 months, we can bring ourselves to where we are at least as good as the national average in all items of concern.

Senator CHILES. What are you doing to try to improve the morale or the working conditions of the people who are handling these routine claims that do drive you a little buggy after you look at them day after day?

Mr. OPLINGER. As mentioned in the GAO report, there has been some change in the turnover. Perhaps at the time the GAO report was drawn up, they were not aware that they were in the process of implementing the salary increase which was made retroactive to the decision date of May 12, and they will be paid retroactive to that date. That is one element. We are on a piece-by-piece basis adding more responsibility primarily to the examiner levels so that their jobs no longer are so much of a routine job. They see more of the finished piece of work that they are trying to accomplish, something generally referred to as job enrichment.

I feel very confident that that will help.

Senator CHILES. Do you all do anything or have any kind of program about hiring the handicapped for these jobs?

Mr. STANSELL. Yes, sir, we work with the handicapped.

Senator CHILES. You find in many areas people have physical handicaps but can do a particular job, and they tend to very much stay on the job. They are very glad to have a job, and they do not tend to be people who are bothered by the fact that they ought to be moving themselves up higher or anything else. They are usually pretty well satisfied and satisfied to stay there.

Mr. STANSELL. We have several on our staff and they are as you describe them.

Long before the age restrictions were federalized or unfederalized and the other restrictions in the way of equal employment opportunity, we were a leader in the Jacksonville area in hiring all kinds of people because we make our judgment on whether or not the person is capable of doing the work only.

I would add a couple of things to what Mr. Oplinger said. He has mentioned a couple of things which we pilot studied as well as hopefully put in as a general plan. We do have a good number of people on what we call flex time, which means a lady who has children going to school can come to work at 9 o'clock and stay until 5 or come in at 7 and go home at 3. The overtime is voluntary.

In addition to that, all of our automation studies, if you will, are pointed toward many of the things you saw on that big chart that the GAO brought in, toward removing the routine easily computerized items into the computer so it will do those jobs without having to have a person do them repetitively. Personally, it would drive me up the wall, and I am sure it would most folks. That is one of the reasons why most people don't like such a routine paper job.

Senator CHILES. Have you considered or do you have any basis of incentive or pay based on goals or efficiency?

Mr. STANSELL. No, sir. To be eligible to do overtime a person has to be at a certain productive level and the normal incentive in a clerical job is doing a good job and moving up to a higher-paying job.

Senator CHILES. Do you have any incentives for your employees or do you set any quotas?

Mr. OPLINGER. I think in answer to your question, Senator Chiles, it has worked from the reverse side. If a person, is not producing, when it comes time for his merit increase, then he does not receive one if he has been doing a poor job. You can call that an incentive; I would certainly call it that. We do not have piecework type of things.

Senator CHILES. It seems to me if you reverse that and say you had to do something in order to be eligible, if they got something extra, they might stay around to get it.

Mr. STANSELL. I am constrained to comment on the overtime percentage. They are not as simple as they look. Seventy-seven percent does not mean 770 out of 1,000 left us and we only have 230 left in there from the beginning of the year. That is not what it means. Obviously, you could have one job filled three times in a year. In the employment environment in which we found ourselves we hired people at the very minimum of qualifications, put them through this 4- to 6-week training program and at the end of the training program in some instances discharged them immediately because they could not learn. Of course, we hire an awful lot of ladies and a good many of their husbands are in the Navy and we lose a fair percentage.

You might be interested in the numbers of people who leave us by reason—pregnancy, going to another city.

Senator CHILES. In the GAO sample of 138 claims to process, 39 required an average of 23 days. According to the GAO report I think 15 days of that was just in getting the request to the party involved. What is the reason for that time, that you determined you needed more information until the call was made or until the letter was sent?

Mr. OPLINGER. Under the present system we are using now, which was installed in the fall of last year and hinges on some other comments in the GAO report, it requires us to go ahead and enter the claim into the system knowing that it requires additional development in order to maintain control and batch integrity. Only after it goes through the computer and is processed as an additional development claim, the computer then prepares a suspension sheet which is forwarded to the additional development area which has to match it then with the original claim with the reason indicated as to what additional information we need. There are sometimes other support documents that need to be gathered in order to fully understand what the additional development is. This is primarily what is causing the delay. It is not a simple matter of taking the claim next door and saying let's call on it.

I might add, too, included in that overall additional development time, we do have a BHI requirement where we write for information that we must not follow up on that within the first 15 days if we do not receive a reply. After the first 15 days we make a second request and we are given up to 30 days in order to receive the information from that so there could be an automatic 45-day delay because of the BHI regulations.

I am not saying they all require that much.

Senator CHILES. Do you feel the Social Security Administration is hindering your performance in any way?

Mr. OPLINGER. I think many of the carriers have suggestions which might require changes in the law which would enhance the program considerably.

Mr. STANSELL. I would like to comment on that, Senator. I think the over regulation is caused partly by the influence of the Congress and, of course, the law that has been passed, but I believe sincerely because I worked on committees for the people in Mr. Tierney's office and very closely with Mr. Richard in our area of the country. I believe sincerely they are moving toward something you expressed an interest in and that is an ability to track what is happening and to track results based on standards that are set up. The enormousness of the complex program by 1958, I believe, carriers in different parts of the country faced with different volumes, different assignment rates—you name it—makes the problem of setting standards one that you just cannot do in a very short time. I think it can be done. I think they are interested in doing it and I say this to you because I believe firmly that the carriers should do the managing and the Government should do the standard-setting and the measuring.

Senator CHILES. You were telling me, I think you said 21 or 23 directors?

Mr. STANSELL. Twenty-one directors.

Senator CHILES. Nonprofit corporations?

Mr. STANSELL. Blue Shield only. Blue Cross is a separate corporation.

Senator CHILES. Blue Cross is different?

Mr. STANSELL. Right.

Senator CHILES. The 21 directors, are they salaried or paid fees?

Mr. STANSELL. They are paid nothing except their expenses to come to board meetings.

Senator CHILES. Are they a part of Blue Cross?

Mr. STANSELL. The Blue Shield board of directors a part of Blue Cross? No, sir. There is one member of the Blue Cross board who is elected to represent the Blus Cross board on the Blue Shield board each year.

Senator CHILES. But the other Blue Shield directors are not a part of Blue Cross?

Mr. STANSELL. No, sir.

Senator CHILES. You say the Government should set the standards that the company should be able to match. How could you put competition into this area, that being the American way?

Mr. STANSELL. Absent the ability to set standards at this point in any meaningful way, I don't think it can be done right now. My statement was directed toward the fact that the efforts to get to that point have to be made and I think they are being made. I don't believe we could do some of those things because of the complexity of the program and the lack of a meaningful standard.

Senator CHILES. It seems somewhere in here we are missing incentives. I am concerned that we are missing them. If you have a situation in which once the carrier is selected and is not selected on a bid basis, and once the carrier is selected, you take the cost and you say you are a taxpayer and I am, too, you take the costs and figure in after the fact things as to what the payments are going to be and we have an operation where we see there could be delays, as we see here,

with a quarter of a million people, it seems somewhere the incentives are missing. Maybe that is being added to when they take away 30 percent of your business and are giving that to another carrier, but I am concerned with not only whether Florida is managing this properly or whether we have proper built-in incentives and so that we do get some competition and so that we do get some results based on that.

I want to tell a part of the people who are a part of this percentage that they are left out or are experiencing this delay or don't worry to get up on top of this and don't worry we have a solution to it. Because it looks to me under the present system that we have, where Government selected the carriers, and I am only looking at Florida but I want to look at these other areas, but I don't see the incentives that are built in that are normally a profit incentive in a profitmaking business. But here we are dealing with a nonprofit organization. Where is the incentive here that is built in to see that we are going to get faster results than this, where there are problems?

It seems to me the problems you are experiencing are not problems that happen over a 1-month period of time. They went on for a long, long period of time. I wonder how they are going in other areas. This is where the bureaucracy always has problems and whether it corrects itself, whether it be the bureaucracy of government or the bureaucracy of your business, but I don't see the incentive built into this thing right now.

Mr. STANSELL. Mr. Tierney mentioned the difference between Blue Cross and Blue Shield and that health care is our business. I can only say that I personally believe strongly in the free enterprise system and the profitmaking system that is the basis of our country, political system. I would say to you what I also said about pay raises for employees and the fact that pay is not the only reason they stay with you or leave you. We had other incentives inherent in what we were doing and we want to do it well that we believe are effective incentives for people who work for us and for the boards of directors who direct our activities.

Senator CHILES. I look forward to getting your detailed statement. I also look forward to seeing the progress that we hope is going to be made as a result of the assignment of Mr. Oplinger.

I think in looking at your statement, certainly the figures that are set up from there, those are just intolerable. There is just no way to expect our people to continue to accept those kind of figures. Again, those figures show us graphically but my office has been kind of telling me about them and I have been hearing about them and listening to some of the calls coming in from some of the people and when you translate to some of the individuals who are suffering, it is something we have to do something about. I don't want to be here just to put the whip on you.

Mr. STANSELL. Let me comment on that, if I may, on a personal note. I am a fourth-generation Floridian and my State is full of my relatives and some large percentage of them are over 65. I have a personal stake in this because they have come to me. We are in the business. I have on two occasions met personally with groups of the medicare employees and I have made the comment to them that each piece of paper they pick up is of great importance to some one individual person and made the point that they are dealing not with

58-526 O - 75 - 6

paper but with somebody's troubles or perhaps somebody getting over troubles because the medical care has been delivered. I can assure you that that is the attitude that prevails in our management of the program because we are concerned.

Senator CHILES. I am certainly going to look forward to your progress.

Mr. STANSELL. We are going to make it.

Senator CHILES. Thank you.

We will recess at this time and leave the record open for a period of 10 days to 2 weeks to receive your additional statements.

I will also enter some correspondence on this problem.

[The information referred to follows:]

APPENDIX

TITLE 42—UNITED STATES CODE

CHAPTER 7—SOCIAL SECURITY

SUBCHAPTER I—GRANTS TO STATES FOR OLD-AGE ASSISTANCE AND MEDICAL ASSISTANCE FOR THE AGED

SEC. 301—Appropriation.

* * * * * * *

§ 302. State old-age and medical assistance plans.

(a) Contents

A State plan for old-age assistance, or for medical assistance for the aged, or for old-age assistance and medical assistance for the aged must—

(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(2) provide for financial participation by the State;

(3) either provide for the establishment or designation of a single State agency to administer the plan, or provide for the establishment or designation of a single State agency to supervise the administration of the plan;

(4) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for assistance under the plan is denied or is not acted upon with reasonable promptness;

(5) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods) as are found by the Secretary to be necessary for the proper and efficient operation of the plan, and (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency;

(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

(7) provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the State plan;

(8) provide that all individuals wishing to make application for assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals;

(9) provide, if the plan includes assistance for or on behalf of individuals in private or public institutions, for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards for such institutions;

(10) If the State plan includes old-age assistance—

(A) provide that the State agency shall, in determining need for such assistance, take into consideration any other income and resources of an individual claiming old-age assistance, as well as any expenses reasonably attributable to the earning of any such income; except that, in making such determination, (i) the State agency may disregard not more than $7.50 per month of additional and (ii) of the first $80 per month of additional income which is earned the State agency may disregard not more than the first $20 thereof plus one-half of the remainder;

(B) include reasonable standards, consistent with the objectives of this subchapter, for determining eligibility for and the extent of such assistance; and

(C) provide a description of the services (if any) which the State agency makes available to applicants for and recipients of such assistance to help them attain self-care, including a description of the steps taken to assure, in the provision of such services, maximum utilization of other agencies providing similar or related services;

(11) if the State plan includes medical assistance for the aged—

(A) provide for inclusion of some institutional and some noninstitutional care and services;

(B) provide that no enrollment fee, premium, or similar charge will be imposed as a condition of any individual's eligibility for medical assistance for the aged under the plan;

(C) provide for inclusion, to the extent required by regulations prescribed by the Secretary, of provisions (conforming to such regulations) with respect to the furnishing of such assistance to individuals who are residents of the State but are absent therefrom;

(D) include reasonable standards, consistent with the objectives of this subchapter, for determining eligibility for and the extent of such assistance; and

(E) provide that no lien may be imposed against the property of any individual prior to his death on account of medical assistance for the aged paid or to be paid on his behalf under the plan (except pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual), and that there shall be no adjustment or recovery (except, after the death of such individual and his surviving spouse, if any, from such individual's estate) of any medical assistance for the aged correctly paid on behalf of such individual under the plan;

(12) if the State plan includes assistance to or in behalf of individuals who are patients in institutions for mental diseases—

(A) provide for having in effect such agreements or other arrangements with State authorities concerned with mental diseases, and, where appropriate, with such institutions, as may be necessary for carrying out the State plan, including arrangements for joint planning and for development of alternate methods of care, arrangements providing assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care, and arrangements providing for access to patients and facilities, for furnishing information, and for making reports;

(B) provide for an individual plan for each such patient to assure that the institutional care provided to him is in his best interests, including, to that end, assurances that there will be initial and periodic review of this medical and other needs, that he will be given appropriate medical treatment within the institution, and there will be a periodic determination of his need for continued treatment in the institution;

(C) provide for the development of alternate plans of care, making maximum utilization of available resources, for recipients who would otherwise need care in such institutions, including appropriate medical treatment and other assistance: for services referred to in section 303 (a)(4)(A) (i) and (ii) of this title which are appropriate for such recipients and for such patients; and for methods of administration necessary to assure that the responsibilities of the State agency under the State plan with respect to such recipients and such patients will be effectively carried out; and

(D) provide methods of determining the reasonable cost of institutional care for such patients; and

(13) if the State plan includes assistance to or in behalf of patients in public institutions for mental diseases, show that the State is making satisfactory progress toward developing and implementing a comprehensive mental health program, including provision for utilization of community mental health centers, nursing homes, and other alternatives to care in public institutions for mental diseases.

(b) Approval by Secretary

The Secretary shall approve any plan which fulfills the conditions specified in subsection (a) of this section, except that he shall not approve any plan which imposes as a condition of eligibility for assistance under the plan—

(1) an age requirement of more than sixty-five years; or

(2) any residence requirement which (A) in the case of applicants for old-age assistance, excludes any resident of the State who has resided therein five years during the nine years immediately preceding the application for old-age assistance and has resided therein continuously for one year immediately preceding the application, and (B) in the case of applicants for medical assistance for the aged, excludes any individual who resides in the State; or

(3) any citizenship requirement which excludes any citizen of the United States.

(c) Limitation on number of plans

Nothing in this subchapter shall be construed to permit a State to have in effect with respect to any period more than one State plan approved under this subchapter. (Aug. 14, 1935, ch. 531, title I, § 2, 49 Stat. 620; Aug. 10, 1939, ch. 666, title I, § 101, 53 Stat. 1360; 1946 Reorg. Plan No. 2, § 4, eff. July 16, 1946, 11 F.R. 7873, 60 Stat. 1095; Aug. 28, 1950, ch. 809, title III, pt. 1, § 301(a), (b), pt. 6, § 361(c), (d), 64 Stat. 548, 558: 1953 Reorg. Plan No. 1, §§ 5, 8, eff. Apr. 11, 1953, 18 F.R. 2053, 67 Stat. 631; Aug. 1, 1956, ch. 836, title III, § 311(b), 70 Stat. 848; Aug. 28, 1958, Pub. L. 85–840, title V, § 510, 72 Stat. 1051; Sept. 13, 1960, Pub. L. 86–778, title VI, §601(b), 74 Stat. 987; July 25, 1962, Pub. L. 87–543, title I, §§ 106(a)(1), 157, 76 Stat. 188, 207; July 30, 1965, Pub. L. 89–97, title II, § 221(a)(3), title IV, § 403(a), 79 Stat. 357, 418; Jan. 2, 1968, Pub. L. 90–248, title II, §§ 210(a)(1), 213(a)(1), 81 Stat. 895, 898.)

Exhibit One

D. C.

DR. STANLEY S. KAPLAN
DOCTOR OF CHIROPRACTIC

June 20, 1975

Senator Lawton Chiles
Senate Building
Washington D.C.

Dear Senator Chiles:

After speaking with you about the chiropractic medicare situation on the plane from Merritt Island to Fort Lauderdale I have taken the liberty to collect several typical reject slips from a number of doctors around the state.

By glancing over them you can see that many claims were completely rejected and a good number of them were paid ridiculous amounts in relationship to the bills. I hope that this information helps you in your review of the Blue Shield Medicare situation.

The whole program is a complete mess. Please understand that these files are just a sampling of what is going on and the situation is much worse than these files show it to be.

I am sure that Blue Shield and Health Education and Welfare is not following the medicare law as intended by congress. A prime example of this would be in regard to the x-ray situation - forcing chiropractors to x-ray all medicare patients and to not reimburse or paying the patient back for the cost.

Congratulations on your announcement for re-election. You know that if you should need my services in this campaign I will be very happy to work for you and should you need my airplane just feel free to call upon me.

Kindest personal regards,

Dr. Stanley Kaplan

SSK/ka

Enclosure

111 NORTH FISKE BOULEVARD COCOA, FLORIDA 32922 PHONE 636-6090

Dr. Donald C. Dempsey
CHIROPRACTIC PHYSICIAN
2235 W. FAIRBANKS AVENUE
WINTER PARK, FLORIDA 32789
TELEPHONE 647-5550

May 14, 1975

Stanley S. Kaplan D.C.
111 NO Fiske Blvd.
Cocoa, Florida 32922

Dear Stan;

RE: Miriam Eaton

This is the lady I wrote you about a bit ago. The one who got payment for half a formula and nothing else.

Take note that she brought me in an M.D. Part B form showing the M.D. claim was paid right on the button at 80% of his $10.00 call. Note, they reduce us to $8.00 (I charge $10.00), and use their scalpels on that figure.

Stan, I know they rely on the confusion and inability to comprehend on the part of the elderly to rip them off.

I really had to look at the form a long time myself to comprehend it.

What they did was to reduce my bill to 80% on the first recording (to $8.00). Then they approved 75% of the $8.00 to make $6.00. And then they paid 80% on the total $6.00 amounts.

Stan, they percentage deducted me three times, while percentage deducted the M.D. one time. That little arithmetic makes us worth $4.80 an office call and the M.D. worth $8.00 to Blue Shield.

A little economic punishment to the patient for not going to an M.D.

Stan, this whole thing is obviously an economic plot against our profession.

Regards,

Donald C. Dempsey D.C.
Chiropractic Physician

DCD:dr

EXPLANATION OF MEDICARE PART "B" BENEFITS

ADMINISTERED BY
BLUE SHIELD OF FLORIDA, INC.
P.O. BOX 2525
JACKSONVILLE, FLORIDA 32203
TELEPHONE 791-6363

THIS IS A STATEMENT OF THE ACTION TAKEN ON YOUR MEDICARE CLAIM.
THIS IS NOT A BILL. KEEP THIS NOTICE FOR YOUR RECORDS.

DATE	YOUR MEDICARE NUMBER / HEALTH INSURANCE CLAIM NUMBER	REPORT NUMBER
04/14/75	412-07-1734-D	07646930

ALWAYS USE THIS NUMBER WHEN WRITING ABOUT YOUR CLAIM

BENEFICIARY OR REPRESENTATIVE

BENEFITS PAID TO
MIRIAM L EATON
1041 N THORNTON
ORLANDO FLA 32803

1. SERVICES WERE PROVIDED BY	2. When From YEAR	MONTH	DAY	To DAY	NO. SERVICES	3. AMOUNT BILLED	4. Amount Approved	5. EXPLANATION OF ANY DIFFERENCE BETWEEN COLUMNS 3 & 4 MEDICARE DOES NOT PAY FOR	SERVICE CODES SEE BACK
D C DEMPSEY	75	02	07	28	04	800		THESE MEDICAL SUPPLIES OR SERVICES	1
D C DEMPSEY	75	02	21	21	01	450		THESE MEDICAL SUPPLIES OR SERVICES	1
D C DEMPSEY	75	01	03	31	07	1400		THESE MEDICAL SUPPLIES OR SERVICES	1
D C DEMPSEY	75	03	07	07	01	200		THESE MEDICAL SUPPLIES OR SERVICES	1
D C DEMPSEY	75	03	07	07	01	800	600	SEE ITEM 5 ON BACK	1
D C DEMPSEY	75	01	03	03	01	800	600	SEE ITEM 5 ON BACK	1
D C DEMPSEY	75	02	07	28	04	3200	2400	SEE ITEM 5 ON BACK	1
D C DEMPSEY	75	01	06	31	06	4800	3600	SEE ITEM 5 ON BACK	1
TOTALS						12950	7200	REMARKS	
							MEDICARE PAID		
Inpatient radiology and pathology physician - services and certain laboratories paid at 100% of approved amount							$00		
Amount payable at 80% subject to the annual deductible						7200			
Amount applied toward annual deductible						6000			
Balance payable at 80%						1200	960	YOU HAVE MET $60.00 OF THE DEDUCTIBLE FOR 1975	
TOTAL MEDICARE PAYMENT							$960	BE SURE TO READ THE IMPORTANT INFORMATION ON THE BACK OF THIS NOTICE.	

MED 6328 REV 7 73

THIS IS YOUR CHECK—DETACH ON DOTTED LINE

EXPLANATION OF MEDICARE PART "B" BENEFITS

ADMINISTERED BY

BLUE SHIELD OF FLORIDA, INC.
P. O. BOX 2525
JACKSONVILLE, FLORIDA 32203
TELEPHONE 791-6363

THIS IS A STATEMENT OF THE ACTION TAKEN ON YOUR MEDICARE CLAIM.
THIS IS NOT A BILL. KEEP THIS NOTICE FOR YOUR RECORDS.

DATE	YOUR MEDICARE NUMBER / HEALTH INSURANCE CLAIM NUMBER	REPORT NUMBER
01/23/75	4120717340	00801245

ALWAYS USE THIS NUMBER WHEN WRITING ABOUT YOUR CLAIM

BENEFICIARY OR REPRESENTATIVE

MIRIAM L EATON
1041 N THORNTON
ORLANDO FLA 32803

BENEFITS PAID TO

MITCHELL SHAPIRO MD
616 E ALTAMONTE AVENUE
ALTAMONTE SPRINGS, FL 32701

48674

1. SERVICES WERE PROVIDED BY	2. When From YEAR	MONTH	DAY	To DAY	NO. SERVICES	3. AMOUNT BILLED	4. Amount Approved	5. *EXPLANATION OF ANY DIFFERENCE BETWEEN COLUMNS 3 & 4 MEDICARE DOES NOT PAY FOR	SERVICE CODES (SEE BACK)
M SHAPIRO	74	12	13	13	01	10 00	10 00		1 A
TOTALS →						10 00	10 00	REMARKS	
Inpatient radiology and pathology physician - services and certain laboratories paid at 100% of approved amount →							MEDICARE PAID		
Amount payable at 80% subject to the annual deductible →						10 00			
Amount applied toward annual deductible →									
Balance payable at 80% →						10 00	8 00	YOU HAVE MET $60.00 OF THE DEDUCTIBLE FOR 1974	
TOTAL MEDICARE PAYMENT →							8 00		

FORM MED 6338 (REV. 7-73)

BE SURE TO READ THE IMPORTANT INFORMATION ON THE BACK OF THIS NOTICE.

76

77

REQUEST FOR MEDICARE PAYMENT

MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT (See instructions on Back - Type or Print)

When completed, send this form to:
Blue Shield of Florida, Inc.
Medicare Part B
P.O. Box 2525
Jacksonville, Florida

Copy from YOUR OWN HEALTH INSURANCE CARD (See example on back)

Name of patient (first, middle initial, last name)
Lerish, Zella Mae

Health insurance claim number
(Include all letters)
260 73 0976 B G D

☐ Male ☒ Female

Patient's mailing address
5825 SW 41 St. ,S. Miami, Fla. 33155

City, State, ZIP code

Telephone Number
661-2014

Describe the illness or injury for which you received treatment (Always fill in this item if your doctor does not complete Part II below)
Backache after falling backwards from step.

Was your illness or injury connected with your employment?
☐ Yes ☒ No

If you have other health insurance or if your State medical assistance agency will pay part of your medical expenses and you want information about this claim released to the insurance company or State agency upon its request, give the following information.
Insuring organization or State agency name and address

Policy or Medical Assistance Number

I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

SIGN HERE ▷ X

Signature of patient (See instructions on reverse where patient is unable to sign)

Date signed
11/1/74

7 A. Date of each service	B. Place of service (*See Codes below)	C. Fully describe surgical or medical procedures and other services or supplies furnished for each date given	D. Nature of illness or injury requiring services or supplies	E. Charges (If related to unusual circumstances explain in 7C)	Leave Blank
	O	XX Rays Proximate to treatment available for review		Non-comp onsitory $	
8/30/74	O	OV with chiropractic manipulation	Subluxation L2,L3,L4 and ilium	$12.	
9/30	O	" "	" "	$12.	

8 Name and address of physician or supplier (Number and street, city, State, ZIP code)
Dr.D.J. Graziano
6205 Bird RD
Miami, Fla.33155 Don J Graziano D C

Telephone No. 665-3569

Physician or supplier code 89202

9 Total charges $ $24.

10 Amount paid $ 24.

11 Any unpaid balance due $ None

12 Assignment of patient's bill
▷ ☐ I accept assignment (See reverse) ☒ I do not accept assignment.

13 Show name and address of facility where services were performed (If other than home or office visits)

14 Signature of physician or supplier (A physician's signature certifies that physician's services were personally rendered by him or under his personal direction)
▷ X

Date signed
11/1/74

*O—Doctor's Office H—Patient's Home (If portable X-ray services, identify the supplier) ECF—Extended Care Facility OL—Other Locations
IL—Independent Laboratory IH—Inpatient Hospital OH—Outpatient Hospital NH—Nursing Home

FORM SSA-1490(2) (8-72)

Department of Health, Education, and Welfare
Social Security Administration

EXPLANATION OF MEDICARE PART "B" BENEFITS

THIS IS A STATEMENT OF THE ACTION TAKEN ON YOUR MEDICARE CLAIM.
THIS IS NOT A BILL. KEEP THIS NOTICE FOR YOUR RECORDS.

ADMINISTERED BY

BLUE SHIELD OF FLORIDA, INC.
P. O. BOX 2525
JACKSONVILLE, FLORIDA 32203
TELEPHONE 791-8303

DATE	YOUR MEDICARE NUMBER / HEALTH INSURANCE CLAIM NUMBER	REPORT NUMBER
3/14/75	267309686D	06710119

ALWAYS USE THIS NUMBER WHEN WRITING ABOUT YOUR CLAIM

BENEFICIARY OR REPRESENTATIVE

MAE PARISH
5825 SW 41ST ST
MIAMI FL 33155

BENEFITS PAID TO

MAE PARISH
5825 SW 41ST ST
MIAMI FL 33155

1. SERVICES WERE PROVIDED BY	2. When From YEAR	MONTH	DAY	To DAY	NO. SERVICES	3. AMOUNT BILLED	4. Amount Approved	5. EXPLANATION OF ANY DIFFERENCE BETWEEN COLUMNS 3 & 4 MEDICARE DOES NOT PAY FOR
D J GRAZIANO	74	08	30	30	01	1200		CHARGES WITH INSUFFICIENT INFORMATION 1.B
D J GRAZIANO	74	09	30	30	01	1200		CHARGES WITH INSUFFICIENT INFORMATION 1.B
TOTALS						2400		REMARKS

	MEDICARE PAID
Inpatient radiology and pathology physician - services and certain laboratories paid at 100% of approved amount	
Amount payable at 80% subject to the annual deductible	
Amount applied toward annual deductible	
Balance payable at 80%	
TOTAL MEDICARE PAYMENT	$ 600

YOU HAVE MET $ [redacted] OF THE DEDUCTIBLE FOR [redacted]

BE SURE TO READ THE IMPORTANT INFORMATION ON THE BACK OF THIS NOTICE.

#2

FORM HCFA-1490 REV. 7-72

REQUEST FOR MEDICARE PAYMENT

MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT (See Instructions on Back—Type or Print Information)

OMB No. 72-R0730

NOTICE—Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal La

When completed, send this form to:
Blue Shield of Florida, Inc.
Medicare Part B
P. O. Box 2525
Jacksonville, Florida

Copy from YOUR OWN HEALTH INSURANCE CARD (See example on back)

1 Name of patient (First name, Middle initial, Last name): GUSTAV TANENBLATT

2 Health insurance claim number (Include all letters): 0,7019447301 A — ☑ Male ☐ Femal

3 Patient's mailing address: 7525 E Treasure Dr — City, State, ZIP code: North Bay Village Fla 141 — Telephone Number: 864-608

4 Describe the illness or injury for which you received treatment (Always fill in this item if your doctor does not complete Part II below) — Was your illness or injury connected with your employment? ☐ Yes ☒ No

5 If you have other health insurance or if your State medical assistance agency will pay part of your medical expenses and you want information about this claim released to the insurance company or State agency upon its request, give the following information.
Insuring organization or State agency name and address — Policy or Medical Assistance Number: 090 07 1730

6 I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

SIGN HERE ▶ Signature of patient (See instructions on reverse where patient is unable to sign): Gustav Tanenblatt — Date signed: 9/3/74

7 A. Date of each service	B. Place of service (*See Codes below)	C. Fully describe surgical or medical procedures and other services or supplies furnished for each date given	D. Nature of illness or injury requiring services or supplies	E. Charges (If related to unusual circumstances explain in 7C)	Leave Blank
8/8/74 9/7/74	O	Manual Manipulation of Spine	Subluxation of occiput & ATLAS	8 Visits @ 10 00 $	
8/14/74 8/16/74 9/4/74	O				
9/6 9/11	O				
		I hereby certify that documentary x-rays do proximate this course of treatment and are available for review.			

8 Name and address of physician or supplier (Number and street, city, State, ZIP code): Dr. Herbert Messinger, 16900 N. E. 19th Ave., No. Miami Beach Fla. 33162 — Telephone No. 947-3573 — Physician or supplier code

9 Total charges $ 80
10 Amount paid $ 80
11 Any unpaid balance due $ —

12 Assignment of patient's bill
▶ ☐ I accept assignment (See reverse) ☒ I do not accept assignment.

13 Show name and address of facility where services were performed (If other than home or office visits)
Herbert Messinger D C 89358

14 Signature of physician or supplier (A physician's signature certifies that physician's services were personally rendered by him or under his personal direction) — Date signed: 9/11/74

*O—Doctor's Office IL—Independent Laboratory H—Patient's Home (If portable X-ray services, identify the supplier) IH—Inpatient Hospital ECF—Extended Care Facility OH—Outpatient Hospital OL—Other Locations NH—Nursing Home

FORM SSA-1490(2) (6-72)

Department of Health, Education, and Welfare
Social Security Administration

EXPLANATION OF MEDICARE PART "B" BENEFITS

THIS IS A STATEMENT OF THE ACTIONS TAKEN ON YOUR MEDICARE CLAIM.
THIS IS NOT A BILL. KEEP THIS NOTICE FOR YOUR RECORDS.

ADMINISTERED BY

BLUE SHIELD OF FLORIDA, INC.
P. O. BOX 2525
JACKSONVILLE, FLORIDA 32203
TELEPHONE 791 6565

DATE	YOUR MEDICARE NUMBER / HEALTH INSURANCE CLAIM NUMBER	REPORT NUMBER
3/31/75	090074730A	08100823

ALWAYS USE THIS NUMBER WHEN WRITING ABOUT YOUR CLAIM

BENEFICIARY OR REPRESENTATIVE

GUSTAV TANENBLATT
7525 E TREASURE DR
MIAMI BCH FLA 33141

BENEFITS PAID TO

GUSTAV TANENBLATT
7525 E TREASURE DR
MIAMI BCH FLA 33141

1. SERVICES WERE PROVIDED BY	2. When From (YEAR / MONTH / DAY)	To (DAY)	NO. SERV. ICES	3. AMOUNT BILLED	4. Amount Approved	5. EXPLANATION OF ANY DIFFERENCE BETWEEN COLUMNS 3 & 4 MEDICARE DOES NOT PAY FOR	SERVICE CODES (SEE BACK)
H MESSINGER	74 09 03	11	03	3000		CHARGES WITH INSUFFICIENT INFORMATION	1. B
H MESSINGER	74 08 05	30	05	5000		CHARGES WITH INSUFFICIENT INFORMATION	1. B

08

WILLIAM T. HUNT
1508 LA JOLLA AVENUE
SUN CITY CENTER, FLORIDA 33570
TELEPHONE 813 (TAMPA) 634-3256

May 12, 1974

Honorable Lawton Chiles
United States Senator
Washington, D. C. 20510
Dear Senator Chiles:

If it were not that I have reached an impossible impasse with Blue Shield of Florida, Inc., at Jacksonville, as administrator for Medicare, I would not bother you with this problem. It is hopeless for me to write them further about a simple pending claim, mistakes with another claim, underpayment by other claims, and their failure to return to me a receipt inadvertently sent to them, and their very obvious breakdown in service or intent to completely ignore me. If it is a general failure to serve Medicare claimants in processing and paying claims and decent courtesy in replying to urgent mail or if it is personal discrimination against my wife and myself and no doubt at least a few others, the need for intervention is obvious.

Attached you will find carbon copies of five seperate and specific brief letters sent to Blue Shield by me under date of April 13, 1974.* As mentioned in these letters I have written Blue Shield numersous times regarding each and every point at issue and I have not received any response whatever until now a meaningless, passover form. This form, their "Med 6288", is attached and I would appreciate its return. As you will note they merely use two items on the form and say my enquiry has been forwarded for review and "Attached is copies of the bill". No copy of any bill was attached, and their mention of review is simply their stalling tactic of months. For example, the small, uncomplicated claim sent them for Mrs. Hunt under date of Jan. 6, 1974, for services of a physician on Dec. 31, 1973, amounting to only $30.00, does not call for a "review"; it just requires processing. In all claims and correspondence I have carefully identified every item every time and been specific to make it easy for Blue Shield.

As stated by me in the top letter herewith attached Blue Shield by their months of callous neglect and indifference or complete breakdown are not only depriving Mrs. Hunt and myself of payments due us from Medicare by Blue Shield of Fla., Inc., but they are also preventing me from sending claims to Aetna Casualty as administrator for Gov't-Wide Indemnity Benefit Plan, F.H.B.A., to secure partial reimbursement from Aetna of disallowances and deductions by Medicare. It is necessary and logical to send Aetna the forms furnished by Blue Shield covering processing and any payments on claims. In this connection I wish to pay tribute to Aetna Casualty Co., Tampa, for their excellent handling of claims and courteous and efficient manner with claimants. Aetna is just the opposite of Blue Shield.

Another point which needs emphasis and which is not covered in detail in the copies of my correspondence to Blue Shield is Blue Shield's considerably increasing practice of disallowing parts of medical bills. This subject is discussed in the fifth copy of a letter attached, and I have written Blue Shield about it several times. Blue Shield ignores any reference to their arbitrary unexplained reductions of medical bills in arriving at their allowances.

Yours very sincerely,

W. T. Hunt

*Retained in committee files.

HERBERT G. FOLKEN
1112 CROWN OAKS WAY
THE SPRINGS
LONGWOOD, FL 32750

June 30, 1975

The Honorable Lawton Chiles
United States Senate
Washington, D. C. 20510

Dear Senator Chiles:

This is to applaud your subcommittee investigation of the administration of Medicare, especially as it relates to Florida, and to encourage extension of the inquiry into every facet of the operation and its interaction with the Federal Employees Health Benefits Program.

The latter, of course, urges collaboration with the PO&CS committees. If properly administered, Medicare B along with the FEHBP Service Benefit, low option is a "best buy" for most federal retirees who are not among the 40 percent who are eligible for Mediacre A. The cost of the B+low option is about the same as the FEP high option alone and the subscriber gains "no deductibles, no coinsurance"in exchange for foregoing hospitalization in excess of 90 days per illness per year. The government already pays 75 percent of the low option premium, a percentage that the House PO&CS committee just refused to generalize, even prospectively, in converting H. R. 73 to the clean bill H. R. 7222. We urge your leadership to amend H. R. 7222 in the Senate to put back the lost provisions of H. R. 73 that would benefit retirees as well as employees.

The PO&CS committees also have before them an HEW-CSC proposal for implementing the removal at the end of 1975 of Medicare from the primary carrier role vis-a-vis FEHBP. It would make better coverage free to the 40 percent of retirees who are fully covered under Medicare and raise the premiums for all other FEHBP subscribers. This hardly seems an equitable solution unless it is tied in with a general increase in the government portion of premiums.

For your investigation, the UCR concept strikes us as the big problem, going far beyond plain error, misplaced documents and slow processing. Some method of screening out really unreasonable charges is necessary, of course. But if they are fairly determined and up-to-date why would not one of ten or more doctors in our recent experience accept assignment? How many of the 35 percent of Medicare B claims that GAO found to be assigned are billed by hospitals? There appears to be a possibility of "discrimination" in UCR favoring hospital billings over physicians'.

The enclosed three letter copies, part of an exchange with Blue Shield, highlights a case that appears to pay as little as one-third as much to a doctor (for in-hospital services) as paid to a nearby hospital for the same patient and service-then a retreat behind SSA's $100 limit for hearings. In another personal experience, a hospital was paid $25 each for many EKG's (plus $7.50 each to a doctor for reading them) while the doctor who admitted the patient is allowed only $10 for the office call that including reading the EKG and decisions that it should be made and that the patient should be hospitalized. Is it any wonder that doctors refuse assignment of claims? At least the latter case seems more likely to result from capricious and unwarranted features of the UCR tables than from clerical error.

$17 for the EKG and

-more

page 2, Chiles

Now come reports that HEW is ordering a annual reduction of $23 million in Medicare B fees - in the face of evidence that current allowances so far under current realistic usual, customary and reasonable charges (dictionary definitions) that few doctors will accept them!

On February 24, when I wrote about seeing you during the week of March 4, I ended the day in hospital intensive care and did not return home to stay until April 24 after open heart surgery, recovery good but still incomplete. Add a later 10 day hospital stay for Mrs. Folken and you have a cram course on Medicare B/FEHBP claims actions. Our experience on timing and errors fits that determined by GAO almost exactly. The 28 claims should have been divided into many more. Blue Shield does best with one-liners! It should be noted, also, that Blue Cross has generally been fast and complete, those to hospitals sometimes even duplicating what Medicare B should pay.

Having said all this, we are still happy to be alive, to have the coverage we do have and your help in making it work better. Many thanks and blessings on your further work in this area.

Sincerely,

Herbert G. Folken

Herbert G. Folken

cc: McCarthy, FlaFedNARFE
McClelland, NARFE

HERBERT G. FOLKEN
112 CROWN OAKS WAY
THE SPRINGS
LONGWOOD, FL. 32750

June 29, 1975

FOR ADRESSEE ONLY

HIB: 215-44-8311 M
Report: 12706745 C

Mr W. H. Stansell, Sr. V. P.
Blue Shield of Florida, Inc.
P. O. Box 2525
Jacksonville, Fl. 32203

Dear Mr. Stancell:

Since writing you on June 25, 1975 in reference to the above caption, I have received a form letter from Blue Shield addressed to Wayne H. Schrader, M. D. , the supplier in the above case. It is captioned, "H. G. Folken, R03439115, service date(s) 4-14-75, thus appearing to be a supplemental action under our FEHBP coverage. Square 19 on the form is checked and the notation typed in is, "Medicare paid inpatient Lab 100%".

This evades the issue raised in my letter of June 25. The charges of 4-14 were indeed paid in full - all $3 of them. So were 24 others on the same claim rendered between 4-10 and 4-21. The four items in contention were on 4-12 and 4-13, the aggregate of the charges $54, the amount paid only $26. My calculator says this is 48%, quite different than 100%.

Thus the issue is confounded or compounded. It is disappointing that the FEP Claims Department review did not clarify nor correct this matter. My original challenge remains in order.

Sincerely,

Herbert G. Folken

cc: Senator Chiles
Robert H. McCarthy for GAO

HERBERT G. FOLKEN
112 CROWN OAKS WAY
THE SPRINGS
LONGWOOD, FL. 32750

June 24, 1975

FOR ADRESSEE ONLY

Mr. W. J. Stansell, Sr. V. P.
Blue Shield of Florida, Inc.
P. O. Box 2525
Jacksonville, Fl. 32203

HIB: 215-44-8311 M
Report: 12706745 C

Dear Mr. Stancell:

The implications of a letter from your office on the above, signed by Mrs. Lynda Dedmon, Supervisor, dated June 18, 1975, copy enclosed, are so appalling as to require your personal attention.

The implication seen here is that your personnel can deny obvious error and gain "immunity" by hiding behind the SSA rule limiting hearings to controversies involving $100 or more. In this case, the error is so apparent that it is revealed by a simple check of actions taken on the claims for identical services by two different suppliers in the same area in successive weeks. You will agree, I am sure that costs or allowable rates for "fractional CPK's" did not go down by two-thirds between March 24 and April 12, nor for "fractional LDH's" from $10 or more to $8. The tests referred to were done on the same patient in two hospitals less than 10 miles apart. Mrs. Dedmon's letter does nothing to dispel or counter the prima facia evidence.

Technically, perhaps, I should not be concerned with this issue inasmuch as our linkage of Medicare "B" with FEHBP Service Benefit, Low Option, should assure us the same ultimate level of coverage. But we feel sure that you are concerned, as we are, with the competent and honest operation of both of these departments with its attendant ~~accountant~~ allocation of costs, properly, to each body of premium-payers.

My wife and I have unfortunately experienced a cram course in your operations, having found it necessary to file, or have filed by our suppliers, more than twenty claims since December 5, 1975 only one of which has been accurately and completely settled (by Blue Cross). Actually, Medicare "B" actions have been more timely that the the tandem FEHBP actions. Our eldest "B" claim still unheard from was mailed on April 3, 1975, whereas not a single "tandem" action under FEHB has been fully and accurately completed on referral from "B" going back to included those of December 5. I wrote to Mrs. Mills about these on May 29, 1975 but have had no response. *Other than Hospital claims.

Your personal attention will be appreciated.

Sincerely,

CC: Senator Lawton Chiles
Robert H. McCarthy for GAO

58-526 O - 75 - 7

MEDICARE PART 'B'

POST OFFICE BOX 2525 JACKSONVILLE, FLORIDA 32203
ADMINISTERED BY BLUE SHIELD OF FLORIDA, INC.

June 18, 1975

Herbert G. Folken
112 Crown Oak Way
Longwood, Florida 32750

HIB: 215-44-8311M
Report: 12706745

Dear Mr. Folken:

We have completed our review of your claim for services rendered to you. Our first step in a review is to determine if a clerical error has been made. We then check to see what the allowable charge is for the procedure, and if the claim was paid according to Medicare regulations. Briefly stated, Medicare regulations require that we pay the lower of:

a. The physician's actual charge
b. The physician's customary charge
c. The prevailing charge of physicians in the area.

Through our review, we established that your claim was processed correctly, and that you were paid the maximum allowable amount for these procedures.

If you are still dissatisifed with our action in your case, you may request a hearing before an impartial hearing officer to determine if the Carrier has complied with the Medicare Part "B" guidelines. In order for a hearing to be requested, the amount in controversy must be a minimum of $100 after deductible and coinsurance have been subtracted. If you wish to appeal our review determination, it will be necessary that you submit a written request for a hearing to the Administrative Assistant, Fair Hearing Section, P.O. Box 2525, Jacksonville, Florida, within six months from the date of this letter.

Sincerely,

Mrs Lynda Dedmon

Mrs. Lynda Dedmon
Supervisor

November 13, 1974

llc S.S. ADM.
FRIEDENSON, LEONARD
H/O

The Honorable James B. Cardwell
Commissioner of Social Security
Social Security Administration
Baltimore, Maryland 21235

Dear Commissioner Cardwell:

Recently I was contacted by Mr. Leonard Friedenson, Andover J-255 CV, West Palm Beach, Florida, social security account number 087-05-3349. Mr. Friedenson applied for social security disability benefits in March, 1974, and hasn't been employed since that time due to lung cancer.

Any assistance provided in expediting his claim will be appreciated as he is experiencing extreme financial difficulties.

With kind regards, I am

Sincerely,

LAWTON CHILES

LC/sr

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BALTIMORE, MARYLAND 21235

REFER TO:
[illegible]-61
[illegible]7-05-3349

January 29 1975

OFFICE OF THE COMMISSIONER

Honorable Lawton Chiles
United States Senator
Federal Building
Lakeland, Florida 33801

Dear Senator Chiles:

Re: Mr. Leonard Friedenson, Andover J 255, Centre Village, West Palm Beach, Florida 33401

Our Bureau of Disability Insurance informs me that Mr. Friedenson was awarded a monthly disability benefit of $275.80 effective May 1974, increased to $306.90 effective June 1974. Mrs. Friedenson was also awarded a wife's benefit of $135.60 increased to $140.80.

November 1974 a check for $2,669.90 was issued which included benefits for Mr. and Mrs. Friedenson for May 1974 through October 1974. Subsequent monthly benefits have been combined in one check for $447.70.

Sincerely yours,

James B. Cardwell
Commissioner of Social Security

Mrs. Leonard D. Friedenson
Andover J 255 Century Village
W. Palm Beach, Fla. 33401

Jan. 3, 1975

Honorable Lawton Chiles
United States Senator
Federal Building
Lakeland, Florida, 33801

Dear Senator Chiles,

In spite of your efforts on my behalf on case #IAD 087-05-3349, I regret to inform you that nothing has been settled on my behalf. Late in Nov. I was happy to receive a check in the amount of $2669.90 and I was awaiting my Dec. payment in order to write to you my heartfelt thanks for your efforts. Alas, Dec. has come and gone and so has the Jan. Date for receiving Social Security checks. I have received no check, communication or notice of the reasons for the amount of the check sent to me in Nov. I know that your efforts on my behalf have been successful in having the one check sent to me.

I have reported the missing Dec. and Jan. checks to the Social Security office in West Palm Beach and they have started the same runaround procedures that they have using since July, 1974.

Many thanks for your assistance on my behalf and I hope that you will be able to aid me in having the H. E. W. finalize my records so that I can receive checks due to me on a regular basis.

087-05-3349

Sincerely,
Leonard D. Friedenson

Mrs. Leonard D. Friedenson
Andover J 255 Century Village
W. Palm Beach, Fla. 33401

Feb. 4, 1975

Honorable Lawton Chiles
United States Senator
Federal Building
Lakeland, Florida 33801

Dear Senator Chiles:

In your letter of Jan. 28th, you advise me that you are again contacting the Commissioner of Social Security. I would like to point out a few facts to you:

1. Another month has come and no check.
2. I have been making two or more inquiries per monthat the W. Palm Beach Social Security office since July, 1974.
3. On Nov. 27, 1974, Commissioner of Social Security J. B. Cardwell wrote to you saying he would follow this through and get back to you.
4. I have filled out and sent cards to the W. Palm Beach Social Security office for the checks not received for the months of Dec., Jan., and Feb.
5. The person who handles congressional inquiries at the W. Palm Beach office a Mr. English, claims that he never had any inquiries on my case.

Mrs. Leonard D. Friedenson
Andover J 255 Century Village
W. Palm Beach, Fla. 33401

6. The West Palm Beach office has no record of award to me six months after I was told on Sept. 4,1974 by a W. Palm Beach representative, Mrs. Cohen that the award was approved.

I have not worked since my lung cancer operation in Nov. 1973. After the proper waiting period I filed in March, 1974 as required. Except for one large check in Nov. 1974 I have not heard nor received any official communication from Social Security in spite of all my inquiries.

By this time I am embittered and disillusioned with our bureaucracy where nobody cares for the needs or rights of a person enough to see that a disposal is made of his case.

Sincerely.

Leonard D Friedenson

CONTINUED

1 OF 2

Mrs. Leonard D. Friedenson
Andover J 255 Century Village
W. Palm Beach, Fla. 33401

March 5, 1975

Honorable Lawton Chiles

United States Senator

Federal Building

Lakeland, Florida 33801

Dear Senator Chiles:

Many, many thanks to you for your assistance in getting my Social Security on a monthly basis. After my award was made in May, 1974, it seems incredible that it should take ten months to put me on a monthly payment basis. I was happy to read that your efforts have resulted in a probe of Social Security by the G. A. O. To one who hasn't any savings, the administrative and bureaucratic delays (such as the Social Security Administration has become known for) can be catastrophic. Again my thanks for your efforts on my behalf.

Sincerely,

Leonard D. Friedenson

April 8, 1975

llc

FRIEDENSON, LEONARD

~~MXM~~ CLOSED

Leonard D. Friedenson
Andover J 255 Century Village
W. Palm Beach, Florida 33401

Dear Mr. Friedenson:

Thank you very much for your recent letter in t further reference to the social security program. I am pleased that your problem was finally resolved and I agree with you wholeheardedly that you should not have had to wait such a long time ~~B~~efo~~r~~eur monthly payments to be properly sent to you.

SHould you feel I am able to be of assistance in the future, do not hesitate to call on me.

With kind regards, I am

Sincerely,

LAWTON CHILES

LC/sr

2042 Shadow Lane
Clearwater, Florida 33515
January 18, 1975.

Honorable Lawton Chiles
U.S.Senator from Florida
2107 Dirksen Senate Office Building
Washington, D. C. 20510

Dear Senator Chiles,

Excuse the imposition for help at the start of a legislative session, but since I myself, with the assistance of the Clearwater Social Security Office, am unable to get a reimbursement from Medicare, Part "B", administered by Blue Shield of Florida in Jacksonville, for a rental invoice in the amount of $ 52.52, which was incurred on December 4, 1973 and submitted to Medicare on January 26, 1974, I find no other alternative but to appeal to you for your gracious aid.

The item involves the rental of a hospital bed and a bedside commode for my wife, because of severe bodily crippling due to rheumatoid arthritis and osteoporosis. Our doctor, J. Rygorsky, M.D., of Clearwater, prescribed them the beginning of August 1973 and they were rented from Dunham's Surgical Appliance Service of Clearwater.

The monthly rental bills were submitted as I had paid them and Medicare paid them regularly, even though a might slow, except the one mentioned above. Usually other medical expenditures were lumped together with the rental bill when a claim was submitted. This procedure was followed also with the claim mailed on January 26, 1974, so that the total amount was $ 88.52.

Under date of March 28, 1974 and report # 05903506 C a benefit check for only $ 25.60, or 80% of $ 32.00, was received, with the notation of "Duplicate Bill" for the $ 52.52 as the reason of this amount not approved and Blue Shield showed the date of Dunham's invoice as 8-3-73. The actual date of the receipted voucher from Dunham's for the above claim was 12-4-73 and bears the number 17877-14. I have the carbon copy while the original went along with the claim. On April 4, 1974, Mr. Cramb of the Clearwater Social Security Office, to whom I talked, dispatched a "Request for Review" to Jacksonville, outlining their error in the date and also send along a copy of voucher # 17877-14. At the same time I had shown him all the copies of the previous Dunham vouchers to prove that an error by Blue Shield had been made. Incidentally the voucher of August 3, 1973 submitted as a claim for the August 1973 rental bears # 11575-18.

According to Mr. Cramb I should hear from Jacksonville by 7-4-74, but not having heard from them, I went back to see Mr. Cramb about August 6, 1974. He too was dismayed that I had not heard, but at the same time told me that an examiner is in their office checking into all the complaints about the poor service that Social Security retirees are receiving from Blue Shield of Florida. He thought this might result in a change by HEW to another firm who would be better qualified and render better service. This housecleaning is sorely needed.

Not until the beginning of October 1974, under postmark October 1, 1974 did I receive a printed form communication, initialed by r b, under

the signature of Sharon Dobus, Dept. Supervisor, that the above claim for $ 52.52, which I submitted on January 26, 1974, was paid on 9-20-73. How absurd to supposedly habe been paid for something four (4) months before the claim was dispatched. It sure takes a brainless wonder to come up with a statement like that.

After giving myself enough time to calm down I went back to the Social Security Office on December 9, 1974 and had a Mr. Tutoli resubmit a "Review" form, where I myself filled in the reason for reimbursement and Mr. Tutoli attached a photocopy of the 12-4-73 Dunham voucher. He asked to give Blue Shield time to 3-24-75 to reply.

Lo and behold, on January 16, 1975, under postmark January 15, 1975, I received another preprinted form telling me again that the $ 15052 (sic) was paid with a check dated 9-20-73. This one bore the signature of Adelma Pooley, Dept. Supervisor and was initialled P.H., and as "Additional Information" the correspondent wrote, quote: "This included the $ 52.52 charges on report # 05903506, which was disallowed as duplicate bills". Both preprinted form reports from Jacksonville referred to report # 25675328, which reimbursed mefor the actual 8-3-73 rental bill.

Again the stupidity of telling me, you were paid for something on 9-20-73 which was not claimed until January 26, 1974. It looks like the second correspondent just copied what the first one came up with, and I believe that neither one of them undertook a serious search to check out the facts. It is little wonder that the Medicare offices run by Blue Shield are in such a glorious mess, when they employ ignorant and inefficient people and that at the taxpayers expense. The supervisors seem to be the worst of the lot. In June 1973 I had returned a check for $ 32.00, because it was a duplicate payment of a claim other than the one mentioned above. Lucky enough I had copied the report and check numbers. Yet on November 6, 1973 I was threatened with having this amount taken off of a future check unless I return either their check or send my own. That letter was signed by Sharon Dobbs. I wrote her stating that I had returned the check shortly after I had received it and to ask the disbursement department that they had received that check back. No response came, but on December 13, 1973 she send me a copy of her November 6, 73 letter. I added a salty postscript to that copy and mailed it right back to her. Finally on December 20, 1973 she mailed a postcard confirming that the original check had been received in Jacksonville. An interdepartmental communication system seems to be sadly lacking or it could be sheer laziness to let others, that could be involved, know of such transactions.

I have been in the business community all my life, the last 25 years as Accounting Department Supervisor for the same employer prior to my early retirement because of my wife's health. Something as sloppy as the Blue Shield of Florida operation for HEW I would not tolerate. It is not so much the time spent I regret but the monetary expense of the running around and corresponding, taking up somebody else's time to get things straightened out which should not have occured in the first place and not to forget the time of your good office is being asked to spend for any help you can give.

Many thanks for your assistance which surely will be appreciated.

Very sincerely
Fred C. Brodbeck
Fred C. Brodbeck
husband of Helen R. Brodbeck
Soc. Sec. # 358-07-2390-B

llc

BRODBECK, FRED

March 17, 1975 closed

Mr. Fred C. Brodbeck
2042 Shadow Lane
Clearwater, Florida 33515

Dear Mr. Brodbeck:

A short time ago you were in contact with my office and I advised you I would be in touch as soon as possible. I have now received some information relating to your inquiry, and I am enclosing it for your reading.

After you have had the opportunity to review the agency's response, if you feel I can be of further assistance with this, or any other matter, please do not hesitate to let me know.

With kind regards, I am

Sincerely,

LAWTON CHILES

LC/jz

Enclosure

2042 Shadow Lane
Clearwater, Florida 33515
April 7, 1975.

Honorable Lawton Chiles
U. S. Senator
Federal Building
Lakeland, Florida 33801

Dear Senator Chiles,

At long last we can send you our most sincerest thanks for your and your staff's help in getting our year old claim against " Medicare, Part B"squared away, because today we received their check to repay us for the claim which we incurred on 12-3-73.

Rest assured your assistance is very much appreciated and we still regret we had to impose on you.

Yours sincerely

Fred C. Brodbeck
husband of Helen A. Brodbeck
Soc. Sec. # 388-07-2890 A & B

[Whereupon, at 12:20 p.m., the subcommittee was adjourned.]

END