COMPETITIVE CONTRACTING FOR THE ADMINISTRATION OF MEDICARE CLAIMS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

NINETY-SEVENTH CONGRESS

FIRST SESSION

DECEMBER 8, 1981

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

90-593 O WASHINGTON: 1982 HG 97—62

COMMITTEE ON FINANCE

ROBERT J. DOLE, Kansas, *Chairman*

BOB PACKWOOD, Oregon
WILLIAM V. ROTH, JR., Delaware
JOHN C. DANFORTH, Missouri
JOHN H. CHAFEE, Rhode Island
JOHN HEINZ, Pennsylvania
MALCOLM WALLOP, Wyoming
DAVID DURENBERGER, Minnesota
WILLIAM L. ARMSTRONG, Colorado
STEVEN D. SYMMS, Idaho
CHARLES E. GRASSLEY, Iowa

RUSSELL B. LONG, Louisiana
HARRY F. BYRD, JR., Virginia
LLOYD BENTSEN, Texas
SPARK M. MATSUNAGA, Hawaii
DANIEL PATRICK MOYNIHAN, New York
MAX BAUCUS, Montana
DAVID L. BOREN, Oklahoma
BILL BRADLEY, New Jersey
GEORGE J. MITCHELL, Maine

ROBERT E. LIGHTHIZER, *Chief Counsel*
MICHAEL STERN, *Minority Staff Director*

SUBCOMMITTEE ON HEALTH

DAVID DURENBERGER, Minnesota, *Chairman*

ROBERT J. DOLE, Kansas
BOB PACKWOOD, Oregon
JOHN HEINZ, Pennsylvania

MAX BAUCUS, Montana
BILL BRADLEY, New Jersey
RUSSELL B. LONG, Louisiana

CONTENTS

COMPETITIVE CONTRACTING FOR THE ADMINISTRATION OF MEDICARE CLAIMS

THURSDAY, DECEMBER 3, 1981

U.S. SENATE,
SUBCOMMITTEE ON HEALTH,
SENATE FINANCE COMMITTEE,
Washington, D.C.

The hearing was convened, pursuant to notice, at 9:46 a.m. in room 2221, Dirksen Senate Office Building, Hon. David Durenberger (chairman) presiding.

Present: Senators Durenberger, Dole, Heinz, Baucus, and Grassley.

[The committee press release announcing this hearing and the opening statements of Senators Dave Durenberger and Bob Dole follow:]

[Press Release No. 81-179]

SENATE FINANCE SUBCOMMITTEE ON HEALTH SETS HEARING ON COMPETITIVE CONTRACTING FOR THE ADMINISTRATION OF MEDICARE

Senator Dave Durenberger (R., Minnesota), Chairman of the Subcommittee on Health of the Senate Committee on Finance, announced today that the Subcommittee will hold a hearing on Thursday, December 3, 1981, to review the issue of competitive contracting for the administration of medicare claims.

[The hearing will begin at 9:30 a.m. in Room 2221 of the Dirksen Senate Office Building.]

Senator Durenberger noted that the last four administrations as well as various commissions and task forces have considered changes in medicare that would enable the Department of Health and Human Services to select contractors on a competitive basis and to permit the use of incentives in compensating intermediaries and carriers. In recent years the Department has engaged in several experiments to evaluate the feasibility of these changes. The objective of this hearing will be to review the status and results of the Department's efforts to determine if competitive fixed price or performance incentives contracts would have the effect of inducing effective, efficient, and economical performance of claims processing under medicare.

The Subcommittee anticipates hearing testimony from the administration, the U.S. General Accounting Office, associations representing intermediaries and carriers, intermediaries and carriers involved in the experiments, and other interested parties. Specifically, the Subcommittee expects the testimony to address the following questions:

Should the currently used cost reimbursement method of payment be replaced by competitive contracts?

What has HCFA learned from its competitive contracting experiments?

What problems have been encountered?

How would a system of competitive contracting affect the quality of service provided to beneficiaries?

Should a system of cost or performance incentives be implemented at this time?

Could the number of intermediaries and carriers be reduced without adversely affecting the quality of services to beneficiaries?

Would this result in lower administrative costs?
What would be the effect of combining the functions of intermediaries and carriers in certain areas?
Should it be done only for dealing with specific services like home health?
Should changes be made to the nomination process?
If so, what changes and why?

OPENING STATEMENT BY SENATOR DAVE DURENBERGER

Unlike many other contracts entered into by the Federal Government, HCFA contracts to administer the medicare program are not the result of competitive bidding. In accordance with Title XVIII of the Social Security Act, HCFA contracts on a cost reimbursement basis to administer medicare. Under these rules, neither a profit nor a loss is allowed. It is expected that nearly three-quarters of a billion dollars will be paid to about 110 contractors during fiscal year 1982.

It has been suggested that greater competition could lead to increased efficiency and economy in our Nation's health system. With this in mind, Congress enacted section 222 of Public Law 92-603 in October 1972 which gave the Department authority to experiment with competitive fixed price or performance incentive contracts. The Department believed that such contracts would have the effect of inducing effective, efficient, and economical performance of claims processing under medicare. In response to this legislation, HCFA has engaged in several experiments to test out this theory.

The objective of this hearing will be to review the status and results of the Department's efforts.

This subcommittee is also interested in hearing testimony on the effect of competitive contracting on the quality of service provided to beneficiaries, the need to reduce the number of intermediaries and carriers, and any suggestions for changes in the part A nomination process.

As you may know I have a particularly strong interest in these competitive experiments and their results, in that I have co-sponsored legislation designed, in part, to encourage competition in the health insurance industry.

I look forward to hearing from the administration, the U.S. General Accounting Office (which has recently completed its review of HCFA's competitive fixed-price experiments), associations representating intermediaries and carriers, and those intermediaries and carriers who have been involved in the experiments.

OPENING STATEMENT OF SENATOR BOB DOLE

I am deeply concerned over the ever—increasing cost of publicly financed health care programs. However, I am equally concerned that efforts to reduce the costs related to these programs do not result in a reduction of the quality of services provided to medicare beneficiaries.

The last four administrations as well as various commissions and task forces have considered changes in medicare that would enable the Department of Health and Human Services to select contractors on competitive basis and to permit the use of incentives in compensating intermediaries and carriers. This suggested change is based on several studies which cite potential cost savings if competitive bidding to select medicare contractors was permitted and the nomination process eliminated. In June 1979, the then administrator of the Health Care Financing Administration estimated that these contracting changes could save the Federal Government $55 million over a 3-year period.

In these times of fiscal restraint, we must look very carefully at opportunities for potential cost savings. However, any contemplated changes to the administration of the medicare program should give full and serious consideration to maintaining the high quality of services to which the elderly of this Nation are entitled. I look forward to hearing from our witnesses today on their experiences with the contracting experiments and any suggestions they might have regarding changes in the system.

Senator DURENBERGER. The hearing will come to order. My apologies for the delay in starting the hearing. There is some indication that there will be a brief recess in the neighborhood of 10:30.

Unlike many other contracts entered into by the Federal Government, HCFA contracts to administer the medicare program are not the result of competitive bidding. In accordance with title XVIII of the Social Security Act, HCFA contracts on a cost reimbursement

basis to administer medicare. Under these rules, neither a profit nor a loss is allowed. It is expected that nearly three-quarters of a billion dollars will be paid to about 110 contractors during fiscal year 1982.

It has been suggested that greater competition could lead to increased efficiency and economy in our Nation's health system. With this in mind, Congress enacted section 222 of Public Law 92-603 in October 1972 which gave the Department authority to experiment with competitive fixed price or performance incentive contracts. The Department believed that such contracts would have the effect of inducing effective, efficient, and economical performance of claims processing under medicare. In response to this legislation, HCFA has engaged in several experiments to test out this theory.

The objective of this hearing will be to review the status and results of the Department's efforts. The subcommittee is also interested in hearing testimony on the effect of competitive contracting on the quality of service provided the beneficiaries, the need to reduce the number of intermediaries and carriers, and any suggestions for changes in the part A nomination process.

As you may know, I have a particularly strong interest in these competitive experiments and their results. And that I have cosponsored legislation designed in part to encourage competition in the health insurance industry.

I look forward to hearing from the administration, the U.S. General Accounting Office, which has recently completed its review of HCFA's competitive fixed price experiments, the associations representing intermediaries and carriers and those intermediaries and carriers who have been involved in the experiment.

Do any of my colleagues have any opening comments they would like to make?

Senator BAUCUS. Mr. Chairman, I have a couple of words here.

STATEMENT OF HON. MAX BAUCUS, U.S. SENATOR FROM THE STATE OF MONTANA

Senator BAUCUS. Mr. Chairman, in our desire to make the administration of medicare cost effective, I believe we should not lose sight of the fact that by and large that Blue Cross/Blue Shield plans and commerical companies that have been serving as medicare agents have been doing a good job. Despite medicare's many complexities, its administrative costs amount to only about 3 percent of total program costs. Ninety-seven percent is paid out in benefits.

It is not fair to compare medicare's administrative costs with those of private health benefit programs. Private programs have marketing costs; they often pay taxes; and many have higher payment rates than medicare. Even though comparisons are difficult, I think it is fair to say that medicare's administrative costs are reasonable.

This is not to say that substantial economies are not possible. They are. But given the present level of efficiency, we will have to be sure that no major, disruptive changes in administration be made until we know how they will affect the other 97 percent of

the program in terms of service to beneficiaries and providers in accuracy of payment.

Poorly planned administrative changes can very easily be penny-wise and pound foolish. Last month, for example, HHS was proposing to cut medicare auditing costs by $40 million even though a dollar spent on auditing has been shown to save $7 in payment errors. I doubt that many of us would want to save $1 if it cost us $7 to do so.

Competitive contracting could result in the same sort of penny-wise, pound-foolish economy unless the Government can assure that the lowest bidder will maintain an acceptable level of program integrity and service.

The testimony that we will hear today will be helpful in determining what steps can be prudently taken at this time to improve the operation of the medicare program.

Thank you.

Senator GRASSLEY. Mr. Chairman, I don't have an opening statement.

Senator DURENBERGER. Thank you very much. Our first witness will be Gregory J. Ahart, Director, Human Resources Division, Government Accounting Office, Washington, D.C.

Greg, we welcome you here today and look forward to your comments. Can you identify your colleagues?

Mr. AHART. Thank you, Mr. Chairman. With me today, on my right, is Mr. Robert Ifferi of the Human Resources Division. And on my left is Mr. Barry Tice. Both have had a heavy part in the work that we will be discussing this morning.

I have a rather lengthy statement I would like to file. And I will try to summarize it as quickly as I can.

Senator DURENBERGER. Without objection, your full statement will be made part of the record.

[The prepared statement follows:]

STATEMENT OF GREGORY J. AHART, DIRECTOR, HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE

Mr. Chairman and Members of the Subcommittee, we are pleased to be here today to discuss our review of the three experiments with competitive fixed-price contracting under part B of Medicare. Our review of the experiments in Maine, upstate New York, and Illinois was requested in January 1980 by the Chairman, Subcommittee on Health, House Committee on Ways and Means. The Chairman asked us to review the three experiments as a followup to our June 1979 report 1/ to the Congress on Medicare claims processing.

In that report we expressed some concerns about the potential impact of competitive fixed-price contracting on the Medicare program. We recommended that the experimental fixed-price contracts be thoroughly evaluated by the Department of Health and Human Services (HHS) before any broad legislative changes are made in Medicare's contracting provisions.

As requested by the Chairman, the objectives in our recently completed review were to (1) follow up on the recommendations made in our June 1979 report, (2) evaluate the performance of the three experimental fixed-price contractors and (3) relate the results of the experiments to the legislative issue of conpetitive fixed-price contracting in Medicare. As requested,

---

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

[This report is in the official committee files:]

our major emphasis was on the performance of the experimental contractor for Illinois because of reports of beneficiary and provider dissatisfaction with the claims processing and related services provided by the new contractor.

Our report entitled "Experiments Have Not Demonstrated Success of Competitive Fixed-Price Contracting in Medicare" (HRD-82-17) addressed to the Chairmen, Subcommittees on Health and Oversight, House Committee on Ways and Means, will be released in the next few days.

In summary, the results of Medicare's three fixed-price experiments have varied. Contractor performance has ranged from satisfactory in the Maine experiment to unsatisfactory in the Illinois experiment. Performance in upstate New York is now considered satisfactory after an initial 6-month period of unsatisfactory performance.

There were different circumstances associated with each experiment that weighed heavily on the results. Although much can be learned from these experiments, we believe they are inconclusive as to whether the broad application of competitive fixed-price contracting in Medicare can produce administrative cost savings without unacceptable negative effects on program payments and services.

To authorize HHS to use competitive fixed-price contracting in the Medicare program, except in experiments, the Congress would have to enact legislation. We believe such

legislation would be premature at this time. We do not have a closed mind on this issue, however. If and when a competitive fixed-price procurement approach can be designed and implemented to assure consistently acceptable or improved levels of performance ~~on~~ in terms of beneficiary and provider services and accuracy of program payments, we would be willing to reexamine the issue.

BACKGROUND

Medicare contracts with carriers which process claims for physician and other practitioner services (part B) and intermediaries which process claims for institutional services (part A). As required by Title XVIII of the Social Security Act, these contracts have traditionally been on a cost reimbursement basis.

In addition to the three part B competitive fixed-price experiments, there is only one experiment with competitive fixed-price contracting in part A. This experiment places all part A services in Missouri under one contractor. Previously, there were five intermediaries servicing institutional providers in Missouri. The contractor became fully operational on July 1, 1981.

HCFA has two experiments underway with incentive contracting. One experiment is in New York, where the workloads of seven Blue Cross plans have been consolidated, and only one plan now has a subcontract 1/ with Medicare. This part A contract is a negotiated

---

1/The prime contractor remains the Blue Cross Association.

fixed-price experimental contract containing provisions for both liquidated damages for substandard performance and incentive payments if performance standards are exceeded. The part B experiment in Maine was recently recompeted and the contract modified to include certain incentive provisions.

Section 12 of the Medicare-Medicaid Anti-Fraud and Abuse Amendments (Public Law 95-142), enacted on October 25, 1977, directed us to study the claims processing system under Medicare to determine what modifications should be made to achieve more efficient claims administration.

In our June 29, 1979, report, we cited many opportunities for HHS to improve its administration of Medicare and recommended a number of actions for the Congress and HHS. We stated that, while competitive fixed-price contracting may well be the ultimate and most desirable goal for modifying Medicare's administrative structure, we believed there was insufficient information to make such a legislative change at that time.

We suggested that a more logical and prudent approach would involve a tripartite strategy featuring

--a careful and objective evaluation of the ongoing experiments in competitive fixed-price contracts to assess their effect on benefit payments and services to providers and beneficiaries,

--further experiments aimed at evaluating (1) whether it was feasible to merge parts A and B under a single contractor and (2) whether incentive contracts will work successfully in the Medicare program, and

--immediate action to reduce the number of contractors in the program by eliminating the less efficient performers.

Our recently completed review of the three part B experiments involved analyzing various performance data compiled by the Health Care Financing Administration (HCFA) for all three contractors and reviewing the steps taken by HCFA and the contractors during the transition phase of the contracts--the period when the new contractors were transferring records and files from the incumbents and preparing their processing systems to begin operations. Where major processing problems--such as claims and correspondence backlogs--arose after the implementation began, we reviewed the actions taken by HCFA and the contractors to resolve them.

Much of our work had already been done for the Maine contract. In our 1979 report, we reported on the transition phase and the early months following implementation. The remaining work involved analyzing the more recent performance data supplied by the contractor and HCFA.

In New York we concentrated primarily on reviewing the steps HCFA took to determine that the new contractor had accurately transferred records and files from the previous contractors and that it had properly set up and tested its new data processing system. Most of our work involved reviewing the records and files of these activities at HCFA's offices in New York City and interviewing the HCFA staff who worked with the contractor.

We also discussed these transitional efforts with the managers at the contractor's Medicare offices in Binghamton, New York.

Our work in Illinois was on a much broader scale. Although we began with the same objective as in New York, several circumstances required us to modify our approach. During our review, most of which was performed at the contractor's offices in Des Plaines, Illinois, we received numerous complaints and allegations about the contractor's performance. Because of the seriousness of these problems, the requestor asked us to shift the focus of our review to address these allegations. Additionally, we could not follow the approach we took in New York of reviewing the step-by-step transitional tasks because of the lack of documentation at HCFA and the contractor in Illinois.

Formal monitoring of the three contractors' performance is based on two sets of standards--System One and System Two. System One has five workload-related standards and is measured on the basis of reports submitted by the contractors, which include quality assurance analyzes. There are seven System Two standards which are based on the contractors' compliance with all pertinent operational instructions in seven functional areas. The three experimental contracts also included provisions for monetary penalties for substandard performance. The penalties are assessed for any standards failed in a 3-month period. The penalties range from $10,570 per standard in Maine to $52,250 per standard in Illinois.

Two of the five workload standards pertain to claims processing quality. Two error rates are considered--the occurrence error rate 1/ and the payment/deductible error rate. 2/ The payment/deductible error rate is very important because it reflects the accuracy of the contractor's benefit payments.

THE MAINE EXPERIMENT

Blue Shield of Massachusetts (BSM) completed the final year of its fixed-price contract to process Medicare part B claims in Maine on September 30, 1981. HCFA estimated that it saved $341,400 by awarding this contract on a competitive basis. BSM's performance has been satisfactory and better than its performance under a traditional cost-reimbursable contract to process similar claims in Massachusetts. The performance penalties associated with the fixed-price contract acted as a major incentive for effective performance. The better performance under the fixed-price contract may also be partly attributable to the performance standards developed for the experiments.

1/The estimated number of errors made in the processing of claims for every 100 claim line items in the universe of claims processed in the reporting period.

2/The estimated amount of payment/deductible dollar errors for every $100 of submitted charges in the universe of claims processed. Payment/deductible dollar errors include actual dollar amounts paid in error, actual dollar amounts not paid which should have been paid, and dollar amounts misapplied (either over or under) to the deductible.

BSM began claims processing in Maine on December 1, 1977. HCFA's monitoring of performance began on April 1, 1978. For the 13 evaluation periods (quarters) ended June 30, 1981, BSM, on a cumulative basis, has passed 147 of the aggregate 156 contract standards. The nine failed standards all relate to claims processing errors detected through HCFA's quality assurance program.

Although the transition of carrier responsibilities in Maine went well, this may be largely because BSM kept many of the claims processing features of the previous carrier, which maintained consistency in payments to providers and eliminated potential problems arising from an entirely new processing system. Because of this approach, however, BSM had to maintain a basically separate staff and was not able to benefit from potential economies of scale from having the same system for both Maine and Massachusetts. BSM's financial reports indicate that the company incurred a loss on the contract.

THE NEW YORK EXPERIMENT

Blue Shield of Western New York (Buffalo Blue Shield) is in the third year of its experimental fixed-price contract to process part B claims for upstate New York. The experiment saved an estimated $10.8 million in administrative costs, and is progressing smoothly after overcoming some initial performance problems.

Buffalo Blue Shield encountered difficulties when it began processing claims, however, resulting in large backlogs of claims and correspondence and high clerical error rates. It was able

to straighten these initial problems out after about six months, and HCFA now considers the carrier an above-average performer. Buffalo Blue Shield's initial difficulties were caused largely by problems that could be experienced by any Medicare carrier in taking over a new service area. They included a new and inexperienced staff, medical policy differences between Buffalo Blue Shield and the prior carriers, and the difficulty of converting files from the prior carriers.

Contract standards were not applicable during Buffalo Blue Shield's first 7 months of operations. For the six evaluation periods (quarters) beginning January 1980, and ending June 30, 1981, Buffalo has passed 69 of the 72 aggregate contract standards.

THE ILLINOIS EXPERIMENT

Electronic Data Systems Federal Corporation (EDSF) is in the third year of its experimental fixed-price contract to process part B claims in Illinois. The experiment saved an estimated $20.6 million in administrative costs, but during the first year of the contract, EDSF experienced numerous performance problems resulting in disruptions of services to beneficiaries and providers, a relatively high degree of inaccuracy in processing and paying claims and a lack of responsiveness to beneficary and provider inquiries. While EDSF has made improvements, performance problems continue to exist, particularly in beneficiary services and the administration of program payments. EDSF's payment errors from April 1, 1979 to June 30, 1981, have exceeded $67.6 million. This is about $34 million more than would

have been made by EDSF if it had met the contract standard for error rates each quarter. While overpayments and underpayments have been almost equal, adjustments favorable to claimants have far exceeded overpayment adjustments, and an estimated $27.7 million in overpayments remains unrecovered. The problematic nature of the contract has required HCFA to use far more resources for monitoring than originally planned, including a special unit established to monitor EDSF exclusively. The $20.6 million estimated savings in administrative costs from the award process and the contract penalties HCFA has collected have been significantly eroded by the Government's additional monitoring costs and the excessive overpayment errors.

Since the contract standards went into effect with the quarter ended December 31, 1979, EDSF has failed 55 of the aggregate 84 standards for the seven quarters evaluated 1/ Most of these failures are in the workload-related standards which EDSF has met only 5 times out of 45, including the first 6 months of the contract when financial penalties (liquidated damages) were not applicable.

Of the 12 contract standards, EDSF has consistently failed 6 to 9 of them each quarter. Six of the standards have never been passed. There has been a gradual improvement,

---

1/Five of the failures are considered tentative as EDSF has the opportunity to correct the deficiences found and reverse HCFA's decision.

however, in its performance against some of the standards, as shown by the table in appendix I.

For each performance standard failed, EDSF's contract payments are to be reduced by $52,250 starting with the quarter ended December 31,1979. EDSF is subject to $2.9 million in liquidated damages for failing to meet the contract standards through the quarter ended June 30,1981--$1.6 million for failing System One standards and $1.3 million for failing System Two standards. 1/

In appendix I we show the prior carriers' (Chicago Blue Shield and Continental) average occurrence and payment/deductible error rates for calendar year 1978. Also, to the extent they could be reconstructed from readily available data, we added other comparable statistics for the prior carriers related to the EDSF contract standards for claims processing in 15 days or less and for claims pending over 30 days. These data show that EDSF did not begin to compare favorably with the previous carriers for the timeliness standard until the quarter ended September 30, 1980, and for the claims pending and payment/deductible standards until the quarter ended December 31, 1980. For the fourth indicator (occurrence error rate), EDSF has never compared favorably with the prior carriers.

1/As of October 21, 1981, HCFA has officially assessed EDSF a total of $1.8 million.

A CHANGE TO COMPETITIVE FIXED-PRICE CONTRACTING WOULD BE PREMATURE AT THIS TIME

We have historically supported the use of competitive fixed-price procurement by the Government, where conditions are appropriate. Generally, this type of procurement results in a fair and reasonable price for the Government, and places the greatest risk of performance on the contractor. Because the contractor assumes full responsibility for all costs over the fixed price, there is incentive for effective cost control.

A change to fixed-price contracting in Medicare would require a change in legislation. Current law provides that HHS enter into cost reimbursement contracts with carriers and intermediaries which result in neither a profit nor a loss from carrying out Medicare activities. As we stated in our June 1979 report on Medicare contracting, a change in the legislative contracting authority may well be the ultimate and most desirable goal for modifying the administrative structure of Medicare. However, we believe such a broad legislative change would be premature at this time because the circumstances and the results of Medicare's three fixed-price experiments in part B have varied, and the experiments are inconclusive as to whether competitive fixed-price contracting can be carried out successfully in Medicare. In addition, the following factors further support our position that such a broad change would be premature.

1. A thorough evaluation of the experiments by HCFA has not been completed and the results analyzed. HCFA awarded a $500,000 contract in September 1981 for an independent evaluation of the experimental contracts. The scope of work covers all phases of the contract procurements, beginning with the preparation of the RFP through the transition, implementation, and operational phases. The scope is much broader and more complex than the scope of our review of the experiments. Also, HCFA has underway several other contracting initiatives, including experiments involving different types of contractual arrangements and different modes of contractor selection and reimbursement. Little is known about the results of these initiatives.

2. The results of the part B experiments have revealed several weaknesses in the contracting procedures followed by HCFA in these experiments. The contractor selection process and contract design used by HCFA in the experiments were insufficient to assure a smooth transfer of responsibilities between contractors or to safeguard the Government's and the beneficiaries' interests in the Medicare program. Performance and beneficiary services deteriorated to varying degrees during and after contractor changeover, and program payments were not adequately controlled. HCFA has stated that what it learned from these experiments will enable it to more effectively manage future contract initiatives.

3. More improvements can be made under existing contracting authority to achieve some of the advantages sought by competitive fixed-price contracting--chiefly, administrative cost savings and fewer contractors--through consolidation of workloads and and the elimination of high cost contractors.

4. Long-term expectations of cost savings from competitive fixed-price contracting should be viewed with caution. Only the administrative costs (accounting for about 3 percent of program costs) are being competed. Also, where administrative cost savings are realizable, we believe these savings are generally only realizable from the initial contract change, and that recompeting the contracts might not produce additional savings beyond those already realized. The re-competition of the Maine contract seems to support this hypotheses 1/.

ANALYSIS OF DUPLICATE PAYMENTS MADE BY EDSF

In our recent report we recommended that the Secretary of HHS direct HCFA to analyze the large amounts of unrecovered overpayments in Illinois--now estimated to be about $27.7 million. We believe that HCFA should analyze the overpayment situations detected through the quality assurance program to determine

---

1/BSM was the low bidder on the new 36-month contract and won with a price of $9,866,706, including implementation costs. This price is considerably higher than the contract price of $5,285,000 for the previous 39-month contract although such a comparision is made difficult by several factors, such as inflation, increases in claim volume, certain changes in the contractor's work requirement, and financial incentive provisions added to the new contract.

if some of the incorrect payments can be identified and recovered. HHS has agreed with this recommendation.

Our analysis of some of these situations showed certain commonalities to these overpayments that suggest that further analysis to identify patterns to these errors may identify specific cases. For example, many cases of duplicate payments were made as a result of multiple account numbers for physicians. There have also been many instances of wrong procedure codes being used by data entry personnel that have resulted in duplicate, as well as other incorrect payments. Further HCFA analysis of the quality assurance results could lead to identification and recovery of incorrect payments.

Because all carriers make overpayments to varying degrees, and the quality assurance programs only specifically identify a small percentage of such cases, we developed a computer model to demonstrate the feasibility of going back through paid claims history to identify specific overpayment cases for potential recoveries. We focused our efforts on duplicate payments in Illinois not only because of the relatively large amount of estimated overpayments, but because we believed the conditions during EDSF's first year of operations were conducive to an abnormally high number of duplicate claims being paid. These conditions were principally (1) claims processing delays which generally lead to repeated claims submissions from beneficiaries and providers, and (2) a high clerical error rate

which can lead to identical claims being processed differently, and possibly not being detected as duplicative.

Our primary objective was not to estimate how many overpayments or duplicate payments the contractor may have made, but rather to identify specific cases of overpayments and to facilitate the recovery of these monies. We obtained claims history records from EDSF involving 1 million beneficiaries and claims payments made by EDSF from April 1, 1979, through July 30, 1980. We randomly selected for detailed analysis the histories for 10 percent of the beneficiaries.

Medicare claims can involve one service or a number of services rendered over a period of days, weeks, or months. Information describing each service is coded by carrier personnel and entered into the carrier's computer system as an individual claim line item. For the 98,755 beneficiaries we randomly selected, EDSF's records showed about 2.2 million claim line items with allowed amounts of $62.6 million. 1/

Our computer model included several definitions for potential duplicates and analyzed EDSF's claims history for payments that matched the characteristics of our definitions. We used several variations of key claims data to define a potential duplicate.

1/There were 191 beneficiaries whose individual histories were so large that we had to process them separately. The results for these beneficiaries are not included in our findings.

Our objective was to continually refine our model until the proportion we analyzed manually had a significantly high percentage of actual duplicates (generally, greater than 70 percent). If this could be accomplished, we believed a similar analysis by HCFA or EDSF of the remaining 90 percent of the beneficiaries' records should be productive.

Although our review of duplicate payments is continuing, the analysis completed to date has identified many instances of duplicate payments. For example, we identified 3 types of potential duplicate situations, which our analysis of sample claims showed would have a high percentage of actual duplicates. In these 3 situations, we identified 2,725 potential duplicate payments--each involving allowed amounts of $25.00 or more, and totalling about $240,000. Based on our review of a sample of 137 of these situations, we estimate that about 90 percent of the payments were duplicative. 1/

Although we are unable to reliably project the total dollars involved in our 3 categories because of the small size of our samples and the variability of actual payments, we believe it is reasonable to assume that if our model, or a similar model, was used to analyze the full beneficiary

---

1/To determine if these and other identified duplicate payments were later refunded, or otherwise voided, we requested canceled checks in several cases of allowed amounts over $100.00. We have received complete information on 20 cases involving the 3 categories discussed here, and checks were issued and cashed in all but 2 cases. On 2 cases, checks were voided after July 30, 1980, therefore the voided transactions were not identified in the history records we used.

history through July 30,1980, the same relative proportion of actual duplicate payments could be found. We plan to discuss our results with HCFA and EDSF in the near future with the view of determining the feasibility of recovering these amounts.

CONCLUSIONS

To use competitive fixed-price contracting in the Medicare program, other than through experiments, the Congress would have to provide HHS with authorizing legislation. The results to date from the Medicare part B experiments indicate that administrative costs savings will result initially, but too many problems are associated with other aspects of contractor performance to assure the success of such contracting on a broader scale. The only experiment in part A is just underway.

Because it is not possible to predict what the circumstances would be in a broader application of this contracting strategy in parts A or B, but recognizing what the risks are in terms of program payments and services to beneficiaries and providers, we believe a change in legislative contracting authority would be premature at this time. However, as indicated earlier in my statement, we continue to have an open mind on this issue, if and when such risks can be adequately controlled.

- - - - -

Mr. Chairman, this concludes our statement. We will be pleased to respond to any questions you or other members of the Subommittee may have.

APPENDIX I

System Two standards	EDSF performance quarter ended								
	6/30/79 (note a)	9/30/79 (note a)	12/31/79	3/31/80	6/30/80	9/30/80	12/31/80	3/31/81	6/30/81
1. Claims process	-	-	failed	failed	failed	failed	failed	e/failed	e/failed
2. Coverage and utilization safeguards	-	-	failed	failed	failed	failed	failed	e/failed	e/failed
3. Program reimbursement	-	-	passed	passed	passed	passed	passed	passed	passed
4. Electronic data processing operations	-	-	passed	passed	passed	passed	passed	passed	passed
5. Beneficiary services and professional relations	-	-	failed	failed	failed	failed	failed	failed	e/failed
6. Program integrity	-	-	passed	failed	failed	failed	failed	passed	passed
7. Quality assurance	-	-	passed	passed	passed	passed	passed	passed	passed
Number of standards passed	-	-	4	3	3	4	5	6	4
Number of standards failed	-	-	8	9	9	8	7	e/6	e/8
Cumulative liquidated damages (millions)	-	-	$.2	$.9	$1.4	$1.8	$2.1	$2.5	$2.9

a/Standards were not applicable for assessment of liquidated damages until quarter ended December 31, 1979. Also, EDSF's performance relative to the System Two standards was not evaluated until the same quarter.

b/Standard is 70 percent for quarters ended March 31.

c/Prior carriers' (Chicago Blue Shield and Continental, respectively) performance statistics for calender year 1978; N/A is not available.

d/Although EDSF's performance was below the standard, HCFA has deemed this standard passed because of problems with the Social Security Administration's computer system that adversely affected EDSF's processing timeliness.

e/Tentative results for System Two standards. EDSF has an opportunity to correct deficiencies.

APPENDIX I

ELECTRONIC DATA SYSTEMS FEDERAL CORPORATION QUARTERLY PERFORMANCE RESULTS

IN ILLINOIS FROM APRIL 1, 1979, TO JUNE 30, 1981

System One standards	EDSF performance quarter ended								
	6/30/79 (note a)	9/30/79 (note a)	12/31/79	3/31/80	6/30/80	9/30/80	12/31/80	3/31/81	6/30/81
1. 75 percent of claims must be processed in 15 days or less (percent) (note b) [76.2, 77.9] (note c)	44.5	39.1	37.6	46.6	67.0	81.6	84.5	d/68.1	73.0
2. No more than 12 percent of claims pending at end of month can be over 30 days old (percent) [7.8, 9.2] (note c)	31.1	27.6	50.0	23.2	25.6	20.7	10.4	10.3	13.7
3. Occurrence error rate must be less than the median of all other carriers Median [13.1, 11.0] (note c)	34.7 (8.5)	32.5 (8.0)	25.6 (9.3)	27.0 (8.6)	23.1 (8.7)	19.3 (9.9)	20.3 (7.9)	18.8 (8.0)	16.6 (7.0)
4. Payment/deductible error rate must be less than the median of all other carriers Median [2.4, 2.8] (note c)	8.1 (2.0)	6.6 (2.2)	5.8 (2.5)	5.3 (2.3)	4.2 (2.0)	3.6 (2.5)	2.7 (1.8)	2.9 (1.9)	2.8 (1.7)
5. Average processing time for informal reviews must be 25 days or less (days) [N/A] (note c)	28.2	21.5	63.2	82.5	50.4	47.1	52.4	68.6	35.0

STATEMENT OF MR. GREGORY J. AHART, DIRECTOR, HUMAN RESOURCES DIVISION, GOVERNMENT ACCOUNTING OFFICE, WASHINGTON, D.C.

Mr. AHART. In our June 29, 1979, report to the Congress on medicare contracting, we cited many opportunities for HHS to improve its administration of medicare and recommended a number of actions for the Congress and HHS. We stated that competitive fixed-price contracting may well be the ultimate and most desirable goal for modifying medicare's administrative structure.

[The GAO report entitled "Experiments Have Not Demonstrated Success of Competitive Fixed-Price Contracting in Medicare" is in the official committee files.]

We believed, however, that there was insufficient information to make such a legislative change at that time because the effects of such fixed-price procurement on benefit payments and beneficiary and provider services have not been determined.

HHS has conducted three experiments with competitive fixed-price contracting in part B of medicare in Maine, upstate New York, and Illinois. We have reviewed the three experiments as a followup to our 1979 report.

In summary, the results of medicare's three fixed-price experiments are varied. Contractor performance has ranged from satisfactory in Maine to unsatisfactory in Illinois. Performance in upstate New York is now considered satisfactory after an initial 6-month period of unsatisfactory performance.

There were different circumstances associated with each experiment that weighed heavily on the results. Although much can be learned from these experiments, we believe they are inconclusive as to whether the broad application of competitive fixed-price contracting can produce administrative cost savings without unacceptable negative effects on program payments and services.

To authorize the Department to use competitive fixed-price contracting in the medicare program, except in experiments, the Congress would have to enact legislation. We believe that such legislation would be premature at this time. We do not, however, have a closed mind on this issue. If and when a competitive fixed-price procurement approach can be designed and implemented to assure consistently acceptable or improved levels of performance in terms of beneficiary and provider services and accuracy of program payments, we would be willing to reexamine the issue.

Our review involved analyzing performance data for all three contractors and reviewing the steps taken by HCFA and the contractors during the transition phase of the contracts. Where major processing problems arose after implementation began, we reviewed the actions taken by HCFA and the contractors to resolve them. Much of our work had already been done for the Maine contract. In our 1979 report, we reported on the transition phase of the early months following implementation.

In New York, we concentrated primarily on reviewing the steps HCFA took to determine that the new contractor had accurately transferred records and files from the previous contractors, and that it had properly set up and tested its new data processing system.

Our work in Illinois was much broader. During our review, we received numerous complaints and allegations about the contractor's performance. Because of the seriousness of these problems, we shifted the focus of our review to address these allegations. Additionally, we could not follow the approach we took in New York of reviewing the step-by-step transitional tasks because of the lack of documentation at HCFA and at the contractor in Illinois.

Formal monitoring of the three contractors' performance is based on five workload related standards, and seven standards based on the contractors' compliance with all pertinent operational instructions in seven different functional areas. The contracts included provisions for monetary penalties for substandard performance.

Blue Shield of Massachusetts, which had the contract in Maine, completed the final year of its contract on September 30 of this year. HCFA has estimated that it saved $341,000 by awarding this contract on a competitive basis. The carrier's performance has been satisfactory and better than its performance under a traditional cost-type contract in Massachusetts. The performance penalties acted as a major incentive for effective performance.

For the 13 evaluation periods, which are quarters under these contracts, ended June 30, 1981. The carrier had passed 147 of the aggregate 156 contract standards.

In New York, Blue Shield of Western New York is in the third year of its contract. The experiment saved an estimated $10.8 million in administrative costs, and is progressing smoothly after overcoming some initial performance problems.

For the sixth evaluation period beginning January 1980 and ending June of this year, the carrier has passed 69 of the 72 aggregate contract standards.

In Illinois, Electronic Data Systems Federal Corp. is in the third year of its experimental fixed price contract. The experiment has saved an estimated $20.6 million in administrative costs. But during the first year of the contract, EDSF experienced numerous performance problems resulting in disruptions of services to beneficiaries and providers, a relatively high degree of inaccuracy in processing and paying claims, and a lack of responsiveness to beneficiary and provider inquiries. While EDSF has made improvements, performance problems continue to exist; particularly, in beneficiary services and the administration of program payments. The problematic nature of the contract has required HCFA to use far more resources for monitoring than it originally planned. The $20.6 million estimated savings in administrative costs from the award process and the contract penalties HCFA has collected have been significantly eroded by the Government's additional monitoring costs and the excessive overpayment errors. EDSF has failed 55 of the aggregate 84 standards for the 7 quarters which have been evaluated. Most of these failures are in the workload related standards.

Senator DURENBERGER. Are in the what?

Mr. AHART. Workload related standards. As I pointed out, there were five workload related standards and seven compliance type standards in the contracts.

We, in GAO, have historically supported the use of competitive fixed-price procurement by the Government where conditions for such procurement are appropriate. Generally, this type of procurement results in a fair and reasonable price for the Government, and places the greater risk of performance on the contractor. Because the contractor assumes full responsibility for all costs over the fixed price, there is an incentive for effective cost control.

Current law provides that HHS enter in a cost reimbursement contract with carriers and intermediaries which result in neither a profit nor a loss from carrying out medicare activities. As we stated in our June 1979 report, a change in the legislative contracting authority may well be the ultimate and most desirable goal for modifying the administrative structure of medicare. However, we believe such a broad legislative change would be premature at this time because the circumstances and the results of medicare's three experiments in part B have varied. And the experiments are inconclusive as to whether competitive fixed-price contracting can be carried out successfully in medicare.

In addition, the following factors support our position that such a broad change would be premature at this time:

First, a thorough evaluation of the experiments by HCFA has not yet been completed and the results analyzed. It has awarded a $500,000 contract this past September for an independent evaluation of the experimental contracts.

Second, the results of the part B experiments have revealed several weaknesses in the contracting procedures followed by HCFA in these experiments.

Third, more improvements can be made under existing contract authority to achieve some of the advantages sought by competitive fixed-price contracting—chiefly, administrative cost savings and fewer contractors—through consolidation of workloads and the elimination of high cost contractors.

And finally, the long-term expectations of cost savings from competitive fixed-price contracting should be viewed with caution. Only the administrative costs, which account for about 3 percent of program costs, are being competed. Also, where administrative cost savings are realizable, we believe these savings are generally realizable only from the initial contract change. And the recompeting of contracts might not produce additional savings beyond those already realized. The recompetition of the Maine contract seems to support this hypothesis.

I just want to mention, Mr. Chairman, that we recommended that the Secretary of the Department direct HCFA to analyze the large amounts of unrecovered overpayments in Illinois which are now estimated at about $27.7 million. We believe that HCFA should analyze the overpayment situations detected through the quality assurance program to determine if some of the incorrect payments can be identified and recovered. The Department has agreed with this recommendation.

To sum up, to use fixed-price contracting in the medicare program, other than through experiments, Congress would have to provide additional authorizing legislation. The results to date from the medicare part B experiments indicates that administrative cost savings will result initially, but too many problems are associated

with other aspects of contractor performance to assure the success of such contracting on a broader scale. The only experiment in part A is just underway.

Because it is not possible to predict what the circumstances would be in a broader application of this contracting strategy in parts A or B, but recognizing what the risks are in terms of program payments and services to beneficiaries and providers, we believe a change in legislative contracting authority would be premature. However, as indicated earlier, we continue to have an open mind on the issue if and when such risks can be adequately controlled.

That summarizes my statement, Mr. Chairman. We will be pleased to respond to questions.

Senator DURENBERGER. Thank you very much. I want to start with asking you to give all of us a bit of an overview of what we are talking about here. As a major buyer of health care for our many citizens, Government apparently made a decision at some point to experiment with some cost saving techniques—namely, competitive bidding. And, in effect, HCFA has been used to carry out those experiments. Can you give me, first, some kind of a dollar dimension for these experiments? How many dollars in benefits were involved during the course of this project? And what was the cost in terms of our payment to the involved contractors?

Mr. AHART. I think we would be happy to do that. Let me ask Mr. Tice to give you that kind of dimension on the three experiments that were involved here.

Mr. TICE. I don't have the benefit payments for the three experimental contractors. Is that what you are asking?

Senator DURENBERGER. Yes. Do you have a ballpark figure?

Mr. TICE. The ballpark estimate of EDSF benefit payments in Illinois—and EDSF, among the three contractors, is processing the largest workload—I believe its benefit payments have been between $1 billion and $1.5 billion during the little over 2 years.

Senator DURENBERGER. And what was their contract?

Mr. TICE. Their contract was for $41.8 million in administrative costs.

Senator DURENBERGER. $41.8 million. All right. So we have a small part of the overall medicare payment here that we are dealing with.

My concerns regarding your testimony—and it will be the general thrust of my questions—deal with your conclusion that it is premature for us to make any judgment as to where we ought to go from here. The results of the demonstrations can be taken in several ways. One, we can say that there were failures with the contractors that caused the experiment to fail or at least not to deliver the information we need. Or we could say that HCFA, didn't set up the appropriate parameters, nor the discipline, nor the guidelines, nor the reporting techniques, nor the evaluation, in such a way so that even if the contractors were doing a good job or were trying or willing to do a good job, we end up not really knowing any more than we did when we started. What are your suggestions with regard to the role that HCFA ought to play on our behalf? What arrangements ought to be or they with contractors that differ from the arrangements that were made over the last 4 years?

Mr. AHART. Well, let me try to answer that in a general way, Mr. Chairman. And perhaps my colleagues can give me some help a little bit later on.

I think by the very nature of experiments—experiments are undertaken so that you can learn something of value for the future. That's what was done in this case. This is what we had suggested that be done in our 1979 report. So I don't think you can call an experiment a failure even though everything doesn't come out exactly the way you would like to have it come out. I think we would all like to have them be total successes.

In each of these contract situations, each of the three experiments, there were differing situations. In Maine, you had kind of a takeover of an existing system largely. It's a fairly small operation relative to the other contracts and so on. And it went quite well.

In Illinois, on the other extreme, you had a contractor who had no previous experience as a carrier, a full-functioning carrier, although it had supported a lot of carriers in the data processing function. It was asked to take over a very large workload from two previous carriers, so they had the consolidation function as well as getting up to speed and operating as a carrier. You would expect more difficulties there than you would in the Maine situation.

What we would see now is as good an evaluation as could be made by HCFA of the experience under the three contracts, and try to learn from that what kind of situations are susceptible to perhaps changeover on a competitive situation as opposed to others where it might not be the best way to go. And try to learn as much as we can about what kind of contract, terms and conditions ought to be built into any future contracts if they go further.

I think there has to be serious concern given as to whether or not the somewhat attractive projected benefits in savings in administrative costs—whether they are a one-time thing, which appears to have been the case in Maine, as opposed to something that will continue. Once you have a contractor in place, they are doing the job; they are obviously in a position to have a little bit of an edge over anybody else who would want to come in and take over that particular responsibility.

The Maine contract, under the recompetition, they came under a fairly high unit cost. The contractors, as we understand it, lost money on the first contract, the experimental portion of the contract. Maybe it will make a little money this time around. We don't know.

But I think by the nature of experiments, we try to learn as much as we can from them. In this particular case, a very important thing that has to be considered is what kind of service is being given to the beneficiaries. They are the ones that the Government is in the business of trying to help. And unless it can be done, recompeted and have a changeover without a great deal of disruption to the service and deterioration of the services even for a 6-month or 1-year period—service to the people that this program is trying to help—then we have some question as to whether a little possible savings on administrative costs is really in the interest of what the Government is trying to accomplish. And I think we need to be assured on that point before we just go out and say everything should go fixed-price competitive to save some administrative costs.

Senator DURENBERGER. Let me yield to the Senator from Iowa.

Senator GRASSLEY. Thank you. Have the problems and difficulties of the contracts, particularly the ones in Illinois, been cleared up?

Mr. AHART. Some of the difficulties are continuing, Senator. Some of them have been largely cleared up. But it has taken a long time to get to where we are now. There are still things that have to be done.

Senator GRASSLEY. Considering all three States, some of them with unique difficulties, have there been difficulties common to all three experimental programs?

Mr. AHART. Well, I think, yes, certainly but in different degrees. I think anytime that you have a takeover and a switch of contractors, you will expect that there will be some difficulties during the transition period. The transition process went very rapidly in Maine; it went a little bit slower in New York, but they had it pretty well cleared up at the end of 6 months. It has gone extremely slow in the Illinois situation. But anytime you have a takeover responsibility by one contractor of another, you will expect that there will be a few things that get a little bit out of joint.

Senator GRASSLEY. You indicated that you aren't prepared, because of the results of the study or the lack thereof, to recommend going permanently to competitive bidding. Is there anything we can get out of you other than that now is not the time to make a change? Is there any leaning one way or the other?

Mr. AHART. Well, our natural leaning is toward competitive contracting, as I pointed out in my statement. But the circumstances for it have to be appropriate to it. Here you are competing on only 3 percent of your program costs. And unless you can assure yourself that the savings on that can be attained at the same time that you keep the quality of the services to the providers, and keep the integrity of the program payments at the level that you could achieve under the other method, we don't think you ought to go that way.

If at some point in the future we can determine, yes, you can control the integrity of program payments, that you can keep the quality of service to providers and beneficiaries that you need and still have some savings on administrative costs, then we would say that would probably be a good way to go. But I think you have to have that assurance on the other aspects of the program.

Senator GRASSLEY. Is there anything wrong with the current method of evaluation?

Mr. AHART. I would like to have Mr. Iffert's or Mr. Tice's point on that. There is a change that is taking place now on the way they evaluate the cost-type contractors. The standards for the experimental contracts were tailored specifically to those contracts and basically geared, as I understand it, to the standards being geared to the average performance of the cost-type contractors. So that would be kind of the baseline for what kind of performance that they required.

I don't know of anything specific that we would have suggested differently at the time, but my colleagues might.

Mr. IFFERT. Well, I think one of the criticisms of the contract standards that is probably well taken is that it is a cut-and-dry,

pass-or-fail situation. If you missed by a tenth of a percent, you are in the same trouble if you missed by 10 percent, which I don't think is to the Government's interest and necessarily to the contractors.

Now I understand that on the new Maine contract they have tried to compensate for this by making both the incentives and the penalties graded so that there is some financial reward and some financial penalty geared to the extent to which a standard is missed.

Senator GRASSLEY. You spoke to an actual action of your agency to support competitive bidding. And I assume that we are into these experiments because of recommendations of GAO in the first place. Have your leanings changed as a result of these experiments?

Mr. AHART. I think our overall bias is in favor of competitive contracting.

Senator GRASSLEY. But that would probably be in any Government program?

Mr. AHART. That's correct.

Senator GRASSLEY. Which would be natural. But is your support for competitive bidding in the medicare program any less now than it was 2 or 3 years ago?

Mr. AHART. Yes. As I say, I think our overall bias is in favor of competitive contracting generally. But the circumstances have to be appropriate. For example, in a lot of research and development contracts, where the quality of performance is the factor that you really want to maximize I'm not sure that you always want to go to get the person that gives you the lowest price. If you are buying something off the shelf and you know exactly what you are buying in terms of quality in product, then you ought to get it at the place where you can get it at the least cost.

In the medicare situation, as I pointed out, the very important parts of that are the integrity of the program payments which is 97 percent of the total dollars and the quality of service that is given to the providers and the beneficiaries, who are really the people we are trying to help; also, the providers that we are trying to get to help the beneficiaries. And these are the most important parts, the integrity of payments and the beneficiary and provider services. And we are not sure that you want to maximize savings in the 3-percent administrative cost if you have to trade off in any deterioration on either of those others.

Mr. TICE. I think if I could just elaborate a minute on why we seem to be leaning toward competitive contracting but basically noncommittal at this time—as we mentioned in the statement, there is a lot of contract initiatives that HCFA has underway where the results are not known. For example, the part A program, which is heavily dependent—the administrative costs are heavily dependent on auditing of the hospitals. No one knows what effect competitive contracting will have on that program. The three experiments, of course, have all been in part B.

Another example would be that in all three experiments, HCFA used basically a similar evaluation methodology. But they did make some changes. For example, in the Maine contract, the price was given a weight of 35 or 40 percent. And in Illinois it was given

a weight of 45 percent. And in New York it was increased to 50 percent.

We think HCFA needs to sit back and learn from these experiments and decide whether that evaluation methodology was appropriate. And if they should go forward with competitive contracting, what would be the evaluation methodology that they would put in place. Should price get 20 percent?

Senator DURENBERGER. Minute's up. Senator Baucus?

Senator BAUCUS. Thank you, Mr. Chairman. Mr. Ahart, in your judgment, does HCFA presently have enough legislative authority to conduct the proper amount of experimental competitive bidding contract procedures, and to get the kind of information you think necessary before we can make a formal decision?

Mr. AHART. Yes. I think the provisions of section 222, which were addressed, give them rather broad experimental authority to experiment with different ways of administration to improve the program overall. And I don't think we would have any specific problems with that.

Senator BAUCUS. In the meantime, do you recommend any interim legislative changes to help HCFA monitor or to help HCFA administer the present program it has?

Mr. AHART. No. I wouldn't think we would have any suggestions along that line, Senator.

Senator BAUCUS. What additional manpower requirements would there be if we were to go all the way here? Is additional manpower needed to monitor the services to be provided or not provided? Manpower to set up the standards, et cetera.

Mr. AHART. Well, I think that is a tough question to answer. They, obviously, have to have manpower now, resources to monitor the contracts whether they be cost-reimbursement or fixed-price competitive. We did point out in the statement that we found in our review that because of the problems that were associated with the Illinois contract that they had to put a lot more resources in that than they had anticipated. So they ought to have enough resources to do what is necessary to properly control any type of contractor including those under cost reimbursement as well as those under fixed price.

Senator BAUCUS. Thank you very much.

Senator DURENBERGER. Senator Dole.

Senator DOLE. I apologize for arriving late. I have no questions, but I would just say generally that this Committee is going to have a responsibility of finding more ways to save money in the next few months. We are not going to overlook competition as an area that we ought to consider. I assume, based on what I have heard from GAO, that that's at least the direction in which you lean. If we can find a more cost effective way, I would hope we would find support for that in the committee. Maybe more time is needed, but we are going to start looking at some of the providers of medicare, not just the beneficiaries, in our efforts to save money.

I assume that OMB is putting together a nice little package for us as we speak. And we will probably see most everybody here again.

Senator DURENBERGER. One last question, if I might. I am very sensitive to the time on behalf of the later witnesses.

In my opening statement I indicated that I was curious about potential changes in part A as well as the experimental contracting we are addressing here. In your statement I think you indicated that in your 1979 report you recommended a three-part approach for HCFA which included experimentation on merging of parts A and B under a single contractor as well as reducing the number of contractors. What's your level of satisfaction regarding HCFA's action in monitoring the experiments overall; particularly, with regard to the things that I have just expressed a concern about?

Mr. TICE. In terms of combining parts A and B consistent with our 1979 report, to my knowledge, HCFA has not started an experiment anywhere in the country that would consolidate parts A and B. I know that they had attempted such an experiment in the States around Colorado. And just recently, I think it was around November 20, the Federal court decision blocking the experiment had been reversed on appeal. And I assume they are proceeding with that experiment. But it hasn't started yet.

Mr. AHART. I think overall HCFA has tried to get a range of experiments, part A, part B. Part B is further along. They have one in process on part A. They are moving toward a combined part A and B. They have also used some of the other techniques that we suggested in the 1979 report. They have done some consolidation of contract areas under part B combining the areas previously served by high cost or low performance contractors with areas under contractors that had a better performance record or better cost record. So they are moving in several different directions. And I think they need to move in several different directions and learn as they go. And try to do the things that make the most sense for the future.

Senator DURENBERGER. I guess what I am getting at is very simply this: The chairman of this committee has just indicated that while we sit here, other forces are at work to reduce the benefits part of medicare because the system of financing people's needs has been so poor. There are a lot of innocent folks out there relying on medicare that will be hurt by this. It seems to me that we spend a fair amount of time scrutinizing contractors when we should also be looking at the performance of HCFA. I would like to ask you whether if you had the responsibility for all these billions of dollars and all of those people, would you go to HCFA to try to improve the way that we get the money to those people? What kind of a job has that organization done for us, and for the American people over the last 4 years? HCFA has had the authority, as the Senator pointed out in his questioning, they haven't come up with anything that we can use to change this system, to find the savings—not on the backs of the folks out there—but in the way we process the payment for claims or whatever other arrangements could be made.

Mr. AHART. I guess I wouldn't condemn them quite as strongly as you seem to be condemning them, Mr. Chairman. I have been involved with medicare, I guess, since its inception. Mr. Iffert has had a long experience with it. We've done a lot of work over the years to try to give them some help and the Congress some help in ways in which that program can be improved.

It is a terribly difficult one. The medical industry is a terribly pluralistic one. The beneficiaries need service from a system which I don't think a lot of them understand terribly well. I don't think we know nearly enough about how you can use the financing mechanism which medicare or medicaid are. How you can use that well to try to influence the industry toward providing good services, quality services, with less cost. I think we have learned a lot in the same 15 years that medicare and medicaid have been in existence. I think we have got a lot more to learn. It's a very difficult thing.

I think HCFA has suffered to some degree by—first there was fragmentation, before we had HCFA, between medicaid and medicare. There was a trade-off made in 1977, I think it was, to bring them together under HCFA so that we have medicare and medicaid at least run out of the same Federal agency. I think there has been concern there. A lot more needs to be done to better integrate those two. And let each learn from the other.

It is just a very difficult undertaking. I think the tack that we all have to take, whether it's Congress, GAO, HCFA or the industry, is to learn as much as we can as we go; find those things that work, and use those things that work. But not go off deep ends and try to run with a new idea just because it sounds good without really testing it out. And making sure that we are not trading off some things on the beneficiary side or on the industry side for the sake of a few dollars here and a few dollars there that bring about results we really didn't anticipate and would not find acceptable had we known in advance.

Senator DURENBERGER. Any other questions?

Senator BAUCUS. Mr. Chairman, what has been the experience of other Government programs in the area of competitive bidding? For example, medicaid.

Mr. AHART. Medicaid, I'm not sure that there has been too much competitive bidding except for the data processing and claims processing services. Mr. Iffert would know more on that than I would. CHAMPUS has had some experience too.

Senator BAUCUS. Could you tell us very briefly about CHAMPUS and/or medicaid experiences with competitive bidding?

Mr. IFFERT. Well, I imagine that the great experiment on medicaid that we were very heavily involved with came back in 1975 in North Carolina when the State threw the whole program up for bid. And that not only included administrative costs, that included benefit payments too. It was fixed-price. There was only one bidder. And it was a $400 million contract. And within a year, the thing collapsed. One of the problems—I guess we were one of the few to realize it—was that the company that won—who they are isn't really important—didn't have a whole lot of money. And there are a lot of risks involved in medicaid. And when the claims started coming in that were considerably higher than anticipated, they couldn't pay them because there wasn't any money in the bank.

They tried to renegotiate it and the State was not willing to do that because they thought it was a firm fixed-price contract. I think our friends in EDS kind of helped bail them out.

Senator BAUCUS. Other States have taken the same kind of steps?

Mr. IFFERT. There have been many, many drug contracts that were done on that basis. There, because the benefit payments are not that big, the risks weren't that big.

Senator BAUCUS. What about the CHAMPUS experience?

Mr. IFFERT. Well, the CHAMPUS experience has been just on the claims processing side of it.

Senator BAUCUS. What has your experience been there?

Mr. IFFERT. OK.

Senator BAUCUS. Very briefly.

Mr. IFFERT. Very briefly. They started back in 1976. And they threw it all out at once. And within a year I guess you could say that that part of the program, particularly in the Southwest, was in shambles. Contractors left after 1 year. And CHAMPUS had to go back, in effect, to bring the people that they had lost back in.

The last time we looked at it, based on 1979 performance data, there were considerable improvements from what had happened before, but there were still problems with beneficiary services and the controls over payments. That's the last time we have looked at it. However, if you talk to the people at CHAMPUS today, they will tell you that competition is the way to go, but I can't validate it.

Senator BAUCUS. Thank you very much.

Senator DURENBERGER. Any other questions?

[No response.]

Senator DURENBERGER. Thank you for your testimony.

Mr. AHART. Thank you, Mr. Chairman.

[Responses by Hon. Gregory J. Ahart to questions asked by Senator Durenberger follow:]

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

HR2-47

December 30, 1981

Mr. Robert E. Lighthizer
Chief Counsel
Committee on Finance
Unites States Senate

Dear Mr. Lighthizer:

In accordance with Senator Durenberger's request of December 10, 1981, enclosed is my response to the questions to be answered for the record in connection with our testimony at the December 3, 1981, hearing on competitive contracting for the administration of Medicare claims.

Sincerely yours,

Gregory J. Ahart
Director

Enclosure

QUESTION 1: How many cost-type contractors would have met the experimental contract standards?

ANSWER : For the functional System II standards, we have no way of knowing because there has been no published information applying these standards to the cost-type contractors. For the statistical or workload standards, however some comparisons can be made in the quality of claim processing area (occurrence and payment-deductible error rates). The EDSF contract sets the standards at the median rates for the cost-type contractors and for the Buffalo Blue Shield and Massachusetts Blue Shield contracts, at the 60th percentile--so between 60 and 50 percent of the cost-type contractors would meet the standards and between 40 and 50 percent would not. In the timeliness of claims processing area, we estimate that for any given quarter for the period October 1979 through June 1981, between 65 to 75 percent of the cost-type contractors would have met the experimental contract standard for processing 75 percent of the claims within 15 days.

QUESTION 2: Do you believe that the standards under the experimental contract standards are too strict?

ANSWER : The contracts do not provide for liquidated damages during the first 6 months of operations, so it would be fair to conclude that HCFA gave some recognition to possible transitional problems. Otherwise, the standards appeared to set goals for what would be considered "average" performance. It seems to us that if one objective of the experiments was to find out whether improved performance would result, it would not make much sense to set the goals or standards which were much below average.

QUESTION 3: In your opinion, are the criteria, currently in use sufficient to measure carrier performance?

NSWER : The criteria or standards currently being used to evaluate the performance of the Medicare contractors is part of the Contractor Performance Evaluation Program (CPEP), which became effective for the Part B carriers October 1, 1980. The standards for the Part A intermediaries became effective a year earlier. For both carriers and intermediaries, the standards consist of two parts. One part relates to the statistical standards which for carriers covers (1) unit cost of claims processing, (2) timeliness of claims processing, and (3) quality of claims processing. The second part relates to the functional standards which involve compliance with operational instructions in various functional areas such as beneficiary services and utilization review. The standards are imposed on an annual basis, although the progress in meeting the statistical standards are computed and reported quarterly and the HCFA Regional Office monitoring for compliance with the functional standards is an ongoing process.

Overall, we view CPEP as a significant improvement in HCFA's capability to measure and compare contractor performance. However, on the basis of completed or ongoing work we have reservations concerning the sufficiency of the carriers' CPEP standards in two areas. One area pertains to undetected underpayments to beneficiaries on unassigned claims where the submitted charge exceeds the allowed charge by relatively high percentage and dollar amounts. As discussed in a recent report

to Senator Chiles (HRD-81-126, September 3, 1981) HCFA's claims processing standards require carriers to identify for manual review and resolution those claims where submitted charges are reduced significantly for payment purposes. CPEP does not address how well carriers review these types of claims, but because they often involve underpayment situations, we believe it should.

The second area involves reviewing for the medical necessity of services claimed. Although this activity is covered in the CPEP functional standard pertaining to utilization review, we question whether it receives the attention or weight it deserves because our ongoing work has shown that this can be a very cost-effective activity.

QUESTION 4: How rigorously has HCFA applied these criteria in evaluating carriers?

ANSWER : As previously indicated, CPEP is a annual evaluation, which for the carriers became effective October 1980. Thus, the first evaluation period is for the year ended September 30, 1981. Although we have reviewed the methodology to be applied by the HCFA Regional Offices in perfonming these evaluations, we have not as yet had an opportunity to make detailed reviews at selected carriers as to how the prescribed methodology has been actually applied. Therefore, we do not believe we have sufficient information to adequately respond to this question.

Senator DURENBERGER. The next witness will be Dr. Paul Willging, Deputy Administrator of the Health Care Financing Administration.

While we welcome you here today and suggest that your statement in full will be made part of the record without objection. Please introduce your colleagues, summarize your statement, and we will worry about whether or not we have to vote while you are testifying.

STATEMENT OF DR. PAUL WILLGING, PH. D., DEPUTY ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION, WASHINGTON, D.C.

Mr. WILLGING. Thank you, Mr. Chairman. I do appreciate the opportunity to discuss with you today our experiences with our contracting strategy within the Department of Health and Human Services. I'm accompanied today by Mr. George Thompson, the Associate Administrator for Health Care Financing Administration for Operations, and by Mr. John Jansack, the Director of our Office of Program Administration which has responsibility for managing our contracts, both the cost contracts and the new experimental contracts.

I will summarize very briefly my written statement. I think I would start by observing that the decision in 1965-66 to go to private industry to process claims for the medicare program was, in retrospect, a very good one. I think the data, with respect to the cost of managing the medicare program, confirms that it was a wise decision; 1.8 percent of the total cost of the medicare program is accounted for in our contractor dollars—a very favorable ratio for administrative costs.

I think further that the decision in terms of how we structured that initial contracting system was a good one. We are talking about a major, new, complex program, a program which had, obviously, elicited some tension and concern on the part of the American health care industry. The decision to go to cost contracts, to include a nomination process, and to limit the contracts to health insurers, given that period, was, in retrospect, a good decision. Times have, however, changed. The program is much more complex. The program is much more costly. The decisions made in 1965-66 I do think warrant reconsideration.

The number of contractors we have is unwieldly even for a program this size. We have 109 contractors. That is too many. The nomination process prevents both certain kinds of consolidations and geographic consistency within State areas. And I think, in particular, the lack of an ability, other than through a demonstration process, to use the competitive forces within the system and to develop contracts on something other than a cost basis creates difficulties in terms of stimulating efficiency and innovation.

In 1977, we set out to demonstrate through our experimental authority a very basic hypothesis: That we could, indeed, achieve substantial, dramatic administrative cost savings by using something other than cost contracts by using competitive forces and at the same time maintaining, if not indeed improving, the level of service to beneficiaries and providers.

There is no question in my mind that we have proved that hypothesis. Certainly, there is no dispute even with our colleagues in the General Accounting Office that we have produced major savings in administrative costs.

The three contracts on the part B side alone will save over $50 million.

I think with your permission, Mr. Chairman, I would like to deviate briefly from my summarization and react to the testimony provided by the General Accounting Office.

Obviously, we disagree. The Department believes that the hypothesis has been tested; the hypothesis has been proven and we are ready now to move out with operational authority in terms of an ability to use as one of a number of tools available to us competitive procurement and other than cost-based contracts.

The GAO has suggested that it is premature to ask for that legislative authority. I think there are some problems with the GAO report. I think one of those problems is the fact that of our six experiments—most of which admittedly are still underway—the GAO has focused primarily on an admittedly difficult situation in the State of Illinois. I think we would agree with the GAO that the costs—the costs in inconvenience, the costs in terms of disruption to the providers, to the beneficiaries in the State of Illinois—were intolerable. Were we ever to anticipate undergoing that kind of a circumstance in the future, we would certainly be reticent about moving forward any more rapidly than we have.

But I think we have to look at the basic premises that we have been trying to test and see to what extent the Illinois experiment itself has either proven or disproven those premises.

I have already indicated that Illinois is only one of six experiments. I think that the problem we have with the GAO report is that it looks primarily at the Illinois experience with respect either to the contractual standards within the Illinois contract itself or in terms of a comparison with other national standards.

There is no question that EDSF has failed and continues to fail some of its contract standards. There is no question that even today EDSF is not among the best contractors in the part B program.

I think it is more important in terms of testing our hypothesis, however, to compare the situation in Illinois today with the situation in Illinois prior to this contract. I think we would see a somewhat different story when we make that kind of a comparison.

Even in terms of the contract standards, I think it important to note that in Illinois Electronic Data Systems Federal Corp., has standards in many areas which are higher than those that we expect our other cost contractors to meet. Its payment deductible error rate, for example. In order to avoid being assessed liquidated damages, EDSF has to achieve an error rate lower than that achieved by 50 percent of all of the other contractors. The same is true of the occurrence error rate. In terms of reviews, EDSF has to exceed standards achieved by other contractors.

Currently we have, I think—in most of the areas of greatest concern, the providers, beneficiaries and the Federal Government—a largely satisfactory situation in the State of Illinois. In terms of the timeliness of claims processing, for example, EDSF, has 13.7 per-

cent of its claims pending over 30 days. Its contract standard is 12 percent. It is failing its contract standard with respect to aged claims, claims over 30 days in the hopper. If the national average is 15.2 percent, here we have, I think, an example of a standard which is set very high in the State of Illinois. EDSF is failing that standard yet it is doing better than most of the other contractors on the average in the country.

I think it's important to bear that type of comparison in mind in addition to simply comparing of EDSF's abilities against its contract standards or EDSF's capacities against national averages.

I would like to focus very briefly again on one of the more critical points brought out in the GAO report—the overpayment error rates.

We have, as one of many standards in testing our contractors, one which relates the percentage of erroneously paid claims to the totality of the claims paid by a contractor. EDSF, for every $100 of benefits paid out to beneficiaries and providers, spends $2.40 of that erroneously. Yet in terms of the prior incumbents, Blue Shield of Illinois and Continental, the figure for Blue Shield was 2.6 percent; the figure for Continental was 3.3 percent. Now my suggestion is that we are in better shape even in terms of overpayments today in Illinois than we were under the previous cost contracts. Does that mean we are satisfied with the 2.4 percent error rate? Of course not. The national average is closer to 2 percent. We expect EDSF to reach 2 percent. Until they reach 2 percent, they will continue to be assessed liquidated damages according to the terms of the contract.

Are we satisfied with the amount of time it took to achieve the current status in Illinois? Of course not. I think it has been intolerable. The beneficiaries and providers in the State of Illinois have had to suffer the disruption, the inconvenience that they have—but does this, in effect, violate the basic premise of the hypothesis that we set out to prove. We think not.

We do know what went wrong in the State of Illinois. It had nothing to do with the concept of competition; it had nothing to do with the concept of using something other than cost contracts. We made mistakes ourselves in Illinois. We asked EDSF to undergo not only a major consolidation of large workloads and a fixed-price contract, but we asked them also to deal with massive new coding changes which in turn confused their own work force, which in turn confused the providers, and which in turn led to a backlog of claims and unacceptably high error rates.

We have learned from this. We have made some major changes in the way we undergo transitions with respect to experimental contracts. The problem in Illinois was the transition problem. We have changed our approach to testing the capability of contractors to assume those transition responsibilities. We have learned to test only a very limited number of changes when we move into one of these new environments. We will not combine testing consolidation, new coding systems, new telephone communications, and the like at the same time. We will limit the amount of risk that has to be undertaken in these kinds of changes. And we will allow much greater periods of time and assure ourselves that we are ready to go operational before we actually try to do so.

I think we know what went wrong in Illinois. We have applied the lessons learned in Illinois to the more recent demonstrations on the part A side in New York where we consolidated seven contractors into one. It became the largest part A contractor in the country with no problems in terms of transition.

We have consolidated workloads in the State of Missouri in a new experiment. No problems during transition.

Transition had been our problem in Illinois. We have learned from that. We don't anticipate that will happen again. We do think that the hypothesis has been tested; that the hypothesis has been proven. And we do ask the Congress to provide the legislative authority to allow us to use competitive procurements, to allow us to use other than cost-based contracts as one of the tools available to us to continue to manage as efficient a system as we can for processing medicare claims.

Thank you very much. I would be happy to respond, with my colleagues, to any questions you may have.

[The prepared statement follows:]

STATEMENT BY PAUL R. WILLGING, PH. D., DEPUTY ADMINISTRATOR

SUMMARY

One of the major goals of the Health Care Financing Administration is to provide the highest quality service to our beneficiaries at the lowest possible administrative cost.

Present medicare contracting mechanisms do not give us the flexibility needed to select and reimburse intermediaries and carriers in the most efficient way possible.

A number of studies have been conducted which have recommended changing the way in which HCFA deals with its contractors.

To pursue these recommendations HCFA has developed an initiative to formulate necessary changes in the medicare contracting process.

We are currently using our experimental authority to conduct a number of experiments to determine the most appropriate ways to select and reimburse contractors.

We have also undertaken a number of administrative actions under present law to improve cost contractor efficiency.

Mr. Chairman, Members of the Subcommittee. I am Paul R. Willging, the Deputy Administrator of the Health Care Financing Administration. With me today is George A. Thompson, Associate Administrator for Operations. We are pleased to be here to discuss our efforts to improve the administration of Medicare through changes in contracting techniques.

Mr. Chairman, there are 28 million aged and disabled beneficiaries who depend on Medicare for their health insurance coverage. The goal of the Health Care Financing Administration is to provide the highest quality service to our beneficiaries. To achieve this goal, HCFA has developed an initiative to pursue changes in the Medicare contracting process which would improve the quality of service to providers and beneficiaries, while simultaneously reducing costs to the Government. The major elements of this initiative are (1) a gradual reduction in the number of contractors through consolidation of workloads, (2) vigorous application of contract standards of performance, and (3) use of additional tools, primarily experimental competitive contracting, for selection and reimbursement of contractors.

BACKGROUND

In 1965, when the Medicare program was enacted, the Congress adopted as part of the Act an administrative structure which was compatible with the historical pattern of administration used by the private health insurance industry. The Federal Government contracts with public or private organizations to facilitate payments to providers of services and beneficiaries. These organizations are known as intermediaries under part A and carriers under part B. Federal funding for Medicare contractors has increased from $93 million in 1969 to $625 million now requested for 1982.

Medicare intermediaries and carriers perform the same basic function in the adjudication of claims (e.g., claims review and payment, medical review, beneficiary services, etc.) and provide similar support services such as professional relations, financial accounting and statistical activities. In addition, intermediaries handle provider reimbursement and audit. Provider reimbursement activities include establishment, review and revision of interim reimbursement rates and periodic interim payments, recoupment of overpayments, and consultant services to providers in establishing and maintaining provider accounting systems. Provider audit includes auditing, final cost settlements, and appeals as they relate to settlements.

Medicare intermediaries and carriers are selected without competitive contracting and are reimbursed for their administrative costs under the basic principle of no excess profit and no loss. Intermediaries and carriers are paid a profit allowance equal to the return on their non-Medicare business. These contractors are not at risk with respect to program benefit payments as these payments are entirely underwritten by the Federal Government.

The original Medicare legislation provided two methods for the selection of contractors. In selecting carriers under part B, the Department had the authority to enter into contracts with private and public insurance companies to handle physician services. Carriers were selected by the Department and assigned to serve specific geographic areas as determined by the Department. The Department was specifically exempted by law from Federal competitive bidding requirements in selecting carriers. Initial carrier selections were based on the insurance company's experience in health care reimbursement and its financial stability. Currently, there are 41 carriers.

The method of selection of intermediaries under part A was through a nomination process whereby hospitals, skilled nursing facilities, home health agencies and other providers nominated an organization through which they wished to deal with Medicare. Providers also had the option to deal directly with the Department. Upon notice to the Department, a provider could change its intermediary; thus, a provider could "shop" for an intermediary that met its needs. Under the original Medicare law, the Government could not require providers to use a particular intermediary, since to do so would violate the providers' rights under the nomination provision.

The enactment of Public Law 95-142 in 1977 gave the Department some flexibility with respect to the nomination and termination process. These amendments authorized the Department to assign and reassign providers to available intermediaries subject to certain appeal rights, and to designate regional and national intermediaries for a single class of providers (e.g., home health agencies) when it is in the best interest of effective and efficient program administration. Thus, a provider might not be serviced by the intermediary which it originally nominated. Where a provider is assigned to another intermediary, the intermediary does have the right to appeal.

As a result of the original nomination process, the Blue Cross Association (BCA) was selected as fiscal intermediary by the bulk of hospitals and by substantial numbers of skilled nursing facilities and home health agencies seeking participation in the program. A prime contract was awarded to BCA which in turn subcontracted with its local Blue Cross Plans around the country to perform the actual functions required of an intermediary. The remaining provider groups and other individual providers nominated commercial insurance companies or the Government. Currently, there are 68 intermediaries.

The administrative structure under which the Medicare program operates was originally adopted to insure a smooth and timely acceptance and implementation of the program. Providers were afforded an opportunity to actively participate in program implementation through the nomination process. The private health insurance industry became active participants in performing intermediary and carrier functions. The noncompetitive approach to selecting contractors and awarding contracts and the reimbursement of all reasonable costs provided an incentive to private and public insuring organizations to participate.

PROBLEMS

The existing structure served reasonably well the needs of the new program. However, after 15 years the special needs of a new program—gaining provider acceptance and providing needed flexibility to achieve quick implementation—are no longer the critical problems facing the program.

More important now are the demands of an ever increasing workload, initiatives for cost containment, developments in technology, and the need to increase beneficiary understanding and effective use of this complex program. There is substantial

evidence that the use of Medicare cost-based contracts as the single contracting appoach does not provide sufficient incentives for efficient, innovative, and cost-effective operations. In 1980, for example, Medicare part A unit costs ranged from $2.66 to $6.08 per claim among the contractors. Similary, part B claims ranged from $1.88 to per claim.

Because contractors are reimbursed for whatever reasonable costs they incur and receive a guaranteed profit on their investment for Medicare administration, they have no financial incentive to be innovative in attempting to improve services to beneficiaries or in saving money. Moreover, the lack of flexibility and authority in the contractor selection process prevents the Government from testing the range of available alternative mechanisms, and choosing those which seem more likely to achieve program objectives.

Thus, the intial administrative structure which addressed original program needs is no longer appropriate in today's environment. The contractor geographic configuration determined in 1965 is very unwieldly today. Differences in workload mix, volume and efficiency have affected the cost of operations among contractors. Under part A of the program, the opportunity for providers to nominate and change intermediaries at any time creates conflicting pressures for the intermediary. If an intermediary audits bills and cost reports diligently, the provider may well seek another intermediary.

Basic principles of public administration and sound business practices suggest that the Government is best able to serve the public when freed to contract with those entities able to do the job at the best price. In contrast, the current system, where this flexibility is very limited and contractors are paid on a cost-plus basis, must deal constantly with problems of performance, costs, and conflicting pressures.

A number of groups which have studied Medicare contracting mechanisms have recommended basic changes. In 1974, the Advisory Committee on Medicare Administration, Contracting and Subcontracting (the Perkins Committee) recommended the development of incentive mechanisms to assure higher carrier performance and experimentation with competitive contracting.

In 1978, an internal HCFA "Steering Group on Administration of Medicare/Medicaid Programs" recommended: combining administration of parts A and B; reducing the number of contractors; eliminating the nomination process; and selecting contractors on a competitive basis to enhance coordination, improve program management, contain administrative and program costs, and promote effective delivery of services to providers and beneficiaries.

In 1979, the General Accounting Office's report, "More Can Be Done to Achieve Greater Efficiency in Contracting for Medicare Claims Processing," contrained various recommendations aimed at achieving more efficient and economical claims administration. One of GAO's recommendations was that HCFA should experiment further with incentive contracting on either a cost or fixed-price basis.

In 1980, the President's Management Improvement Council recommended that we proceed with the legislative initiative to authorize a comprehensive approach to Medicare contracting. Other recommendations were to develop a full Medicare contracting position, and to consolidate Medicare contracts based on optimum workload volume, combining part A and Part B claims processing.

In accordance with these recommendations, HCFA developed its initiative to change the non-competitive cost-based Medicare contracting program to improve the quality of service to providers and beneficiaries at reduced cost to the Government.

EXPERIMENTS

I would now like to discuss the experimental contracts. The basic goals of our experiments are to provide a better level of service to beneficiaries at the lowest possible administrative cost. To meet these goals we disigned a series of experiments to identify the optimum contract workload.

Develop the best means of selecting and reimbursing contractors, and develop more approriate methods of encouraging contractor performance through the use of positive and negative incentives. We have learned a great deal from our experiments which will help us to improve Medicare contracting arrangements. Exploration of these issues will involve a limited series of projects designed to test specific contracting variables in both part A and part B of Medicare.

PART B EXPERIMENTS

In December 1978, HCFA completed a two-year, negotiated contract with the incumbent carrier, Maryland Blue Shield, to test reimbursement for Medicare administration on the basis of a fixed rate per claim.

In 1977, Maine became the site of the first part B experiment to test selecting carriers on a competitive basis and to reimburse them on a fixed price basis with liquidated damages as a mechanism to encourage high quality performance. Massachusetts Blue Shield won the competitive fixed price contract which ran from December 1977 through September 1981 (3 years, plus a 1 year extension).

In 1978, HCFA decided to embark on a part B contracting experiment in the State of Illinois to test consolidation of two large carrier workloads, to further test contractor selection by competition and reimbursement on a fixed price basis, and to test opening up competition for carrier contracts to organizations other than health insurance companies. On March 31, 1978, we issued a detailed Request for Proposals. After formal evaluation of all proposals, Electronic Data Systems Federal Corporation (EDSF), a nonhealth insurance organization, was awarded the contract. Actual claims processing commenced on April 1, 1979 when EDSF assumed the workload for Cook County. Thereafter, on July 1, 1979, it assumed the workload for the remainder of the State.

The third competitive fixed price contract was in upstate New York. The purpose of this experiment was to further test consolidation of carrier workload by the competitive selection process, fixed price reimbursement, and the use of the consolidation process to achieve greater uniformity in program administration in the affected geographic area. Under this contract, three incumbent cost-reimbursed contractors were replaced. One of the incumbents, Blue Shield of Western New York (BSWNY), was the successful bidder over one other incumbent and four other bidders. The contract covers the period November 1, 1978, through September 30, 1982, and became operational during June to October 1979 as the three previous service areas were phased in.

On October 1, 1981, the initial part B experimental contract for Maine with Massachusetts Blue Shield expired. The Maine contract was recompeted to test the market for recompetition and to test the addition of financial incentives to fixed price reimbursement as a mechanism for encouraging high quality performance. The recompetition was won by Massachusetts Blue Shield, the incumbent, and will run for three years with an option to extend for a fourth year.

PART A EXPERIMENTS

In 1979, HCFA decided to extend the experimental contracting program to part A in the State of Missouri and the Kansas City, Kansas metropolitan areas to test competitive selection, fixed price reimbursement, and liquidated damages tied to performance standards in the part A environment. The winning bidder was Blue Cross Hospital Services, Inc., of St. Louis. Through court action an attempt was made to stop the designation of the single contractor. However, the final ruling upheld our authority to conduct the experiment.

The second part A experiment is a negotiated fixed price experiment to test incentive payments for performance substantially exceeding expectations or assessment of liquidated damages for performance below specified levels. This contract was negotiated with Blue Cross/Blue Shield of Greater New York. During the period November 1980 to May 1981, the new part A central site, located in Syracuse, assumed the claims processing workloads of the seven previous part A subcontractors in the State.

COMBINED PARTS A AND B EXPERIMENT

A combined part A and B experiment had been initiated but delayed until recently by a legal challenge. The experiment seeks to combine the administration of Medicare parts A and B for the States of Colorado, Wyoming, and Utah under a single contractor. On November 1, 1979, as a result of litigation initiated by current Medicare contractors and hospital associations, HCFA was enjoined from proceeding with the fixed price procurement in these three Sates. The Department appealed the decision to the U.S. Court of Appeals and on November 20, 1981, HCFA was notified that the decision was favorable to the Government. We are now studying the decision and the Secretary will reassess and determine the future course of this experiment.

LESSONS LEARNED

As a result of the experiments conducted thus far, we have learned a number of very valuable lessons regarding competitive contracts that should improve future contractor transitions. First, we have learned that contractors can maintain a high

level of service to beneficiaries in a competitive environment as demonstrated in the Maine and New York contracts.

Second, competitive-bid contracts do result in cost savings for all of the experimental contracts let to date, we estimate we have saved $58 million over conventional cost contracts,

Finally, we have learned a number of important lessons concerning various contracting modes and how implementation of new contracts should be handled in the future. For example, we have learned that transitions to new contractors always raise potential disruption but can be managed effectively if steps are taken to minimize risks. Further, the operational readiness of the successful offeror should be fully and formally tested before it is permitted to become operational. This should include assessing the operational readiness of contractor staff by monitoring training programs and assisting the incoming contractor in the ordering and inventory of require HCFA forms.

In addition, during the transition process, attention should be directed toward assuring the new contractor's ability to provide superior beneficiary services and provider assistance.

For the operational term of the contract, it is essential that specified performance standards and levels of productivity be clearly established in the contract. HCFA monitoring of performance measures, such as number of claims processed, quality of claims processed and percentage of claims pending over 30 days snould be intensely pursued during the initial operational period.

These lessons have already been useful in managing transitions to new carriers outside of the experimental program and have led to specific actions in the Maine recompetition to build these risk protections into the Request for Proposals and transition management process.

In addition to these ongoing efforts to learn from the experiments, a formal evaluation of the experiments is being conducted by an outside contractor through our Office of Research, Demonstrations, and Statistics. This assessment will provide us with important information regarding the overall contracting experience and a better sense of how the experimental contracts interrelate.

ADMINISTRATIVE ACTIVITIES

In addition to our experiments, HCFA has also been engaged in other efforts to improve cost contractor efficiency. Some of the actions we are taking to achieve this goal include not renewing contracts with poor performers and contracting to consolidate workloads where appropriate. As a result of these actions, since 1979 we have reduced the number of contractors from 123 to 109. The carriers in Delaware and the District of Columbia have been replaced. Also, we have reduced one contractor's workload from 18 States to 3, and we are in the process of consolidating another company's workload so that it will be serving as an intermediary in 16 States instead of the present 36 States. In addition, HCFA with the support and help of BCA has reduced the number of Blue Cross Plans serving as Medicare intermediaries in New York from seven to one and in Tennessee from two to one. The number of carriers in Wisconsin was reduced from two to one, and after one carrier, South Dakota Blue Shield, withdrew from the program, North Dakota Blue Shield assumed their workload. We are also in the process of assigning home health agencies to regional intermediaries.

Within the constraints of the experimental authority under current legislation, HCFA has been able to demonstrate the benefits derived from introducing greater competition into the contractor selection process, reducing the number of contractors, and allowing contractor reimbursement on an other-than-cost basis with liquidated damages and incentive payments to encourage quality performance. We expect to use the "lessons learned" from our current experiments in designing new experiments. We will continue to take vigorous administrative action to nonrenew or terminate poorly performing cost contractors and reduce the number of cost contractors through nonrenewal of contracts and consolidation where this would improve the efficient and effective administration of the Medicare program.

In addition, we are reviewing contractor functions, procedures and performance standards, in light of current and anticipated budget restrictions, to ascertain those which can be reduced or eliminated in order to realize administrative cost savings without sacrificing the quality of services.

Depending on the results of our current activity in designating regional intermediaries for home health agencies, as now required by law, the potential exists for extending the use of the regional intermediary authority to other classes of providers, e.g., hospital or SNFs. The feasibility of such an initiative is the subject of cur-

rent study. While we intend to exercise more intensely our current authority to assign or reassign providers to intermediaries, the process is expected to take some time because of several technical requirements in the law.

During the next four years, additional experimental contracts are being planned to test other modes of selecting and reimbursing Medicare contractors. HCFA expects to develop a Medicare part A experiment which will provide for separate contracts for bill processing and reimbursement audit function. We are also looking at the possibility of eliminating individual claims altogether under part A and paying providers on an estimated basis prior to final settlement. Additional combined part A/B experiments are also planned as well as a part A/B experiment for the selection of a contractor to serve Puerto Rico and the Virgin Islands.

CONCLUSION

In conclusion, Mr. Chairman, we believe the experiments to date confirm the judgments of common sense, sound business practices, and the in-depth studies of Medicare contracting—that the Federal Government should have the authority to select Medicare contractors competitively, on the basis of quality and cost of services.

Mr. Chairman, this concludes my prepared testimony, I would be happy to answer any questions you may have.

Senator DOLE. Let me say we have a vote in progress. Senator Durenberger rushed over to vote so he should be back shortly.

Senator GRASSLEY. Well, as you stated, your testimony differs considerably from that of the General Accounting Office. But based upon what you know about the experiments you are ready to move forward and request the necessary legislative changes—and I assume that's what the administration did last March. Is my recollection right?

Dr. WILLGING. That's correct, Senator. I think that the legislative proposal which was essentially to remove the nomination process and to allow reimbursement on other than a cost basis is still viable. I think it is safe to say that we have learned considerably from these experiments. I am not sure we are as convinced today that simple fixed-price reimbursement is the way to go. I think we have to pay more attention to the background of those who bid for these contracts. Processing medicare bills is not simply a paper process. It is not simply passing pieces of paper through a computer system. There are beneficiary relationships; there are provider relationships; there is an understanding of health care delivery and financing that is critical to effectively managing a medicare contract.

We have learned from that. We would not perhaps implement the type of legislative authority that had been requested in exactly the same way that we would have implemented it 4 years ago for example, blanketing the country with nothing but competitively procured fixed-price contracts. The implementation plan, I think, has undergone some changes. But I do think we are ready for the legislative authority.

Senator GRASSLEY. You state that fixed-price contracting ought to be available as an alternative. But that would indicate that your Department isn't sold on it as the way of bringing the program dramatically under control.

Dr. WILLGING. Well, I would suggest that I think to the extent we are talking about the administrative processes, we do have the process under control. I don't think that changing the contracting approach within the Health Care Financing Administration will

deal with some of the much larger issues that this committee is concerned with. It will not change the approach we take to reimbursing hospitals, for example. It will not change the approach we have in terms of some of our coverage issues as far as medicare is concerned. I think it will provide a much more innovative, efficient system in terms of the actual processing of bills, and the reimbursement process within medicare.

Senator GRASSLEY. Have you changed your figures of projected savings from suggested cost savings that were available in your March statement to us.

Dr. WILLGING. We are reanalyzing the cost savings available in terms of how we would implement the authority. I think we have to look, as has been suggested in previous testimony, at contracts currently in place, even cost contracts, as to whether or not one actually saves money by going out competitively. As Mr. Ahart suggested, when we recompeted in the State of Maine, we perhaps did not save any money. We had a contractor performing very well there. We have some very good performing cost contractors in the program. We have to ask ourselves—and this is currently being analyzed within the Department—the degree to which one should be perhaps more flexible in terms of where one applies this tool. Does it make sense to go out and compete where you have a well-performing contractor when the costs are perhaps going to be higher simply because of the cost of preparing bids? Perhaps not. That's the sort of thing we want to look at in terms of reanalyzing the figures. However, there will be savings over time, I think there is no question.

I think that the very availability even under an experimental authority of different contracting mechanisms have contributed to a dramatic reduction over time in the cost of processing claims in medicare. In 1976, it cost us $3.14 to process a part B bill. In 1980, it cost us $2.61 to process a part B bill. I think simply having the tools available to us instills a discipline and an integrity in the system which will be beneficial across the entire array of contractors even those not competitively procured.

Senator GRASSLEY. Maybe I was misjudging what I thought was obvious, but wasn't the goal of the experiments to find out if we wouldn't be saving money?

Dr. WILLGING. The goal was to find out if we could save money and at the same time maintain an acceptable level of service. We will save money.

Senator GRASSLEY. But there was no idea that we would come up with a cost-fixed contract and move forward with it if it was more expensive; was there?

Dr. WILLGING. I think that to be quite frank in terms of the Health Care Financing Administration, myself included at that time, that we were looking at a concept and I would describe it fairly frankly as being competition for competition's sake. I think where I have reanalyzed my position, as have many of my staff—the issue now is the best possible service at the lowest possible price. That does not always mean competition. And, indeed, I suspect that having gone out and recompeted in Maine, it may not have been the best approach to take.

Our problem is that in the absence of the broader legislative authority, we had no choice but to recompete in Maine if we wanted to maintain a fixed price contract since we don't have the authority to develop noncost contracts on a negotiated basis.

Senator GRASSLEY. Well, then 2 years ago it left open the possibility, under the concept of competition for the sake of competition, of moving forward even if it did cost more money.

Dr. WILLGING. I think we perhaps did not think it through that well at that time, sir.

Senator DOLE. Since we are in the second round of voting, I think we will temporarily recess. Senator Durenberger is on his way back.

Before I left, I just pulled out a report from 1970 which then estimated—in 1965 it was estimated that by 1990 medicare would rise to the figure of $8.8 billion. It's now over $50 billion. We really have a responsibility in this committee to address this runaway program. And we are going to pursue every idea we can to save money. We must. I think Senator Durenberger wanted to go into that in more detail. But we will stand in recess for about 2 minutes.

[Whereupon, at 10:46 a.m., the hearing was recessed.]

AFTER RECESS

Senator DURENBERGER. I don't know how many of my colleagues will get back. In the meantime, I will continue the questioning.

What is the value of HCFA in this process? You are in effect, asking us to trust you on the basis of the GAO recommendation and what we have seen so far. You are asking us to trust you in an area which is easily misunderstood. For example, there is the publicity on the Illinois case and the situation over on the House side when there were hearings on competitive contracting. I'm on the Governmental Affairs Committee. One of my colleagues there, Senator David Pryor, is an expert on contracting. And he has made contracting out to be an evil part of the governmental process. You just have to trust those people out there to do public good if they are in the for-profit business or something like that.

So I feel, personally, that we have a lot at stake in competitive contracting as well as in what I spoke to earlier. But, in effect, you are asking us to put an awful lot of trust in your good judgment or in you as a person or as a new administration in HCFA or something else. And I would like you just for a minute or two to answer the question of why we should trust you.

Dr. WILLGING. Well, I won't ask you to believe that it is just because I am a nice guy, Mr. Chairman, although that is indisputably true. [Laughter.]

I think Congress provides us with legislation to implement. Congress has provided us, and we all recognize this in the medicare program, some strange legislation to implement. The way we reimburse hospitals in this country has not been the most efficient, innovative approach. You have spoken to that issue; the Department has spoken to that issue.

What you have to ask of us and what you legitimately ask of us in the Health Care Financing Administration is how good a job do

we do of implementing that legislation? How good a job do we do of paying those bills within the framework of the legislation provided us?

I think—and we don't take credit for this in HCFA alone, I think it is also our colleagues in the contractor community who have done a superb job to date of fulfilling that trust.

A program which expends only 1.8 percent on the administrative costs through contracting, I think, is a track record of which many industries would be proud. However, in terms of these specific questions before this committee—should we make changes in that contracting process? You shouldn't just trust us. You should test us as to whether we know what it is we are talking about. Do we know what went wrong in Illinois? Are we confident and are you confident that we know how to change what went wrong in Illinois? Should Illinois be used as the sole test as to whether we are ready to move on? Illinois is just one out of six demonstrations that we have conducted or are conducting thus far. We do know what went wrong in Illinois.

What went wrong in Illinois had nothing to do with the hypothesis of competitive contracting. I don't believe it had anything to do with the hypothesis of using contracts other than cost contracts. We made a bad decision in terms of coding in the State of Illinois. The contractor made a bad decision in terms of location in the State of Illinois. We tried to test too many things in Illinois: consolidation, large workloads, coding, new systems in terms of beneficiary inquiries. That was a mistake. We don't do that anymore. We do not intend to do that in the future.

But if you believe we know what went wrong and that we can avoid these mistakes in the future, then we would agree that we must avoid them. If we were to anticipate in any new operational approach to competition or to other than cost based contracts—if we were to anticipate the same 2-year disruption in every one of those, we would be no more anxious to move ahead than you would be to have us move ahead.

But we do know what went wrong. We believe the hypothesis has been tested. We think we are now ready to move, albeit, not in a massive, altogether within 2 year's approach but we are ready, now, to move into operational authority.

Senator DURENBERGER. OK. Let me ask you another question that is kind of a general type question, but it was part of the response of GAO to the question we have just discussed.

The reference to provider relations. This whole process. And the difference in the way we contract part A and part B. Discuss with me, just very generally, the problem of hospitals, in particular, I suppose, the value of good provider relations. And how that affects who should be making the choices or influencing the choices in this whole process that we are dealing with.

Dr. WILLGING. The question of provider relationships, Mr. Chairman, is clearly one that we have reassessed in terms of our experimental authority. It is critical. I must admit to my own failings in this regard. I came out of the medicaid program. I had dealt with the competitive structure in medicaid. All fiscal agent contracts in medicaid are competitively procured. But they are, to a considerable extent, claims processing types of activities.

Provider relations is a critical component of the functions performed by our medicare contractors. I think that that had been one of our biggest difficulties in Illinois.

In Illinois, 2 years ago, I don't think you could have found a provider who would have had much good to say about the Department, about the Administration, about EDSF, or about medicare in general. That has changed. And growing provider satisfaction is reflected not only in a number of our performance indicators, but in such indicators as the assignment rate in the State of Illinois. The number of physicians who are, in effect, willing to take assignment is now higher in the State of Illinois than it was before EDSF came on board.

We have also learned that we have to provide greater attention in our procurement process to the nature of the experience held by the vendors in terms of being able to bid for these kinds of contracts. The ability to push paper through systems is not sufficient. Price alone cannot be as critically viewed as we did in some of our previous contracts. Provider relations—a demonstrated ability to effectively deal with that function is indispensable.

Senator DURENBERGER. Let me ask you a couple of specific questions. You talked about consolidation in a general way in your opening statement. Tell me what you believe to be the real value of consolidation of intermediary carriers.

Dr. WILLGING. There are three values, Mr. Chairman. I believe the previous question about consolidation was perhaps interpreted differently than I would have. We have been doing an awful lot of consolidation. We would like to, in terms of future demonstrations, test combined A and B. But that is not where we feel consolidation can most fruitfully take place now.

When when we talk about consolidation, we are talking about combining a number of part B contracts in a State or combining a number of part A contracts. I see three values in that.

One is the fact that by increasing contractor workloads, in many areas, you achieve fairly dramatic economies of scale.

Second, we, within the Health Care Financing Administration, require less overhead resources to monitor those contracts.

And, third, we achieve greater geographic consistency in terms of coverage determinations, and in terms of the way we process bills.

We have done a fair amount of consolidation. We consolidated two part B contractors a couple of years ago in the State of Wisconsin. We consolidated two part A contractors starting last October 1 in the State of Tennessee. We have been pleased and gratified with the support provided us by the Blue Cross association in consolidations in the State of New York where we moved from seven contractors to one. And proposed consolidations in the States of Pennsylvania, Ohio and West Virginia.

We had, I believe, over 130 some contracts a number of years ago. We are now down to 109. There is only so far one can go with the present nomination process, however, in terms of consolidation. We are able to do it with the Blue Cross association because they are our prime contractor and essentially the subcontracts in the various States can be more easily consolidated with their support.

But we have more intermediaries than the Blue Cross association. That's the reason for our desire to remove the nomination

process, but not to move away from the concept that the familiarity, the ease of relationship, between the intermediary and the providers is still a critical function and is something that has to be preserved even if not through the formal mechanism called the nomination process.

Senator DURENBERGER. May I ask you if you have considered implementing any kind of a system of either cost or performance incentives for negotiated fixed-rate contracts?

Dr. WILLGING. Without legislative change, we may not do that, Mr. Chairman.

Senator DURENBERGER. I understand that, but would you recommend that we consider appropriate legislative authority to prevent that?

Dr. WILLGING. That is part of what we are looking for. There are really two separate issues. One is the method whereby we procure a contractor, competitive versus noncompetitive. The other is the method whereby we reimburse a contractor. They do not necessarily have to go hand in glove. Even in terms of our experiment in the State of New York with Blue Cross/Blue Shield of Greater New York, we did not use a competitive process to procure that contractor. We did, however, use a different reimbursement process where there are incentives and disincentives built into what is essentially a fixed-price contract. Yes, that is the kind of authority we would be looking for.

Senator DURENBERGER. Let me ask you a related question. One of the policy issues we will soon address—it will be forced on us in some fashion either by the reaction to the budget cuts or forced on us by Governors, State legislators and a lot of other people—is making some general decision about the Federal role in income security.

As you well know, most of the Governors in this country have taken a strong position in favor of federalizing a large part of the income security system. Specifically—as it relates to this committee—such programs as AFDC and medicaid.

On the other hand, the President, with his experience in California and with the advice of persons who led him through that experience, Mr. Carlson, has taken the position that you cannot federalize needs-based systems. And as long as I have you here with your own background, let me ask you if you have some general views on the possibility of federalizing completely the public subsidization of health care. To what extent is it important to have someone besides the Federal Government interested in efficiency, effectiveness and cost?

Dr. WILLGING. Mr. Chairman, you don't expect me to answer that question, do you? [Laughter.]

I will try to be circumspect, prefacing my remarks with a statement that they are personal in nature and only personal in nature.

I have spent some time in the medicaid program. There are clearly in terms of a broader attempt by the Federal Government to deal with the totality of the health care financing system in this country, advantages if the Federal Government could deal with them together with the same kind of authorities.

In terms of medicaid specifically, however, it is a State-based program. And it is with the exception of problems we have had in

some States, reasonably well managed. It is much different from medicare in that it is better able to deal with the particular circumstances in given States. That is the beauty of medicaid with respect to optional services; and with respect to the provisions for the medically needy program; with respect to the provisions in terms of reimbursement. I would like to think that we have incredible advantages accruing to us from the fact that there is a program like that attuned uniquely to the needs of States and localities. I would think that that should not change. And I think that is as far as I safely would choose to go on that question.

Senator DURENBERGER. I want you to feel free to respond in a personal way—as opposed to an official way. [Laughter.]

Dr. WILLGING. This is off the record, Mr. Chairman? [Laughter.]

Senator DURENBERGER. Let me ask you just to add an observation as it relates to a particular category of persons. I am talking about those who are medicare eligible. The interplay between our medicare program and our medicaid program is creating substantial problems for medicaid. Specifically, I think, and for the States. Would you have some general, and again personal, comments as to whether or not a stronger Federal role would not be more appropriate for that category of persons?

Dr. WILLGING. Well, we already do have a large number of dually entitled citizens. Approximately 4 million are eligible both for medicare and medicaid. I think in the absence of any basic legislative and structural change in the nature of the programs, there still is a broad arena of activities available to us to make life easier in the case of those particular individuals, even in the more mundane area of claims processing. It is very difficult the way we currently structure the system. Difficult for the providers, difficult for the beneficiaries to deal with two separate programs.

And even more confusing when one takes into account the fact that reimbursement differs across those programs. In terms of the areas of demonstration, we have in front of us things we would like to do above and beyond the six that have currently been conducted. We would like to look for ways wherein the individual or the provider would submit only one bill to one program or the other, to make it as easy and smooth a process as possible. That won't change the nature of the benefits, of course. That won't change the nature of the reimbursement system. But within our purview, within our present authority, I think we can at least minimize the burden, the inconvenience on the beneficiary. And that is where we would like to move in the future.

Senator DURENBERGER. Thank you very much for your testimony.

Dr. WILLGING. Thank you, Mr. Chairman.

[Responses by Dr. Willging to questions by Senator Durenberger follow:]

DEPARTMENT OF HEALTH AND HUMAN SERVICES,
HEALTH CARE FINANCING ADMINISTRATION,
Washington, D.C., January 26, 1982.

Mr. ROBERT E. LIGHTHIZER,
Chief Counsel, Committee on Finance,
Washington, D.C.

DEAR MR. LIGHTHIZER: In response to the request of Senator David Durenberger, enclosed are our answers to the questions relating to the December 8, 1981 hearing

on competitive contracting for the administration of Medicare claims. If we can be of any further assistance, please advise me.

Sincerely yours,

PAUL R. WILLGING, PH. D.,
Deputy Administrator.

Enclosure.

ANSWERS TO QUESTIONS SUBMITTED BY SENATOR DURENBERGER

Question 1. On what basis did you select the locations for your experiments? Was the ability to project the results a factor?

Answer. Each of the areas selected for the experimental contracts was a deliberate decision to test specific variables.

In the Maine Part B experiment, HCFA was testing the economic efficiencies attendant to competitive selection of a contractor for a relatively small volume area where a cost contractor had voluntarily withdrawn from the program.

In the Illinois Part B experiment, HCFA tested the ability to improve services and reduce cost to the Government by combining the territories of two Medicare cost contractors into a single competitively selected contractor.

In Upstate New York, Part B experiment, HCFA tested the administrative and cost efficiencies of combining the territories of three Part B contractors operating in the same State under a single competitively selected contractor.

In the New York Part A experiment, HCFA sought to test the viability of a negotiated fixed-price contract with incentive payments. This experiment also reduced the number of subcontracting Blue Cross Plans participating in the Medicare program in the State of New York from 7 to 1.

In the Missouri Part A experiment, HCFA was testing the viability of using a competitive procurement to combine the territories of 5 intermediaries under a single contractor.

The proposed combined Part A/B multi-State procurement, affecting State of Colorado, Utah and Wyoming sought to test the economies of scale and efficiencies of expanding the competitive procurement to select a single contractor to serve the combined Medicare workloads for the Part A and Part B of the three States.

This project was delayed due to litigation. However, the Government has received a favorable decision from the United States Appellate Court and is, therefore, now reassessing this project to determine the future course of action.

Question 2. In your statement, you indicated that HCFA has developed an initiative to change the noncompetitive cost-based Medicare program. Please explain the alternative approaches included in your initiative. Do you believe a legislative change is needed? If so, what do you intend to propose?

Answer. This initiative will be included in the Department's fiscal year 1983 proposals. We will respond as soon as possible with details.

Question 3. How appropriate would a change in the law be at this time considering that the results of the ABT Associates evaluation of the experiments will not be completed until the end of September 1982?

Answer. This initiative will be included in the Department's fiscal year 1983 proposals. We will respond as soon as possible with details.

Question 4. Some of your experiments seem to be testing several factors such as competition, fixed price, use of incentives, and consolidating service areas and contractors. How will HCFA determine which factors led to the various experimental outcomes?

Answer. The relationship between some of the factors and outcomes has become evident through informal evaluations. For example, it has already been demonstrated that competitive contracting is a viable alternative to current contracting methodology, and that prospective contractors have displayed interest in engaging in the competitive process. Administrative costs can be reduced without degradation, and often with improvements, in service to both beneficiaries and providers.

Contracts with positive and negative incentives have produced innovations and operational methodologies that were heretofore not seen in cost reimbursement contracts. Initial operational problems have been encountered in consolidating service areas and contractors, but they were corrected.

The relationship between the factors and outcomes will be formally addressed in an evaluation contract awarded on September 29, 1981 to an outside consultant—The ABT Associates Inc., 1521 New Hampshire Ave. N.W., Washington, D.C. 20036. Report is due in late September or October of 1982.

Question 5. When was the evaluation tool designed? Shouldn't this have been at the time the experiment was designed?

Answer. A program of continuous performance monitoring and evaluation was designed with the inception of Medicare fixed-price contracting. This program called for: regional office monitoring of the experiments and submittal of monthly reports; and periodic review of contractor performance by Central Office staff.

In addition to the ongoing evaluation by HCFA it was determined that an external evaluation by an independent organization was appropriate and awarded it to ABT Associates, Inc. with latitude to design the protocol.

Question 6. What efforts have you made to evaluate all the other carriers currently in place?

Answer. In the beginning of the Medicare program, contractor performance was measured and evaluated by central office performance review teams. This function was subsequently given to regional office staff in an effort to decentralize various organizational responsibilities. In 1972, regional office staff preparing Annual Contractor Evaluation Reports (ACERs) which are still prepared today and are based on the results of several reviews of each contractor done throughout the course of the year.

The Contractor Performance Evaluation Program (CPEP), developed, in part, in response to Public Law 95-142 (the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977), is a further refinement of earlier evaluation programs and currently serves as the performance evaluation system for all cost contractors, both Part A and Part B.

The objective of the CPEP is to enhance the quality of contractor performance through a system of contractor review and appraisal with respect to nationally mandated performance standards and criteria. HCFA regional offices have the primary responsibility for reviewing, evaluating, and determining the adequacy of contractor performance. HCFA central office focuses on achieving reasonably uniform results within the context of national ground rules governing review and evaluation policies.

Question 7. Is there a need for greater flexibility in future experiments to allow for adjustments in contract price, subject to negotiations for inflation and changes in workload? Would greater flexibility attract a great number of bidders?

Answer. In our negotiated fixed-price contract with Blue Cross and Blue Shield of Greater New York for operation of Medicare Part A in New York State are included provisions for negotiated adjustment in contract price due to inflation and substantial changes in workload. We plan to continue to experiment with factors that provide flexibility. We plan to have prospective contractors factor in projected inflation in their "bid price". We would, of course, also provide for negotiated adjustments for unforeseeable situations which impact the scope of the contractor.

Greater flexibility in contract terms would eliminate some of the risk involved in participating in an experimental contract and would probably attract more potential contractors.

Question 8. GAO has suggested that the Illinois experiment cost additional money because of the degree of oversight needed. Are you in agreement?

Answer. Because the nature of the earlier problems which surfaced under the Illinois contract, additional attention from HCFA was necessary to assure all corrective measures were completed. Comparable time and effort is directed to regular Medicare cost contractors that experience similar difficulty. The only information available on the overseeing and evaluation of EDSF contractor is an estimate from the Chicago Regional Office regarding its time. The Regional Office estimates that approximately 18.75 person years of regional office staff time for the period October 1, 1978 to June 30, 1981 has been devoted to this function for EDSF.

Question 9. How has the performance of those participating in the experiments compared to the performance of the cost-reimbursed contractors?

Answer. In the areas of costs of processing Medicare workloads, processing times and quality (Part B only) the experimental contractors compare very favorably with the cost contractors. The one exception is EDSF in Illinois. While EDSF did encounter significant problems in its initial performance as a Medicare carrier, it currently compares favorably with cost contractors in timeliness of claims processing and cost per claim processed. EDSF still has some problems in the quality area but continues to significantly improve.

Question 10. Given the special nature of the Medicare program, carriers and intermediaries are expected to do more than merely process claims and pay bills. Considering your experience with the experiments, should future contracts be limited to health insurers?

Answer. The Administration will address the issue of expanding Medicare contracting to entities other than the health insurers in legislation to be submitted to Congress in 1982. However, HCFA would anticipate continuing to permit qualified

organizations which are not health insurers to participate in HCFA's experimental contracting activities.

Through these additional experiments HCFA hopes to gain more knowledge of what is and is not feasible in contracting for Medicare intermediary and carrier services.

Question 11. Several years ago the Department of Defense converted its contracts with fiscal intermediaries under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) from a cost-reimbursable to competitive fixed-price basis, in which a set fee is paid for each claim processed. As part of this conversion process, the number of fiscal intermediaries was reduced from nearly 100 to 9. What can be learned from this?

Answer. HCFA is, of course, interested in learning from the experience of other components of the Government, such as CHAMPUS.

However, we must recognize that the CHAMPUS program is a much smaller program than Medicare and therefore not entirely comparable.

The CHAMPUS program has a smaller beneficiary population, addresses a different age group of beneficiaries, and has a smaller volume of claims and total amount of benefit payment.

Question 12. Have you considered implementing a systerm of cost or performance incentives or negotiated fixed rates with your current contractors?

Answer. Although these alternative approaches may be desirable, current legislation precludes us from reimbursing contractors on other than a cost basis. Only under the experimental contracting provisions have we utilized either of those approaches.

Question 13. Considering the favorable November 20, 1981 decision of the U.S. Court of Appeals regarding your experiments in Colorado, Wyoming, and Utah, why would you not proceed as planned?

Answer. HCFA does intend to proceed with a combined Part A and B experiment. However, since two years have elapsed since the initiation of the experimental procurement, we need to reevaluate whether the original site is appropriate. In addition, we must update the Request for Proposal (RFP) to incorporate enhancements applicable since the original RFP was released.

Question 14. What is your opinion of the suggestion in an OMB staff paper that 15 years of technological advances now offer alternative approaches to Part A processing, possibly eliminating the entire intermediary claim processing function?

Answer. We have studied that paper and agree that new technology might produce cost savings.

We currently have underway a major Medicare initiative which is evaluating various options for streamlining the Medicare program including those discussed in the OMB paper. We are planning to test some innovative approaches.

Question 15. What plans do you have with respect to the Office of Direct Reimbursement?

Answer. We are studing various methods to determine the future course of ODR's role in the Medicare Program.

Question 16. What is the value of consolidating intermediary and carrier operations?

Answer. HCFA plans to test this question in a future experiment. Some possible advantages are:

Reduced cost through combination of administrative functions.

Integration of functions that are common to the two programs, such as provider and beneficiary relations, utilization control and fraud and abuse activities.

Reduce the number of contractors in the program and the adjunct overhead cost.

Facilitate the Government day-to-day monitoring of contractor performance.

Senator DURENBERGER. The next witnesses will be Mr. L. E. Carter, second vice president, Travelers Insurance Co., Hartford, Conn., on behalf of the Health Insurance Association of America; accompanied by Mr. William C. White, Jr., vice president, The Prudential Insurance Co. of America, Millville, N.J.; and Mr. Frederick J. Malley, Jr., vice president of Equitable Life Assurance Society of the United States, New York.

Have there been any substitutions or absences? Mr. Carter, you can explain that to us.

STATEMENT OF L. E. CARTER, SECOND VICE PRESIDENT, TRAVELERS INSURANCE CO. HARTFORD, CONN., ON BEHALF OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. CARTER. Mr. Chairman, with me today is Fred J. Malley, as you have mentioned, vice president of the Equitable Life Assurance Society. Mr. William White can't be with us today because of illness.

We appear on behalf of the Medicare Administration Committee of the Health Insurance Association of America and the 11 member companies that have served as medicare carriers and intermediaries since the program began.

Because of the fact that we will not cover the entire statement, I would ask that it be included for the record.

Chairman DURENBERGER. I beg your pardon?

Mr. CARTER. I just asked that our written statement be included.

Chairman DURENBERGER. Without objection it will be, and you may summarize that statement.

[The prepared statement follows:]

STATEMENT OF THE MEDICARE ADMINISTRATION COMMITTEE OF THE HEALTH INSURANCE ASSOCIATION OF AMERICA, SUBMITTED BY L. E. CARTER, CHAIRMAN

Mr. Chairman and members of the Subcommittee on Health, I am Luther E. Carter, Vice President, Medicare Administration, The Travelers Insurance Company. With me are Mr. Frederick J. Malley, Jr., Vice President of the Equitable Life Assurance Society of the United States; and Mr. William C. White, Jr., Vice President of the Prudential Insurance Company of America.

We appear on behalf of the Medicare Administration Committee of the Health Insurance Association of America and the eleven member companies [1] that have served as Medicare carriers/intermediaries since the inception of the Medicare Program in 1966.

We appreciate the opportunity to present our view on this most important subject. Before addressing the specific questions raised by this Subcommittee—I would like to say that we are not sure that the questions you have outlined reach the crux of the problem, or that the changes being considered will bring about the desired results. It may well be that the problem is not with the contractors or the type of contracts. The Medicare program has been a successful cooperative effort in its joint administration by the Government and private contractors based on the contractual theory of no profit/no loss. In recent years, however, administration of the program has become so highly structured in a process oriented manner that there is little room for innovation or for contractors to manage effectively. The total administrative costs of the program in fiscal year 1981 were less than 2.8 percent, of which the Health Care Financing Administration utilized a substantial portion. (i.e., The total administative costs were $1,155,000,000. Of this HCFA costs were $461,000,000 and the carriers/intermediaries costs were $694,000,000. The total contractors' costs were less than 1.7 percent).

We strongly believe that the administration of the Medicare Program could be substantially improved if HCFA were to limit its activities to establishing policy, setting result oriented goals, and monitoring those results. This would enable substantial reductions at HCFA and would permit the contractors to operate in a more effective manner.

Should the currently used cost reimbursement method of payment be replaced by competitive contracts?

The clamor for a change in contracting strategies in recent years seems to ignore the successful development and administration of the Medicare Program since its inception. The percentage of administrative costs to total program costs is among

[1] Aetna Life & Casualty; Connecticut General Life Insurance Company; Equitable Life Assurance Society of the United States; General American Life Insurance Company; Metropolitan Life Insurance Company; Mutual of Omaha Insurance Company; Nationwide Mutual Insurance Company; Occidental Life Insurance Company of California; Pan American Life Insurance Company; Prudential Insurance Company of America; The Travelers Insurance Company.

the lowest in Government. Unit cost for claims processing has continued to decrease despite inflation, many program changes, etc. The recent abatements in program activities will even more dramatically reduce the cost.

We believe it is accurate to state that the Government's procurement policy is generally based upon obtaining the best price for the Government. This is as it should be, provided the Government is wise enough to interpret whether the best price is truly the best value. All too frequently, the lowest price disregards the quality of service and other essentials that go into the administration of health care services as can be seen so clearly in one of the experimental contracts administered by a data processing firm. In that instance there were demonstrated long delays in claim payments, poor beneficiary service, poor quality, high percentages of improperly paid claims, and allegations of administrative wrong-doing such as destruction of correspondence and records, improper counting of claims to avoid penalties, etc.

The Health Care Financing Administration has indicated that substantial savings would result from fixed price contracts; yet the evidence seems totally to the contrary. For example, the only experimental fixed price contract that has been rebid thus far is that for Maine. The initial contract was awarded for $2.88 per claim or about twelve (12) cents below the national average for cost type contracts. Recently, the contract was again offered for bid, and awarded at an estimated $3.30 per claim or sixty-eight (68) cents above the national average for cost type contracts.

While we continue to believe that the administration of Medicare under the present administrative structure has been of substantial benefit to the Government. We have realized the need for experimentation. We are, however, most concerned that this successful program is not permanently damaged by a major shift to contracting strategies which though not yet fully evaluated, have shown little evidence of success.

How would a system of competitive contracting affect the quality of service provided to beneficiaries?

This is one of the more crucial problems involved in rebidding the Medicare contracts on a periodic basis. There would be a constant upheaval in beneficiary services, and one need only talk with the beneficiaries in Illinois to gain a full appreciation of this impact. At best, beneficiaries are confused by the Medicare Program—They would just get familiar with interpreting one contractor's claim documents, then along comes another. Improved management of program payments and improvement of service to beneficiaries and providers will result only with a stable contract environment consisting of experience and successful contractors. We believe that widespread and hasty competitive contracting would cause a serious deterioration in beneficiary services.

Should a system of cost or performance incentives be implemented at this time?

Records will show that this Committee of the Health Insurance Association of America has strongly favored the use of incentives since the Medicare Program began. In 1978, we made a thorough study of Medicare contracting strategies and developed a model Cost-Plus Incentive Fee contract for the then Bureau of Health Insurance's consideration. To the best of our knowledge, this effort on our part was totally discarded in favor of fixed price contracting. We believe that Cost Plus Incentive Fee contracts offer advantages of cost benefit reduction to the Government as well as incentive to contractors to perform effectively and efficiently to realize a profit. These contracts would provide for more meaningful participation by experienced third party companies, while acknowledging that penalties may be, and should be, imposed for poor performance.

Could the number of intermediaries and carriers be reduced without adversely affecting the quality of services to beneficiaries?

The Health Care Financing Administration has indicated in various position papers that administration of the program could be improved by reducing the number of contractors. To our knowledge there is no hard evidence to support this. Some of the objectives stated by HCFA to support a reduction in contractors are debatable and may be in conflict with each other or the overall goals of maintaining a viable competitive contracting market place for the effective and efficient administration of Medicare.

While it may be argued that there are all too many contractors now, there appears to be no magic number that will assure effective and efficient administration of the program. The real test should be whether there now exists a number of ineffective and inefficient contractors. If so, then HCFA now has the authority to terminate such contractors.

What would be the effect of combining the functions of intermediaries and carriers in certain areas?

Assuming the provider nomination process was changed, there are other factors that must be considered before adopting a general overall policy of combining the administration of Medicare Parts A and B in geographic areas. While there are some common elements of the administration of Parts A and B, there are also many dissimilarities. The actual claims processing of the two Parts is completely different. In fact, because of these extreme differences, existing contractors that administer both Parts A and B generally have not found it to be cost effective to develop a common claims processing system.

A single beneficiary master record could provide improved coordination of clinical data, but because claims under Parts A and B are received at different times, significant use of the clinical data would have to be on a post-facto basis. Exchange of data between separate contracts for A and B could produce the same results. It may be true in some cases that a combination of Parts A and B under one contractor would reduce administrative costs, but this result is related to the contractor's workload volume, rather than to economies achieved as a result of combining the claims processing functions. It must be remembered that in Medicare Part A the contractor is dealing with institutional claims review, and all that implies, plus a careful audit of provider costs; while Part B involves a reasonable charge bill paying operation for professional services, durable medical equipment, and other personal supplies and services.

Intensive efforts to combine these areas could well be as counterproductive as the Health Care Financing Administration's efforts over the past several years to combine Medicare and Medicaid.

Should changes be made to the nomination process?

The Omnibus Budget Reconciliation Act of 1980 authorized the Secretary to designate regional intermediaries to handle Home Health Agencies. This process has not yet begun. Before any modifications are made to the nomination process for other providers, we urge that your Committee and HCFA fully evaluate both the cost and administrative effectiveness of this Home Health Agencies change.

In conclusion, Mr. Chairman, we believe that the current method of contracting for Medicare administrative services has been proven effective, both in terms of cost and performance. By all standards the program has been well administered. The contractor costs have been continually reducing and now amount to less than 1.7 percent. The experimental fixed price contracts have not proven effective either in terms of costs or performance. We do not recommend a change in contracting strategy other than possible consideration of Cost Plus Incentive Fee. There is an old adage that may be appropriate in this instance, "If it ain't broke, don't fix it."

We wish to thank you again, Mr. Chairman, for the opportunity to present our views on this most important subject. We will be pleased to respond to any questions you may have.

Mr. CARTER. Before getting into the specific questions raised by the subcommittee, we would like to say that we are not sure that the questions raised or the changes being considered will bring about the desired results. It may well be that the problem we are addressing here in the medicare program is not the type of contracts nor the contractors themselves.

It has been said several times today that the medicare program has been a very successfully administered one in the joint administration between the Government and the private sector. One of the things we would like to point out is that in fiscal year 1981, the total administrative costs of the program were about 2.8 percent. And I would like to further point out that only about 1.7 percent of that is involved in the contracting of medicare costs. In other words, you are only talking about 1.7 percent, not 3 percent.

A large portion of those administrative costs, of course, are consumed by the Government itself. We feel that this is an area which could receive some consideration. For instance, over the last few years the medicare program has become one that is very highly structured in a process oriented manner. We believe that if HCFA

for instance, were to limit their activities more toward establishing policy, setting goal oriented results or final results, and then monitoring those results, that substantial savings could be achieved.

I would say that HCFA, over the last few months, has been making some substantial progress along this line.

As to the questions themselves, about replacing the cost-type contracts with competitive ones, we think from what has been said here this morning and from our experience that all of this clamor to replace cost-type contracts completely ignores the successful development and administration of the medicare program to date. The unit cost for claim processing has constantly been declining in the face of substantial inflation and a lot of program changes.

The recent cutbacks in funds and the abatements of activities that are now taking place are going to show an even more dramatic drop in those costs.

We think it's fair to state that the Government's procurement policy is based on obtaining the best price for the Government. We agree with this as long as the Government is wise enough to interpret that the best price is truly the best value. Occasionally the lowest price disregards quality, and we think that has been very clearly demonstrated in the experiment in Illinois, and there's no point in rehashing the disaster that occurred there; it's been gone over several times this morning already.

HCFA is indicating that substantial savings could result from fixed-price contracts. I think that this is perhaps the most important point that we have to make today, that there has been only one of those contracts, so far, that has been rebid, and, as pointed out, that was in the State of Maine.

The initial contract was awarded at $2.88 a claim, which at that time was 12 cents below the national average for all of the cost contracts. However, recently this contract was again offered for bid. It was awarded at an estimated $3.33 per claim, or 68 cents higher than the national average for cost-type contracts. We think that this is a very important point that should be considered.

We, as an industry, are not against competition. I think the insurance industry is perhaps one of the most competitive in the country. However, medicare itself may well not lend itself to competition, by the very nature of the product. It's not like building tanks and planes, and as was pointed out earlier, you are talking about an infinitesimal part of the total program here—less than 1.7 percent.

We, as I stated before, do not feel there is a need to change contracting strategies and that the Government has received and continues to receive substantial benefits from the cost-type contracts.

As to how a competitive contract affects the quality of beneficiaries' services, we think that this is one of the most crucial problems involved. Were competitive contracts to be rebid on a periodic basis, you are going to have a constant upheaval in beneficiary services. One only need to talk to some beneficiaries in Illinois to get a full appreciation of that impact.

At best, the beneficiaries are confused with the medicare program. Were you to rebid these contracts periodically, beneficiaries are just going to get used to one contractor when along comes another.

We feel very strongly that the improved management of program payments and improved service to beneficiaries will result only where you have a stable contractor with experience and a successful track record in handling those beneficiaries.

As to cost or performance incentives, the records will show that this committee of HIAA has strongly favored the use of incentives since the program began. As a matter of fact, in 1978 we expended a great deal of time in developing a model cost-plus-incentive-fee contract which was submitted to the, then, Bureau of Health Insurance for consideration. To our knowledge, this was totally discarded in favor of fixed-price contracting.

As to the number of intermediaries and carriers, HCFA has on various occasions issued position papers indicating that the number of contractors should be reduced. We have found little or no evidence to support this theory.

Some of the objectives that have been stated by HCFA, we think, are debatable, are in conflict with one another, and in some cases would tend to eliminate the competitive marketplace that they strive to create.

There may be too many contractors; I don't know. I doubt that there's a magic number. But I think the real test of whether or not there's too many is, are the ones they have operating ineffectively or inefficiently? If they are, then HCFA now has the authority to eliminate those contractors, and we would certainly have no disagreement were that to be done.

As to the effect of combining the functions of intermediaries and carriers in given geographical locations, of course this would assume that the provider nomination process is changed. And even were that the case, there still are a lot of factors to be considered. When you are dealing in medicare, part A and B, there are a number of common elements in those two programs. However, we think there are more dissimilarities than there are similarities. The actual processing of claims under part A and B are really totally different. We have a number of carriers and intermediaries now who operate in given geographical areas, and generally it has been found that those contractors have not developed a common claim processing system because it simply has not been cost effective.

There could be some benefit from the coordination and use of clinical data. However, because of the very nature of part A and B, claims come in at different times, and it's almost an impossibility to coordinate that data. And even were this true, exchange of data between the existing contractors would produce the same result.

Senator DURENBERGER. Are we getting near the end?

Mr. CARTER. Yes, sir.

Senator DURENBERGER. Go ahead.

Mr. CARTER. Thank you.

We feel that a lot of effort to combine part A and B could be as counterproductive as the efforts have been to combine medicare and medicaid.

In conclusion, Mr. Chairman, we believe that the current method of contracting has been proven effective both in terms of cost and performance. By all standards, the medicare program has been well administered. On the other hand, the experimental fixed-price

contracts have not proven effective either in terms of costs or performance. We don't recommend a change and, to quote an old adage, "If it ain't broke, don't fix it." We think that well might be appropriate in this case.

We want to thank you for the opportunity of presenting our views. We would be happy to respond to any questions.

Senator DURENBERGER. Thank you. I will be happy to give you that opportunity. Let's start with "If it ain't broke, don't fix it."

That's a matter of perception, and one of the reasons that we have been going into these experiments, competitive contracting and so forth, is that one perception of whether the system is broke is whether or not we can afford to finance the accessories. A lot of people in the health care society are trying to find ways to expand the scope of our coverage and the quality of our coverage to as many as possible. So I take it, when you say "If it ain't broke, don't fix it," you are not saying that we should not be experimenting or exploring alternative methods of claim handling.

Mr. CARTER. We agree completely, Mr. Chairman, that experimentation should take place. I don't feel that the experiments thus far, though, have proven effective, or, more importantly, that they have been evaluated sufficiently to make a decision.

Senator DURENBERGER. All right. Now, that's the part I wanted to get to second, in terms of the evaluation.

You were here for the GAO and the HCFA testimony. We are now faced with making a decision between HCFA that says "Give us some legislative authority and trust us to use it," and GAO—a position that you apparently agree with, at least the major part—"We can't trust them yet."

How would you condense the principal objection that you have to our trusting HCFA at this point? Or would you have for us some suggestion by way of legislative language that would go along with their request for greater authority but set out some statutory guidelines so that we could trust that authority?

Mr. CARTER. I agree largely with the testimony of the General Accounting Office earlier, that HCFA currently has authority to make changes in contractors that are inefficient.

It was my understanding, contrary to Dr. Willging's statement, that HCFA does have the authority to go back—for instance, in the State of Maine, they did have the authority to go back and reinstitute a cost-type contract if it proved to be more cost effective than recompeting it.

Senator DURENBERGER. Do you believe they currently have that authority?

Mr. CARTER. That is my understanding. I could be wrong, and I may be subject to correction.

Senator DURENBERGER. Would they have, in your opinion, or should they have, at HCFA, authority to use cost-plus-incentive-fee and fixed rate programs simultaneously?

Mr. CARTER. I think only under the experimental authority that is granted to them under section 222, at this point in time. Yes, sir.

Senator DURENBERGER. All right.

Let me deal with something that you said in your summary, that probably ought to be clarified for the record in case the Chair misunderstood it. First, I think you said something that everyone can

agree with in this day and age about the approach the Government takes toward regulating behavior of society in this country that we ought to be more performance or results oriented rather than concentrating on telling people how to get to those particular results. In other words, we ought to be looking at what we got for our money and not how we got it. And as a general rule, it is one that I easily subscribe to in the whole area of regulatory reform, environmental health, safety, and so forth.

I would raise a question, though, as it relates to the access of people to health care.

It is certainly possible, in certain situations, for a contractor to provide us with an end result that saves us money compared to the way things were handled in the past. But that could be at the expense of, say, provider relations, the subject we got into a little bit earlier. And it could result in providers pulling out, thus denying persons access to health care.

So, would you in some way modify the general concept of performance orientation to say that maybe in this process we ought to look to some degree at how we get there?

Mr. CARTER. Harking back to something Dr. Willging said, obviously it's not a case of "just trust us." I think you will find that, in the case of the insurance industry, one of our major assets is our reputation. And the fastest way to lose that reputation is to provide poor service, Senator, to beneficiaries. And I believe the records will show that that's one area in which we have excelled over the life of the medicare program.

I'm not saying that others wouldn't do as well, but I think the experience that we have seen to date shows that, particularly in the area of beneficiary services, we have excelled in that area.

Senator DURENBERGER. Well, that's getting me to my final and related question, because I think I heard you say that one of our problems here is getting hung up between low bidders and quality. And I think the implication of what I heard you say is that you sacrifice quality to take a low bidder in this situation.

Mr. CARTER. Well, I guess we can only refer back to some of the experiments that have taken place to date. I think they have shown, at least in one instance, that that has been the case.

Senator DURENBERGER. But let's just take the insurance industry as an example. Is that what you would say about the health insurance industry in this country? They stay away from this contracting process? Is the low bidder always the one that delivers the least quality service?

Mr. CARTER. No. I would not say that.

Mr. MALLEY. I think, also, Mr. Chairman, in answer to that, I think we would shy away from that type of approach if it meant having an impact on our image, which is what Mr. Carter referred to earlier.

I mean, medicare, to us, constitutes such an insignificant part of our total business. You take our company, for example. It's about 1½ percent of our total business. It gets lost in the shuffle someplace along the line, and we are not about to jeopardize 98 or 99 percent of our business by having a poor performance record for the 1 percent on which we are making absolutely no profit. It would make absolutely no sense to us.

Senator DURENBERGER. And I am not in either the insurance industry business or the claims handling business, so I need to ask these questions. I have heard today for the one-thousandth time that the insurance industry is the most competitive industry in America. And I keep trying to find out what keeps the industry so competitive? Is it the fact that they can hold down the cost to the purchaser of their service, or is it that they are uniquely qualified to win out on the basis of quality of service? Or is it something in between?

The importance of the question is that in this experiment we seem to have several different types of contractors. We have insurance companies in some traditional sense, but we also have somebody like EDS, and then there may be others that I'm not familiar with. They are not in the insurance business, they are in the data processing business. I wouldn't want your characterization of the Illinois experience—you called it a disaster—to lead me to believe that only the insurance industry can handle experimental contracting because any other kind of a data processing industry always leaves the consumer with less than adequate quality.

On behalf of the industry, I would like to hear you speak to that issue, because it bothers me.

Mr. CARTER. I did not mean to leave the impression that because the Illinois situation happened to be handled by someone other than an insurance company that that was the only problem here.

I would refer back to something else in my statement, and that is the fact that medicare itself probably does not lend itself to competitive contracting—competitive fixed-price contracting—the reason being that it is so difficult to measure service, and it's so difficult to set up a contract that will cover all of the eventualities. The medicare program is a constantly evolving thing. There are program changes, regulatory changes, coming out on a daily basis. So it makes it extremely difficult to set that up on a fixed-price basis. That is the kind of problem I was driving at.

Senator DURENBERGER. All right. And that's what I wanted to give you the opportunity to lay out in the record.

Mr. MALLEY. I would agree, Mr. Chairman. We are not trying to contend that we are the only ones that have that expertise. I think, as Dr. Willging indicated, there are some of the early problems in Illinois that were due, perhaps, to the fact that the winning bidder on that particular procurement happened to have most of his experience in the data processing area. And as Dr. Willging said, there is a lot more to the medicare claims process than just putting things into a computer; there is the very important elements of beneficiary and provider services. EDS can defend themselves on this, but from my knowledge of them, they did not have that kind of background experience. I think they have come a long way now in accumulating that type of experience over the last 3 years, as has been indicated in the improvement in their statistics.

So what I think we have to be careful of is awarding one of these contracts to somebody that doesn't have that kind of background to handle the very important elements of this program on a going-in basis, because I think we will live to regret it. And 2 or 3 years is too long a period of time to have to wait to get things turned around to a satisfactory level.

Senator DURENBERGER. Senator Dole?

Senator DOLE. I have only one question. Did either of your companies participate in any of the Maine, Illinois, or New York bidding activities?

Mr. CARTER. No, sir.

Senator DOLE. You didn't consider that of any import.

Mr. CARTER. Do you mean the two companies that we represent?

Senator DOLE. The two companies you represent.

Mr. CARTER. No; we did not.

Senator DOLE. You did not. And the reason you did not?

Mr. MALLEY. Well, we saw fit not to bid on them because we thought the future of the medicare business was uncertain, at best. We already were involved in administering the program in four States. And until things settled down and it became a little more clear as to what the future direction would be, we opted not to bid.

Senator DOLE. What about Travelers? Did you think about it?

Mr. CARTER. Yes. We looked at the situation and felt that it just did not offer an opportunity to realize a profit and a very definite possibility of losing a substantial amount of money.

[Responses by Mr. L. E. Carter to questions by Senator Durenberger follow:]

THE TRAVELERS INSURANCE COMPANIES,
Hartford, Conn., January 4, 1982.

Mr. ROBERT E. LIGHTHIZER,
Chief Counsel, Committee on Finance,
Washington, D.C.

DEAR MR. LIGHTHIZER: Attached are the Health Insurance Association of America's responses to the seven questions arising out of the Hearing held on Dec. 3, 1981.

We appreciate the opportunity to include our comments.

Very truly yours,

LUTHER E. CARTER,
Chairman, Medicare Administration Committee,
Health Insurance Association of America.

Enclosure.

1. Do you feel that the experiments already initiated by HCFA, when completed, will provide us with adequate information on which to determine the appropriateness of a change from cost contracting?

We do not believe that the experiments currently underway will provide adequate information for several reasons:

HCFA has limited the Part B experiments to fixed price contracts. They have declared the experiments a success even though they have not been evaluated. The only experimental contract that has been rebid (Maine) resulted in a cost of 68¢ per claim (8 percent) higher than the average cost contract.

Little effort is being expended to assess the impact on program benefit dollars.

To our knowledge, the calculated "savings" do not take into consideration the termination costs of existing contractors, nor the costs to rebid the contracts.

The value of the cost contractors' assistance to HCFA (Technical Advisory Groups) is not being considered.

The impact of these contracts on the availability of contractors.

The difficulty in measuring the impact on beneficiary services.

The above list is not comprehensive. We are concerned that with the attitude displayed to date, the evaluations will be geared toward supporting an already preconceived goal.

2. What are your thoughts on legislation that would give the Department greater flexibility in determining the type of contracting needed? Perhaps allowing the Department to use cost plus, incentive fee, and fixed rate simultaneously?

Based on the findings of the General Accounting Office, and the fact that HCFA is only now beginning an evaluation of the experiments, the results are obviously

inconclusive. We feel that HCFA currently has adequate authority to continue experimentation, including other types of contracts.

8. You indicate concern for beneficiary services when there are periodic changes in the intermediary or carrier. How long should contracts be in effect? Would similarity in claims forms help in the transition? Is this possible?

It is difficult to state how long a contract should be in effect. On the one hand, it is not realistic to expect a contractor to forecast costs for beyond a three year period. Yet on the other, to change contractors on this time frame would be disruptive to beneficiary services, decrease contractor productivity, and incur large transition costs.

This brings us back to the basic question of whether or not Medicare lends itself to other than cost contracts. We think not.

We feel that, at a minimum, contractors should not be changed for a period of five to six years.

Medicare claim forms are now relatively similar. The major problem lies with the difference in the way the contractor works with beneficiaries and providers.

4. You mentioned a "cost plus incentive fee" in your statement—can you briefly give us more details?

Most Medicare contractors have preferred the cost reimbursement contracts because of our experience that the Medicare program does not lend itself to rigid fixed price contracting. We have, however, favored trying the Cost Plus Incentive Fee (CPIF) approach.

The CPIF contract is a cost reimbursement type with an opportunity for a fee based on a relationship of the total allowable cost to a target cost. The final fee is determined after completion of the contract. This type of contract offers mutual benefits to both parties. It would satisfy the contractor's concern about recovering its costs in face of an ever-changing program, and to earn a profit.

It also satisfies the government's belief that the assumption of some risk promotes better performance. The CPIF technique works especially well when the procurement is initiated on a sole source basis. This would alleviate the constant upheaval in beneficiary services and eliminating the substantial termination cost.

5. What is the form of your contracts with private industry? Do they pay "cost" for claims processing?

Our contracts with private industry are generally written on a risk basis whereby a rate structure is developed that takes into consideration previous and projected claim experience, administrative expenses, and potential profit.

Certain other plans (i.e., Administrative Services Only) are written on the basis whereby the policyholder assumes the liability and our companies basically charged a fee for service for processing claims. This fee includes both administrative costs and profit factors.

6. What is your opinion of the suggestion in an OMB staff paper that 15 years of technological advances now offer alternative approaches to Part A processing, possibly eliminating the entire intermediary claim processing functions?

It is our observation that this proposal was probably written by a computer systems analyst with little or no knowledge of the Part A Medicare program or the functions performed by the intermediaries.

It proposes to trade $150,000,000 (.8 of 1 percent) in administrative costs for an automated system with no concern for the program benefit dollars, i.e., it makes no provision for review and determination of coverage services, apparently allowing all costs claimed by a provider as long as some technical edits are met.

The paper addresses itself to the large automated hospitals and does not consider the large majority of providers that do not fall into this category (small, rural and specialty hospitals, skilled nursing facilities, rural health clinics, home health agencies, outpatient physical therapy facilities, etc.).

The paper suggests a direct operational relationship between the providers and HCFA. This has not proven to be effective in the past.

We are providing the OMB with a detailed response on why this proposal should not be considered. In summary, we feel that it fails to consider pertinent intermediary functions and neglects to consider the cost in terms of increased expenditures of program dollars, as well as the substantial impact on HCFA staffing and related administrative expenses. It is surprising to us that this proposal which is totally lacking in concern for total program dollars ever got beyond its first level of review.

7. One argument against the nomination process is that providers could "shop" for an intermediary that met their needs. What has been your experience in this regard?

Our experience is that providers do not "shop" for an intermediary that meets their needs. In reality, requests by providers to change intermediaries are few in

number. For a request to be approved, the provider must document and prove that such change would be in the best interest of the Medicare program. These requests are closely screened by HCFA and few are approved. We do not believe that this process has disadvantaged the Medicare program in any way.

Our next panel will be a trio of Blues: Bruce Cardwell, vice president of Government programs, Blue Cross and Blue Shield Associations, Washington, D.C.; Sheila Smythe, executive vice president, Blue Cross and Blue Shield of Greater New York, New York, N.Y.; John Larkin Thompson, president, Blue Shield of Massachusetts, Boston, Mass.

Senator DURENBERGER. All right. Thank you very much, gentlemen. I appreciate your testimony.

STATEMENT OF BRUCE CARDWELL, VICE PRESIDENT OF GOVERNMENT PROGRAMS, BLUE CROSS AND BLUE SHIELD ASSOCIATIONS, WASHINGTON, D.C.

Mr. CARDWELL. Thank you, Mr. Chairman.

I would like to start out, on behalf of the trio, by summarizing both the experience and the position of the Blue Cross and Blue Shield Associations and our member plans in the matter of medicare experimentation. I would like to offer also our suggestions and recommendations for further improvements in the administration and management of the program.

Both Ms. Smythe and Mr. Thompson are here because they both have had firsthand practical experience with two of the experiments. The thing that distinguishes their experience is that Mr. Thompson's experience deals with a competitively awarded contract under the Secretary's experimental authority. Ms. Smythe is experienced with a project that was initiated by the Blue Cross system itself and was negotiated around a fixed price, but also using the experimental authority.

I want you to have a full opportunity to hear from them, to ask them questions; but, as I say, let me cover some of the basic issues on behalf of all three of us and on behalf of our plans at large.

You have already been told now, by just about every witness, that this program has had a long and continuing history of growing stability. I would add to that our experience and my own personal experience, having been both in the Government and now working with Blue Cross and Blue Shield. I think it's the single Federal social service program that enjoys the most citizen confidence. And I think that in examining ways to improve or alter the administrative structure of the system we should keep the attitudes of consumers, beneficiaries, providers, and the citizenry at large, in mind. We should take steps that do not destabilize the system and steps that do not lower consumer confidence in it.

It's also been mentioned that the program has a record of growing improvement—self improvement. And that is beyond doubt. Mr. Willging said that much of the improvement had occurred just in the last several years. I would like to amend that by noting, and it's in our statement, that if you examine the program's record of performance both in lowering its cost of operations and improving its productivity you will find that throughout the 1970's, starting with 1970, in fact, and going through the end of the period, there are some remarkable achievements. The cost dropped 49 percent

after adjustment for inflation, and productivity went up 80 percent. If you examine those same statistics in terms of real dollars, no adjustment for inflation, there was still a cost reduction achieved over the period of 16 percent.

None of this is to say that there is not room for further improvement in the program's administration. There certainly is. The very nature of the program is that it changes, and so must its administration.

At the risk of covering points that have been made by others and that you, yourselves, may already have examined, I would like to just offer three observations: first, that there is a cost-versus-benefit risk involved in any change in an intermediary or a carrier. There is no clear-cut criteria. GAO doesn't have one, HCFA doesn't have one, and the contractors do not have one that can measure this risk in advance. In fact there is no guarantee that a replacement contractor will necessarily improve on or even match the performance of the original contractor. A price-motivated decision will not satisfy that question.

Next, as we have emphasized throughout our submissions to the committee, with every changeover there is a risk of disruption and dislocation. And if the experiments have shown anything so far, its the fact that that is one of the things that inherently follows a changeover in contractor.

On the point of the 1.7 percent of the total program costs that represent contractor expenses, we must appreciate that within that margin there is still a very narrow margin for further improvements. And the kinds of improvements we are looking for are not all within the control of the contractor. Many of them reside beyond his reach and have to do with the behavior of providers, the behavior of beneficiaries, and custom and culture in the community. So there is a very narrow margin within which we are working when we make these experiments.

The chairman had raised a question about perception, when someone suggested that the system was doing very well and if it wasn't broken, why fix it? I think there is an explanation why we came to be here, why we are talking about the role of competition as one possible way to improve or modify administration of medicare.

The first is that a fixed price offers new motivational incentives not found in cost reimbursement, that the contractors will, it is assumed, be motivated to find new and better methods to adopt advanced technology and to consolidate their operations, cut their overhead, and do all kinds of things that would cut costs, that the price will motivate the contractor to do that. Cost reimbursement, it is assumed, does not. I use the word "assumed" because I want to speak to each of these in a minute.

Next, the present configuration of medicare contractors consists of too many parts and pieces—there are 109 of them. Why must there be 109? Isn't that inherently too many?

And, finally, that the system should be more data processing oriented, that advanced data processing technology could bring efficiencies that would both cut costs and at the same time maintain the quality of operations and benefits. We don't agree that fixed price is necessarily the best way to motivate medicare contractors,

recognizing that Blue Cross and Blue Shield are nonprofit organizations.

We see the objective application of output-oriented performance requirements built into contracts, including cost requirements, as a more effective motivational force, at least for us. Such standards, coupled with peer pressure and our own self-image among the Blues and among other nonprofit contractors, we believe are powerful motivators. We think those motivators are actually now at work.

We don't disagree that there is room to improve overall efficiency by consolidating contracts and reducing the number of contractors. And I would like to go on record at this time to say that the Blue Cross and Blue Shield Associations are prepared, on their own initiative, to offer such consolidations to the Health Care and Financing Administration. And Ms. Smyths's experience represents an example of how that might be done.

Finally, we are quite prepared to acknowledge that not all of the contractors are good performers. And we certainly believe that the Secretary should, in fact he must, have a continuing program to drop poor performers.

And, again, we are prepared to come forward with our own programs within the present system to improve performance, including cost reduction.

Let me go next to the question of the issue of fixed price versus cost reimbursement. We would like to remind the committee, based on our experience, that we no longer have an operational cost reimbursement arrangement in place for medicare administration. Although the contracts are centered around the principle of cost reimbursement, they have evolved toward something that for practical purposes is really a modified fixed price.

This has come about because through the years the Government has learned how to seal off and limit the options of the contractor to exercise his own choices about how the work is performed. This is done in two ways: First, there is a budget that is agreed to in advance, and that budget is full and final. It cannot be changed and reimbursements will not be made above the budget amount unless they are pre-cleared in advance with the Government and, in effect, something equivalent to a change order takes place, although it doesn't carry that formal a label.

Second, the performance standards and criteria that have evolved and been put in place during the last 2 years are very process oriented. They tell the contractor what he must do, how he must do it, and in our opinion, and as one of the early witnesses said, we think that this approach to performance measument is going to, in the long term, inhibit cost savings and cost efficiency because it prevents the contractors from applying their own business experience and their own business acumen to the basic processes of the program. In other words, the Government tells the contractors what to do, when to do it, and how to do it.

So the idea that the Government just runs around and pays the contractors whatever the contractors say they spent should be put aside, because it does not exist. This is really, essentially, a modified fixed-price contract.

On the matter of the nomination process, we still believe that it is a useful device for determining and arranging for provider input in the business of how to select a contractor, will he have the capacity to perform, and the like. And we would urge the committee to keep in mind the important role that the provider plays in such processes. If it's not done through the nomination process, per se, it should, we believe, be done through some other arrangement.

I would close, Mr. Chairman, by noting that we are not concerned about competition in and of itself. We are a non-profit organization; we are mission oriented; we are not profit oriented. But, nonetheless, we are in business. And to carry on our community service and our mission, we have to succeed in business. And in that process we do compete with other people who are in the same business; we compete quite well.

We are holders of a large share of the health insurance system. We have succeeded in four out of the five highly experimental contracts. We have been the successful bidder. If this were to become public policy, we believe we could again succeed.

The question is: Should it become permanent public policy? Should it be coupled with some sort of mandated changeover of the system. We think not. We would recommend against it.

Senator DOLE. If the other members of the panel wish to give their statements now, we can then ask questions of the entire panel.

Mr. CARDWELL. All right. Why don't we ask Ms. Smythe to describe very briefly the experimental contract for the State of New York under Part A of Medicare?

Senater DOLE. Let me indicate, so you'll know what's happening, there is another rollcall vote, in process. So if you see some of us coming and going, you will know the reason. We still hope to make a good record.

STATEMENT OF SHEILA SMYTHE, EXECUTIVE VICE PRESIDENT, BLUE CROSS AND BLUE SHIELD OF GREATER NEW YORK, NEW YORK, N.Y.

Ms. SMYTHE. The seven Blue Cross part A intermediaries in New York State believed, after 15 years of the medicare program, that there were some changes that could be effected to the advantages of all of those in this important program. And so we and our prime contractor, the Blue Cross Association, approached HCFA with an unsolicited proposal.

Essentially, we believed we had a meaningful concept, which I'll elaborate on in a minute, which came at the right time, in the right environment, and which received a receptive audience in HCFA, also within the Blue Cross system, and among the providers, most especially, the hospitals.

But, most importantly, we believed that what we had conceived would be transparent to the medicare beneficiaries. We believed that this was all important as we watched some of the problems that had developed over time.

We also wished that our program would be geared to continue to serve this special and important population, and we engineered it to be staffed by personnel whose sole concentration would be to

continue to recognize the balance of the needs of HCFA, which were to have fewer contractors and lower administrative costs, with the needs of the providers who clearly would benefit from improved use of technology and other operating efficiencies, and also with the needs of our own Blue Cross philosophy and, apparently, that of many members of this committee; namely, that the program benefits, payments and services should at the least not be jeopardized and, at best, further enhanced.

Let me backtrack. The late 1970's provided changes in technology and methodology that set the environment in New York State for the 1980's and for the concept that we devised.

The technological advances in computer hardware and software have been addressed in many arenas of our society, and I will not dwell on them here. It is clear that they also advantaged the medicare program by centralizing certain of the core paper-factory type of functions. But further, in New York State, the upgrade in the coding of the hospital diagnosis to the ICDA version 9 had been completed in all the hospitals in the State. Furthermore, and very, very significantly, in New York State we had just implemented as a cooperative venture, heavily spearheaded by Blue Cross and including the State, the insurance industry, hospitals, and the Federal Government, a uniform hospital inpatient billing form which provided a common set of data elements, and also a uniform hospital discharge data set, which meant that all the information going to all payers from hospitals in the State were essentially using the same form, or at the very least the data elements.

Additionally, the State of New York was closer to completing the implementation of a single medicaid State-administered operation. And finally, and very importantly, more of the hospitals, especially the larger medical centers, had made advances in their own hospital computer operations, significant in terms of future savings to both the medicare programmatic and administrative costs and I think very relevant in terms of some of the things that have been talked about this morning, in that it is not just computers, it is not just paper, but it is a tie-in with provider audit, provider cost-containment and beneficiary services, that really gets to the heart of the medicare program and its effectiveness.

The heart of this concept, then, was to centralize some of the basic EDP paper-type activities while freeing the seven plans but under a single plan's management and instruction, to utilize their local expertise and hone their talents in the areas of cost containment, hospital audit and reimbursement, and beneficiary and provider relations at the local grassroots level.

In summary, our goal was to reduce administrative costs reasonably while making services more meaningful for providers and beneficiaries; further, to utilize the Blue Cross resources more effectively while not jeopardizing the savings in the 98 percent of the program benefit costs, and also to better serve the Government.

Lest I conclude by painting too rosy a picture, let me say that the path that has led here today has not been easy. It has taken long hours of discussion, a changing of views and a compromising on all sides, and a hammering away at allowing reasonable costs and time to allow for intensive planning and training, and a super-

abundance of communication before, during, and after the transition and implementation.

We were helped in no small measure by the providers, the hospitals most especially, who recognized our corps of professionally trained staff and were willing to cooperate and trust, and also the full support of the Blue Cross plans in the State, although it might have been perceived by some that they were losing some of their individual authority, and our understanding that at all costs it had to be, as I have said before, as transparent as humanly possible to the medicare beneficiary.

We invite you to visit the statewide program. We believe that, so far, we would consider the transition and early implementation and operation to be a cautiously optimistic success.

As Dr. Willging noted, we are today the single largest part A subcontractor under the Blue Cross Association prime contract. We process some 4 million claims a year under part A.

Thank you, sir.

Senator DOLE. I think what we'll do, so I won't miss the vote, we'll stand in recess again for about 2 minutes. And I think either or both Senators Heinz and Durenberger will be here in a minute or two.

Thank you.

Mr. CARDWELL. Thank you, Mr. Chairman.

[Whereupon, at 11:53 a.m., the hearing was recessed.]

AFTER RECESS

Senator HEINZ. Gentlemen, I am sitting in for the chairman of the subcommittee, Dave Durenberger, and I only heard a portion of your opening statements. I was here for some of Mr. Cardwell's testimony. I am informed, Mr. Cardwell, that you have completed your statements. I understand that your two associates may have some comments of their own. Is that correct?

Mr. CARDWELL. If the committee is interested, I would like to suggest that you hear from Mr. Thompson. His experience has had to do with the Maine competitively bid contract. It's the only one of the competitive contracts that has been rebid, and he was also involved in that rebidding process.

Senator HEINZ. Mr. Thompson, please proceed.

STATEMENT OF JOHN LARKIN THOMPSON, PRESIDENT, BLUE SHIELD OF MASSACHUSETTS, BOSTON, MASS.

Mr. THOMPSON. Mr. Chairman, I would like to offer just a few observations based on our Maine experience, without going over all of the testimony that has preceded my appearance.

We were the successful bidder in 1977, and again recently in the rebid process, in the State of Maine. It's worthwhile noting that in neither case were we the low bidder in the sense of the cost that was put in that element within the contract. In both of those instances we were the second-lowest, but experience factors in the bidding process generated us as the successful contractor.

We initially got involved in the Maine experiment because back in 1976 and 1977 there seemed to be a policy direction within HCFA that the entire medicare program was going to a fixed-price

competitive-bid process. And Maine offered the opportunity to get some experience in what is a different process from what we had experienced in Massachusetts. It was a reasonably small State, so the exposure was not unjustified from the standpoint of the experience to be gained.

It has been a very interesting experience for us, and I am pleased that it has been a satisfactory one, in the sense that my organization has performed well in Maine. Happiness in our business, in the words of Peanuts, is having a satisfactory fixed-price contract.

We rebid because we felt we had gained some experience during the 3 years and the option year, and felt that we would like to try again in that environment.

That aside, I think it's fair to recognize that there are some aspects to the fixed-price environment that I think as a policy issue are really quite troublesome.

Earlier testimony pointed out that the process by which we are evaluated, the process by which we either pay penalties or gain incentives, is a highly process-oriented process. There are some 97 elements that are being evaluated of our productivity on a quarterly basis; 97 different benchmarks to be measured to determine whether we've done well or not. I think you can appreciate that with that number of different criterion standard being applied, that at least the hope for opportunity for innovation is substantially diminished; because if we make an error, if we wind up being penalized, each penalty is some $10,500. You, as the contractor, wind up, to a certain degree, almost becoming myopic over the need to juggle these 97 interrelated points to make sure that no one of those lights goes off and trips your penalty.

Another part of the program that I think deserves special consideration was what would have happened had we not been the successful bidder second time around? We would have been disappointed, to be sure, but the providers and beneficiaries in Maine would have been faced with dealing with and interrelating to a whole new set of characters coming into the State.

When we first went in there in 1977, it was a difficult process. I was personally involved in meetings with representatives of the Maine Medical Society, the Maine Chiropractic Society, and a number of other provider groups and beneficiary groups. It was not an easy transition. They viewed Massachusetts as outsiders; they were uncomfortable that it was somebody other than an institution with which they had a relationship coming into their area. It was an extremely difficult process to gain a working relationship with those people.

In addition, it cost them some money, which does not appear and cannot appear in the GAO accounting process; but it cost the providers some money because they had to adjust to the changes we made in coding systems. That is disruptive to providers. Had we not won in 1981, the providers would then have been faced with a turnover of their carrier and going through that process all over again.

Fortunately, we have been able to maintain the assignment rate in Maine at some 60 percent. Maine has run at about that level over the entire period we have been there.

I am not sure, but I think it is something you have to consider very seriously, what happens to the assignment rate if you say to those providers, on a 3- or 4-year basis you are going to deal with somebody different, whether there is any opportunity to maintain that rate of assignment. And, at least on the part B side, the ultimate essence of the program as it relates to beneficiaries is the capacity to provide a high level of assignment to protect the beneficiaries.

Part of the testimony, in fact a substantial amount of it today, has dealt with the issue of generating a lower cost to the program by going through this route. Again, it's just interesting to note, at this moment, that the price in Maine is substantially higher on a per-claim basis than the price in Massachusetts. The Massachusetts part B program, which we also administer, is on a cost-reimbursement basis. Maine is on the fixed-price basis. And there is a differential today of some 45 or 50 cents a claim. The services we provide in Maine are more expensive than they are in Massachusetts—services to providers and beneficiaries. But if cost is the driving element, if cost is the issue that is going to control whether this becomes a permanent part of the medicare program, at least at this time the cost in those two contiguous States is less in Massachusetts than it is in Maine. It's somewhat of an anomaly, as you can see.

I would be pleased to respond to any questions, if you would like to put them forth. But I would like to reaffirm one point made earlier by Mr. Cardwell, and that is that there ought not to be any illusions that those people who are operating in the carrier environment throughout the country on cost reimbursements somehow have an open checkbook on the Federal Government. Our budgets are in fact fixed budgets. They are negotiated between ourselves and the regional office representing HCFA, and while the statute is written in the terms of reasonable cost reimbursement—and that's the standard that is applied—as a practical matter we come up with a prospective budget, and we have to live with it. If we spend over that, then it comes out of our pocket and not the Federal Government's. And that has been the practical experience, although the statute doesn't necessarily support that.

Senator HEINZ. Mr. Thompson, thank you very much. I do have a number of questions on behalf of myself and other members of the committee, but I am not going to ask them verbally because they may cover some of the issues which you addressed when I was not present. So I will, if I may, submit these questions to you for written responses to be included in the hearing record.

[Responses by Mr. James B. Cardwell and John L. Thompson to Senator Durenberger's questions follow:]

BLUE CROSS AND BLUE SHIELD ASSOCIATION,
Chicago Ill., December 23, 1981.

Attention: John Kern, Professional Staff Member.

Hon. DAVID DURENBERGER,
Chairman, Finance Committee,
Subcommittee on Health, Washington, D.C.

DEAR MR. DURENBERGER: Attached are the Blue Cross and Blue Shield Associations answers to questions posed by the Senate Finance Committee following our testimony of December 3, 1981 regarding Medicare Competitive Bidding Experiments.

Answers to the questions posed to Blue Cross and Blue Shield of Greater New York and to the Massachusetts Blue Shield Plan will be submitted under separate cover as soon as they are received.

The Associations would be pleased to offer its comments on any other questions the Committee might have on this topic.

Sincerely,

JAMES B. CARDWELL,
Senior Vice President,
Government Programs Division.

1. How would you describe the degree of support for competition among your members? Would they be inclined to support a system of positive and negative incentives without competition?

We would describe support among our Plans for the principle of competition as being high. Because it is the basis on which they conduct their businesses generally, Blue Cross and Blue Shield Plans have not objected to the principle of competition for use in the Medicare program, but rather to the specific structure, process and frequency utilized by HCFA in its experiments and advocated by the Administration in its recent legislative proposal. We do not believe the approach to competition which they advocate to be suitable for Medicare and its special characteristics and needs. Nor do we believe it can fulfill the claims and objectives of its advocates. In fact, we go further and predict that it would destabilize the program severely and that it would eventually drive up the program's overall costs.

In considering the questions, we would note that competition is already present in Medicare administration among the "cost reimbursement contractors" and is growing with the emergence of performance standards. Each contractor's performance is reviewed and evaluated in all aspects continually throughout each year. The evaluations are available to other contractors and to the public. That creates a peer pressure among contractors to improve performance. In addition, within each contract, all levels of management are concerned that their Medicare operation not be rated as a poor performer. Poor performance evaluations have to be explained to Boards of Directors and to the membership at large. Further, those contractors with consistently poor performance know they are exposed to nonrenewal of their Medicare contracts.

Review of general contractor performance over the last five years and longer will demonstrate consistent improvement in performance. We believe this is the result, in no small part, of competition among contractors for continuation of their contracts.

Use of the competitive principle, as employed in the current HCFA experiments, is of another sort. It has been overly preoccupied with price and participation by bidders with various backgrounds, and ignores the service and quality needs of the Medicare program. Undertaken on a large scale, this could undermine the program's stability and entail major risks of operational breakdowns.

We also call the Committee's attention to the fact that there have been instances, outside the experimental process, where cost reimbursement contractors have been selected through successful competitions, based on a weighing of cost vs. capacity. The selection of a Part B replacement carrier for Washington, D.C. is an example of this.

One consideration in evaluating either approach to competition or the concept of cost reimbursement itself is to recognize that current "cost reimbursement" contractors have limited opportunities to be innovative in their administrative duties. All contractors are bound to follow proscriptive and rather detailed General Instructions issued by HCFA covering all aspects of their contractual responsibilities. They are all obliged by their contracts to do things the same way and in the same timeframes. They cannot, therefore, introduce new and perhaps better and more efficient techniques which they have learned in their own lines of business, or which work better in a particular part of the country they are serving. We introduce this point at this time because we see this as a lost opportunity under existing law. In addition, when problems develop in Medicare administration, current contractors are not free to resolve the problem. Instead, they have to go through a complex and lengthy process of debate and clearance with HCFA. Contractors are required to raise problems with HCFA and to wait for a revised national policy and operational instructions before a change can be effected. This is also a lost opportunity for use of competitive performance challenges among current Medicare contractors—and the lost opportunity would not be eliminated by merely requiring contracts to be awarded competitively.

Our testimony has identified the complex interrelationships that exist in Medicare among the Government, the contractors, the health care providers and beneficiaries. In assessing the role and method of competition, these must be sensitively balanced to assure the smooth operation of the program, with due and balanced regard for cost efficiency vs. program effectiveness. Our general position is that evolutionary movement is a more desirable approach to administrative reform and that abrupt, widespread and periodic disruptions in what has been a generally well-operated and accepted program should be avoided—at all cost.

We believe the Plans would also support, in the great majority, the concept of positive and negative incentives with or without competitive bidding. Again, it becomes a question of how the idea is carried out. There are already positive and negative incentives at work within the present program. Good performance evaluations are a positive incentive for the current contractors, while poor evaluations are a negative incentive. The presence or absence of provider and beneficiary satisfaction and acceptance also represents an important incentive (or disincentive)—one that is now present in the program. Success in this regard with respect to Medicare is important to the Plans' general business reputation and success. The presence or absence of periodic operational crises and relationship problems are recognized by all Medicare managers at all organizational levels as being important. These serve as strong incentives to reach the highest possible levels of performance.

We assume the Committee's question is really directed at financial incentives and penalties. We find the basic idea to be acceptable, but are concerned about whether the idea is introduced abruptly and whether the specifics of such a technique would result in equity, balance and flexibility.

Use of financial incentives and penalties might possibly improve program administration. However, as with some of the other administative techniques that have appeared to have promise in the past, we would fear that this one might also become overblown, costly, excessively rigid and not balanced in terms of an equitable opportunity for gain on both sides. Its original promise might soon become lost to the burgeoning life and ends of the process itself. A careful examination of this technique as used in the current HCFA experimental competitive contracts should provide some early evidence of whether the idea will work well in practice. We are also interested in the evaluation of nonfinancial incentives in the case of non-profit contractors.

2. Are the current standards that the intermediaries and carriers are measured against sufficient?

In our opinion, the answer is no. We find HCFA's present performance "Criteria and Standards" to be excessive. They are not sufficiently output oriented and are too process oriented. They center too much on whether a HCFA defined process is being carried out precisely, without regard to the value of the process itself.

HCFA has issued a very large body of General Instructions to its contractors. The terms of the contracts obligate the contractors to follow each of those General Instructions precisely and in detail. In effect, these General Instruction, covering all aspects of the Medicare program, tell contractors what to do, when to do it and how to do it. Failure to follow one instruction is technically a breach on contract and invites a failure rating against a performance criteria or standard—even where such individual breaches in and of themselves do not affect an end result.

The apparent theory behind this approach to performance measures, Criteria and Standards and General Instructions, is that if a contractor precisely follows all the detailed General Instructions, he or she has taken the first and most important step toward good performance. Only if the contractor acceptably meets this primary test will HCFA then look at output measures, unit costs and timeliness of processing claims and auditing of providers.

Performance Criteria are those that primarily measure how well the contractor follows HCFA's General Instructions. Performance Standards are quantified performance measures that show the contractor's cost efficiency and timeliness of claims processing and provider audits. Unless the contractor satisfies the Criteria measures, HCFA will not review costs, claims processing results or provider audit results. HCFA views the compliance with the process-oriented criteria as establishing the "integrity" of the contractors' performance. Therefore, unacceptable performance in this area renders its cost and other output results as suspect.

Without exception, the contractors see this order of priority as faulty. It puts the cart before the horse. In their viewpoint, it is more important for the contractors' costs to be acceptable, for beneficiary claims to have been processed in a timely way and for providers to have been effectively audited. The contractors see little value and many impediments in having to follow each General Instruction to the last

letter. Many of the detailed procedures included in HCFA's General Instructions are seen as either completely unnecessary or in need of redesign.

Finally, the present evaluation and monitoring processes offer too many opportunities for subjective judgments by the many Federal contract examiners across the country and have become so detailed and pervasive as to have taken on a life of their own—in contrast to their intended goal of improved overall performance. Contractors have begun to be conditioned by this preoccupation with form and detail and are now spending almost as much time on complying with the detail itself as they are with the conduct of the basic work. It is reaching a point where decisions are made around the effects on performance evaluations rather than on program goals or the adequacy of service, quality and efficiency.

3. Do you have any comment on the HIAA "cost-plus" concept?

We are not fully familiar with the HIAA concept.

Blue Cross and Blue Shield are non-profit underwriters and are generally not concerned about the "no-profit" limitations of the current Medicare contracting arrangement. In fact, there is a possibility that the recovery of full costs, plus a fee, could raise problems for some Blue Cross and Blue Shield Plans under the enabling laws of their States—if the premise of a fee implied a profit. We have not examined this question in depth and do not want to suggest it as an insurmountable obstacle. But, we do see a need to proceed with caution. It may be possible to rationalize the fee as simply a device to assure that none of the administrative costs the Plans incur are transferred by inadvertence to its other lines of business. During periods of rather arbitrary budget limits, such as the one we are now going through such transfers of Medicare costs have been a real concern for Blue Cross and Blue Shield Plans.

In any case, we would be prepared to discuss the possible advantages of the HIAA proposal.

4. You note that the system is not ready for the integration of part A and part B at the carrier and intermediary level. What do you believe would be needed to allow such a determination to be made?

In its statements supporting the merger of Part A and B administration, HCFA has advanced a number of reasons why they believe such mergers would benefit Medicare. Such mergers would, they claim: Reduce the number of contractors, thereby reducing administrative costs, improve controls over program administration and improve uniformity; provide opportunities to reduce administrative costs through economies of scale, and provide opportunities to develop and use "integrated" EDP processing and data storage systems which might enhance the effectiveness of utilization review and other important aspects of Medicare administration.

Our position on this question has always been that these stated expectations deserve attention and testing to determine whether the results would be as stated. Such tests should also measure whether or not the improvements, when weighed against the disruption of established arrangements, produce a significant and long term gain. It is not, or should not simply be a matter of whether fewer contracts result, for example. Consideration of what has been lost or weakened as a result of the change is also relevant.

There are factors that come into play in the consideration of such mergers that are not readily apparent but can affect the overall result. By concentrating volume, we could influence relocations to major population centers with higher labor and other costs. This could cancel out efficiency gains associated with the idea of integration. High volume operations also tend to become autonomous and are less likely to share costs and resources with non-Medicare lines of business in the same setting. In other words, by concentrating Parts A and B, there could be some loss of other cost-sharing opportunities.

Evidence in Medicare operations tends to show that the concept of economy of scale has a point of diminishing return and does not always function the same way in a service industry of this type as it may in manufacturing or other industrial settings. The idea of an integrated EDP system for Parts A and B has not been clearly demonstrated as being more cost effective.

There are quite a few current contractors with both carrier and intermediary contracts in the same organization. It would appear that these locations offer an immediate opportunity to study "merged" Parts A and B administration without tainting the results by also mixing into the study the effects of fixed-price competition and/penalties. This mixing of different questions in the same experiment may have been a mistake of the other Medicare experiments. As a minimum, they make them harder to evaluate.

One could suppose that in these locations, the contractor, already having both Part A and B contracts, would have merged those administrative functions that are

contemplated as susceptible of merging. If they haven't already done so, it would be enlightening to find out why. In any case, such locations offer an opportunity to examine the idea without changing sites and without incurring the risk of disruption normally produced by changeovers.

5. In light of the U.S. Court of Appeals' ruling of November 20 on the legality of HCFA's part A experiments, do you envision any further legal action if additional part A experiments are initiated?

We do not envision any further legal action in the cases in point. Our general policy is to avoid litigation. We prefer negotiation and discussion of differences and serious problems are better resolved through those means. We cannot say that situations won't develop where it might be necessary to litigate, but we will certainly do our best to avoid them.

6. One argument against the nomination process is that providers could "shop" for an intermediary that met its needs. To what extent do providers change intermediaries?

We do not have data immediately available for all intermediaries. However, our own data should be reasonably representative. For a 14-month period ending October 30, 1981, there was a total number of provider changes amounting to only 35 of the 12,000 providers served by the Blue Cross intermediary, i.e., BCA and the subcontracting Plans. That is .0029 of 1 percent.

We do not believe providers have ever been entirely free to move from one intermediary to another to find what they may perceive as an easier or more advantageous relationship. Nor do we believe that any significant number of providers think there is that much to be gained by such changes.

There are, from time-to-time, a limited number of instances where personal relationships become strained, or where there are temporary operational problems at the intermediary level which lend to requests for a change.

There is a high level of uniformity among intermediaries in the methods, techniques and diligence employed in the process. What providers normally look for is a capacity to understand that custom of the community and to be efficient and timely in the processing of audits.

In any event, we believe the HCFA has sufficient legislative authority to deny and change an intermediary where examination of the rationale for change suggests "shopping" or other invalid reasons for the change.

"Shopping" is not a real problem at this stage of the program.

7. Do you feel that the experiments already initiated by HCFA, when completed, will provide us with adequate information on which to determine the appropriateness of a change from cost contracting?

We would expect that careful and objective evaluation of the completed experiments will provide a degree of insight as to the effects of a change from cost reimbursement contracts—but not as much as an objective observer at arms length might like.

We believe the experiments were not well conceived or organized at the outset for purposes of later evaluation; nor—we sense, is there any way to overcome this deficiency at this late date. Further, we sense that all HCFA wanted to demonstrate in the first place was that the approach would cut raw costs.

There is evidence that HCFA, at least, is satisfied with a conclusion that the initial contracts were cheaper, without studying whether cost savings will be sustained over time or what the effect has been on service and quality. Similarly, except for GAO, we see no interest in testing whether or not the other effects of the process counterbalance the one-time, short-term administrative cost reductions. For example, before any of these experiments were completed and evaluated, HCFA moved to put this procurement technique in place as a matter of permanent policy.

In their present state, the experiments cannot be accepted as pure tests of the effects of periodic fixed-price competitive procurement. They have all mixed multiple variables, each of which might have had a unique influence on the outcome—financial penalties and incentives and a new method of contractor selection were mixed with a new pricing method. It will be difficult to determine whether the results of the experiments result from competition per se, from the use of fixed price per se, the use of financial incentives/penalties per se, or from a combination of all three.

It would also appear that a true test of periodic fixed-price competitive procurements should involve a series of such competitions in the same place. The periodicity of the concept is certainly a significant factor. How can it be said that the concept has been tested and evaluated if there has not been two or more such competitions in the same location? The closest we have come to this is the extension of the Maine experiment, where some differences in cost appear to have occurred. It could

also be questioned whether this was a true competition since the only other bidder withdrew.

All the experiments tended to make the bid price the primary determinant for awarding the contracts. That characteristic certainly had major influence over the interests of potential bidders, the orientation of their proposals and the manner in which they are carrying out their contracts. There may be some things to be learned from a periodic fixed-price competitive bid which make price equal or even less important than service to beneficiaries, cost-effective performance in audit or claims review, etc.

Again, we see no criterion in place, no controls in the experiment to determine the influence of the various factors on the result. The transitional experience suggests to us the need for greater weighting for capacity, and potential quality of performance. Yet, the experiments cannot tell us whether the price will change if these factors are given greater weight.

8. What are your thoughts on legislation that would give the Department greater flexibility in determining the type of contracting needed? Perhaps allowing the Department to use cost, cost plus incentive fee and fixed rate simultaneously?

PROBLEMS TO BE SOLVED

We feel that events have obscured the problems that were originally cited as being solved through enactment of mandatory price-based competitions and by introducing monetary incentives and penalties. Thus, we would like to start by reviewing the original ideas about problems to be solved and gains to be made through new legislation in this area. The assumptions were, that—

1. By authorizing the Secretary to convert the present system to one that is determined by price based competition, poor performers and extraneous contracts could be dropped more easily,

2. By using fixed price and/or monetary incentives, the net cost of Medicare would be reduced.

DROPPING UNSATISFACTORY OR UNNEEDED CONTRACTORS

No one questions the need for the Secretary to drop inefficient or unneeded contractors. But, an examination of present law shows that it is sufficient for this purpose (42 USC, SEC. 1395h). We even see the Secretary's present authority as being sufficiently flexible to permit cost-based competitions as a means of selecting replacement contractors. The recent replacement of the Part B carrier for the Washington, D.C. area is an example to this.

In short, the Secretary should not use the lack of direct competitive bidding authority or the cost reimbursement principle as an excuse for not acting in those instances where it is appropriate to drop or replace a contractor.

IMPROVING EFFICIENCY/REDUCING ADMINISTRATIVE COSTS

Admittedly, incentives for improved productivity balanced against incentives for improved quality are always in order. Our concern is that fixed price and/or monetary incentives and penalties will, over the long term, push against quality to the ultimate disadvantage of the program. In fact, it is our contention that the ultimate cost of bringing quality of performance back into balance, once it gets out of line, will always exceed any near-term cost reduction. Also, we respectfully remind the Committee of the sustained record of decreasing costs and increasing productivity under the present pricing system.

As noted in our testimony, we believe the present cost reimbursement system has already evolved into a fixed price equivalent and we see the need for care to see that this evolutionary pattern does not also eventually push against effective performance.

While the concept of greater flexibility in contractor selection and pricing methods appears advantageous on its face, we do not believe that broader latitude is needed at this time.

Finally, if monetary incentives are to be employed for non-profit organizations such as Blue Cross and Blue Shield, we would urge that the program also consider non-monetary incentives. We see the development of output oriented performance and cost standards as being the most important step to take in this direction.

BLUE SHIELD OF MASSACHUSETTS,
Boston, Mass., December 14, 1981.

Hon. DAVID DURENBERGER,
Chairman, Committee on Finance, U.S. Senate, Subcommittee on Health, Dirksen Senate Office Building, Washington, D.C.

DEAR MR. CHAIRMAN: I am pleased to respond to the various written questions put forth by the Subcommittee as follows:

1. What changes have made in your operations based on input received from HCFA during the experiment?

Blue Shield of Massachusetts (BSM) 1977 proposal assumed that the procedure code structure utilized by Union Mutual Life Insurance Company could be converted to the procedure coding structure in use in Massachusetts. It became apparent, during the implementation phase of the contract that the difficulties inherent in mapping one coding system to the other were significant. It was a HCFA decision that BSM develop and maintain separate coding systems for its two Medicare contracts.

With that exception, virtually all changes made in the operation on directives received from HCFA have been the direct result of quarterly performance evaluation reviews. Most of these changes have been procedural rather than substantive. An unfortunately large proportion of the HCFA-recommended modifications have involved essentially cosmetic changes intended to bring the final product more completely in line with the requirements of a specific reviewer. The impact of such changes on the rapid, accurate processing of claims or on the level of service afforded the beneficiary and provider communities is marginal. Examples of changes requested by HCFA are listed below:

a. In cases of prolonged hospitalization with associated levels of medical care, the prepayment utilization review department which processes these claims was instructed to obtain the PSRO's determination regarding the medical necessity of the hospital stay. While the determination on the claim for medical care is not dependent on the decision of the PSRO, the PSRO documentation must be part of the bill. This procedure has never been required for the processing of similar claims submitted in Massachusetts.

b. Instructions to correspondence personnel regarding the appropriate format and wording of letters to beneficiaries changed several times over the course of the contract.

c. The correspondence inventory control report which is used to prepare the quarterly reports submitted to HCFA was changed twice to accommodate varying definitions of "reopening" as opposed to "informal review."

These changes, and numerous others, were implemented as a result of deficiencies noted in the quarterly contractor evaluation reviews, under standards set in the Maine Monitoring Plan. Emphasis on performance evaluation during the course of the contract dictated the form of the recommendations. The recommendations and their subsequent implementation were intended to produce a passing score relative to the Maine Monitoring Plan rather than to improve the efficiency of the operation.

2. Do you have any suggestions as to what actions HCFA and HCFA Regional Offices might take to assist those participating in future experiments?

To provide the greatest possible assistance to future contractors, HCFA should reexamine the entire contractor evaluation process in a more realistic light. At least some part of the rationale behind the incorporation of performance standards into these contracts was to ensure against inadequate or unsatisfactory performance resulting from an unrealistically low price. This is understandable and such protection should certainly be afforded both the government and the public in any future procurements. However, the monitoring plans in effect for current experimental contractors go far beyond reasonable requirements.

The performance evaluation/liquidated damages provisions of the current Maine contract require a level of performance considerably higher than *average*. Furthermore, every aspect of the contractor operation from claims control to timely reports is evaluated *annually* and damages may be assessed for failure in any area. At least as to BSM we believe this has resulted in a serious distortion of the goals and objectives.

The Part B contract is by its nature a service contract. Ideally, the primary goals in administering such a program should be to improve service while streamlining processing and reducting cost. The performance evaluation criteria should not interfere with the management techniques which will achieve these ends most expeditiously. In evaluating a Medicare B carrier, HCFA is reviewing a *PROCESS* rather than a *PRODUCT*. Continuous, stringent review of each element of the process

changes the process itself and the end rapidly becomes the means. The result is management, from the perspective of both organizations, purely to satisfy standards. Efficient management of the program for the benefit of the beneficiary runs a poor second and is frequently lost sight of altogether. Ironically, the evaluation criteria do not necessarily ensure adequate performance from the beneficiary's perspective.

Performance levels in future contracts should be set such that carriers and intermediaries can benefit from their experience. Contractors should have the flexibility to use their discretion and good judgment to ensure efficient and cost-effective management. If it were possible to administer a fixed-price contract in the same manner in which an organization administers a cost contract, the government would benefit from increased efficiency, economy of scale and reduction in cost. Realistically, damages should be assessed for clearly unsatisfactory or irresponsible performance which demonstrably affects the providers and beneficiaries in the service area. High inventories in either claims or correspondence, or large numbers of claims pending 30 days or more are examples of situations where penalties should be incurred.

3. The rebid for the Maine contract exceeds the national average cost per claim. Can you explain this increase in your new bid? Doesn't this seem to argue against the reason for competitively bid contracts, which are supposed to result in lower costs?

The rebid for the Maine contract is the direct result of four years of experience managing a fixed-price contract in an environment that requires that primary emphasis be based on the passing of standards. In preparing our bid for this contract we evaluated the 1981 CPEP package and the liquidated damages/incentives section of the RFP with great care. Obviously, the largest portion by far of the bid price is in personal service costs and in establishing that level we projected staffing consistent with the effort necessary to meet the minimum satisfactory levels set forth in the contractor performance evaluation criteria. It must be remembered that the level of performance required of a fixed-price contract is significantly higher than that required of a cost contractor. It follows that it costs more to do better. In addition, fixed-price contractors must be able to estimate the inflation factors which will apply to the future life of the contract, potential volume increases, liquidated damages and a series of other potential risks. Staffing, space, etc. must be adequate to cover all the possibilities. Some of the specific reasons for the difference in cost include:

a. High levels of performance requiring well trained, stable and experienced staff and supervisors.

b. Liquidated damage avoidance, extra personnel required to do daily performance monitoring reports, fast reaction to deteriorating performance, cross-training of personnel and supervisors to manage volume fluctuations.

c. Requirement within the RFP to locate within the State of Maine and thus be unable to share facilities, management, etc. with current operations.

d. Requirement to have a separate data processing system, obviously increasing cost due to the low volume in Maine, otherwise stated, no opportunity for economies to scale.

e. Added personnel and systems monitoring expense due to incentive payments based on "best in nation" performance levels with incentive payment prospects very low and potential for liquidated damages based on "best in nation" performance levels with damage prospects reasonably high.

4. Should positive and/or negative incentives be used in competitive contracting?

As indicated in the response to question number 2, we believe negative incentives should be used to ensure the program against disastrous management. Beneficiaries and providers should be protected to the degree possible from an irresponsible or unscrupulous contractor. However, we perceive no real benefit to the program in the award of incentives. The incentive level of performance is an extremely costly proposition. Furthermore, the degree of positive impact such performance has on the program as a whole is minor. Very little has been gained when a beneficiary receives a reply to an inquiry in nine days rather than ten or workload reports are routinely submitted five days before the due date.

More importantly BSM does not regard the Medicare B program as an opportunity to make a profit. Considering the contractor standards currently in effect, the cost inherent in achieving a level of performance high enough to generate incentive payment would be inconsistent with the actual gain achieved.

5. Do changes in the Medicare program tend to create significant problems under a multi-year fixed-rate contract?

Changes in the Medicare program pose a continuing problem to the fixed-price contractor. Major legislative or regulatory changes trigger a long and tedious process of analysis, evaluation, request for adjustment in price, negotiation of price ad-

justment and implementation of the change. Where as in our case, the contractor also functions as a cost-reimbursed carrier in another State, the problems are compounded. We are reluctant to undertake costly major implementation efforts in our Maine operation without reasonable assurance that funding will be approved. However, the process of approval on a request for a price adjustment can take as much as nine months. Common sense dictates that the implementation efforts for both contracts be run in parallel to minimize cost and disruption to processing. We have, on occasion, implemented major changes prior to approval for those very reasons. Delays in negotiation of other modifications have forced us to process differently in Maine as compared with Massachusetts.

As frustrating as the change request process can be, however, major or minor changes in the program can cause much more serious problems. The Medicare B operation is so complex and interrelated that a change in any area can have a far-reaching impact. All program modifications must be considered not only in terms of cost, but also in terms of the potential disruption of some key functions which could cause the failure of a standard and payment of damages. For example, a requirement that carriers develop more extentively for possible worker's compensation benefits could increase the development rate enough to cause a failure in the days work on hand over 30 days standard.

Moreover, with the start of this fiscal year, we are faced with a new problem in this area. Cost-reimbursement contractors have been instructed to abate or reduce certain services in order to reduce costs. We anticipate that similar directives will be received during the course of this year and next. Most of the changes are extremely intelligent and will have no discernible negative impact on the program. None of these changes are applicable to the operation in Maine. Somewhat less than three months into the operational period of the contract, BSM is processing Massachusetts claims very differently from Maine claims. The flexibility and potential for back-up we had anticipated from two Medicare operations has been effectively eliminated. As further changes are received it will become increasingly difficult to manage both contracts.

6. Based on your participation in the fixed-price experiments, what do you believe to be the positive and negative aspects of fixed-price competitive contracting?

The fixed-price procurement process gives HCFA an alternative method of replacing a contractor where is no obvious successor.

We have indicated what we feel to be the negative aspects of fixed-price contracting in our responses to questions 1-5 above. Essentially, we believe the competitive bid process is not appropriate for a service contract. The cost to the program of the performance standards/liquidated damages provisions of the contract is completely disproportionate to the gains achieved in level of performance. The Performance Evaluation Criteria hinders efficient, cost-effective management.

7. Was your first experiment financially profitable to you? Is your bid on the second contract expected to yield a profit?

BSM elected to bid on the Part B contract in Maine in 1977 because we perceived major changes in contracting methodology were in the wind. We were anxious to participate in the first fixed-price experiment. We did not expect to make a profit and, in fact, we did not.

When the contract was rebid we felt an obligation to participate. After almost four years of successful administration of the program in Maine, we were reluctant to withdraw. We had established a good working relationship with the beneficiary and provider communities, and we felt we had an obligation to continue that relationship. Our bid reflects our best estimate of the actual operating costs for the period. It is not our intention to make a profit; it is our hope that we will break even.

It was a pleasure to have the opportunity to testify before the Subcommittee on this important matter. Should you desire any additional information, we would be pleased to respond.

Very truly yours,

JOHN LARKIN THOMPSON,
President.

Senator HEINZ. Thank you very much.

Mr. CARDWELL. Thank you, Mr. Chairman.

[The prepared statement of the previous panel follows:]

Statement of James Bruce Cardwell, on Behalf of the Blue Cross and Blue Shield Associations

Mr. Chairman, Members of the Committee, I am James Bruce Cardwell, Senior Vice President of the Blue Cross and Blue Shield Associations. I am accompanied by Ms. Sheila M. Smythe, Executive Vice President of Blue Cross and Blue Shield of Greater New York and by Mr. John Larkin Thompson, President of Blue Shield of Massachusetts. Both Ms. Smythe and Mr. Thompson have had first-hand experience with experimental, fixed-price contracts for Medicare administration.

We would start, Mr. Chairman, by noting the continuing involvement of Blue Cross and Blue Shield in all aspects of the Medicare program—going back to its inception in 1965. Today, of the 114 private sector Medicare carriers and intermediaries, 88 are Blue Cross and Blue Shield Plans.

On the subject at hand, we would also note that, of the five experimental carrier and intermediary contracts let so far, four involve Blue Cross and Blue Shield Plans—two of which are represented here today by Ms. Smythe and Mr. Thompson.

We want the Committee to have an opportunity to hear directly from both Ms. Smythe and Mr. Thompson. But, with you permission, I would first like to offer a background and summary of the Blue Cross and Blue Shield position concerning not just competitive bidding, but improved Medicare management in general.

BACKGROUND

We will not take much of the Committee's time in a review of the origins of this subject, except to say that many of the questions now being addressed by this Committee have been around for a long time—going back at least to the early 1970's. The Medicare provisions of the Social Security Act are clear in their intent that the private sector carry out the basic processes of settling beneficiary and provider claims, evaluating utilization review and other provider practices, and assisting beneficiaries in the exercise of their benefit rights. With the exception of the Illinois experimental contract, these functions have always been performed on behalf of the Government by established health insurers—commercial carriers and Blue Cross and Blue Shield Plans.

This arrangement has prevailed for over 15 years and, on the whole, has produced a remarkably stable and well-managed program—one that enjoys a high degree of beneficiary satisfaction and confidence. In fact, citizen confidence in Medicare has increased during a period when confidence in most institutions, particularly Government, has declined. Mr. Chairman, we see this as the program's crowning achievement, one that should be kept in clear perspective as this Committee examines ways in which to improve the program's administration.

Throughout the 1970's, the program has maintained a steady record of increased efficiency at the contractor level—a record of lower unit costs and improved productivity. From 1973 through 1979, after adjusting for inflation, costs have been reduced by 49 percent and productivity has increased almost 80 percent. Even with inflated dollars, administrative costs of Medicare contractors have dropped by a net of 16 percent during the same period.

None of this is to say that there is not room for further improvement in the program's administration or that the program should resist change. To the contrary, we believe that further improvements are achieveable and that the inherently changing nature of the benefits program itself will always call for modifications in the program's administrative practices. Later in our testimony, we will offer our recommendations for ways in which further improvements may be made in Medicare management.

ROLE OF COMPETITION

Moving to the specific subject of this hearing, the question, of course, is: Where does a marketplace competitive bidding process fit in any effort to perfect the program's administration? Can it make the program better? Can it make the program more efficient? Can it improve the quality of program services to providers and beneficiaries?

In examining these questions, several important considerations need to be kept in mind—

1. First, Medicare consists of a complex set of relationships—between Government, the local community, hospitals and other institutional providers, physicians and other professionals, various vendors and suppliers and, finally, between all of these parties and the beneficiary. The carrier or intermediary plays a critical and pivotal role in the balancing of these relationships. How well this is done deter-

mines both the cost and quality of the program as well as the degree to which the program may or may not enjoy beneficiary and public confidence. It is a role, the success of which depends on knowledge of and experience with the community and the various parties at interest.

2. There is a cost vs. benefit risk involved in any change in an intermediary or carrier, and there is no clear-cut criterion that can measure this risk in advance. In fact, there is no guarantee that a replacement contractor will necessarily improve on or even match the performance of the original contractor.

3. Next, as we will emphasize throughout our testimony, with every changeover, there is a risk of disruption and dislocation which, under many circumstances, cannot be measured objectively in dollars and cents or unit costs. The experimental contracts have produced some situations where these dislocations have disrupted service and, as a result, increased costs.

4. Finally, although they represent significant amounts in their own right, contractor administrative expenses account for less than 2 percent of total benefit costs—and it is a simple fact that the net margin for further administrative savings within that 2 percent is limited. In contrast, the margin for increasing benefit costs through miscalculations in the selection and placement of carriers or intermediaries is relatively high—perhaps very high.

In the face of these factors and, if, as we say, the program is working relatively well and shows strong signs of self-improvement, one might ask why its administrative structure needs to be changed in the first place. In short, if it is not broken, why fix it? Although it is a bit nebulous and cloudy, we believe the answer can be found in a rather natural and lingering question that has always been in the background of the Medicare program. The Congress initially decided that the basic nature of Medicare, with its complex set of interrelationships, did not lend itself to competitive, price-based selections of carriers and intermediaries. However, because price-based competiton is the traditional method by which Government business is conducted with the private sector, it is only natural that the question of why Medicare should be among the exceptions to the rule would be raised from time-to-time. But, during the last several years, as total program costs have risen, what had only been an occasional question about price-based competitive bidding has become a preoccupation, at least with the Executive Branch. We believe this preoccupation has been driven by three assumptions:

1. That fixed price offers motivational incentives not found in the present cost reimbursement system, incentives that will make contractors inherently more efficient. Contractors will, it has been assumed, be motivated to find new and better methods, to adopt advanced technology, to consolidate operations, to pare their overhead and to do a host of other things that will cut costs—without impairing quality.

2. That the present configuration of Medicare contractors consists of at least some marginal performers and too many individual contractors, and that the mere process of open competitions will provide a convenient apolitical way to drop poor performers and reduce the number of individual contractors.

3. That the system should be more data processing oriented and that competitions would encourage non-health organizations to bring their expertise into the program. This expertise is expected to make the claims, audit and reimbursement and beneficiary service processes less labor intensive, more impersonal, and, thus, more efficient.

We would like to comment on each of these assumptions:

Motivational factors

First, we accept the assumption that there are circumstances where price can motivate improved efficiency. But, we think the opportunities for improved efficiency are marginal in most Medicare settings and that many of the present variables that might offset administrative costs are beyond the contractors control—unless he wants to short cut the quality of the reimbursement process or beneficiary service.

We disagree that fixed price is the best way to motivate Medicare contractors. We see the objective application of output oriented quality and performance standards—including cost standards—as a more effective motivational force, particularly for non-profit contractors such as Blue Cross and Blue Shield Plans. Such standards, coupled with peer pressure and self image among non-profit contractors are powerful motivators. They are already at work.

Consolidation of contracts

On the matter of reducing the number of contractors, we do not argue that the system could not be more efficient, or at least as efficient, with fewer contractors. Nor do we argue that poor or marginal (including high cost) contractors should be retained. They should not. They need not. Again, the use of objective, output meas-

ures of performance can provide a clear and effective way to identify poor performers. The Secretary already has clear authority to drop them when he finds them and by perfecting the program's performance criteria, he will have the means by which to exercise that authority.

We would like to use this opportunity to go on record with the Committee to the effect that the Blue Cross and Blue Shield Associations are prepared to offer consolidated contracts in these States where we are currently represented by multiple Plans.

We believe we can do this without undue disruption and with improvements in efficiency, in fact, Ms. Smythe is here today representing just such a consolidation, one that was put in place using the Secretary's present experimental authority. This arrangement consolidated under a single Blue Cross Plan for the entire State of New York what had been seven separate intermediary operations. This consolidation came about as a result of an unsolicited proposal made by the Part A Blue Cross Plans in New York in collaboration with the Blue Cross Association. The contract, which started in 1980, is scheduled to run until 1984. It has a fixed price with penalties for performance shortfalls and incentives for performance gains. It includes beneficiary service components, continues the basic provider relationships that had previously existed and is supported by those providers. Most important, because it was a cooperative venture between the original contractors and the new central contractor and because it included a provider and beneficiary relations transition plan, the changeover from the old to the new has occurred without disruption in either provider or beneficiary services and without alarm or uncertainty on the part of the elderly. Because it takes advantage of higher volumes and centralized processing technology, it has also, so far at least, resulted in lower unit costs. We see this contract as a model alternative to large scale, mandatory competitive bidding of the type proposed last winter by the Adminstration—a proposal that was rejected by the Congress.

In any event, Mr. Chairman, the Blue Cross and Blue Shield Associations are prepared, at their own initiative, to offer consolidations of multiple intermediaries in the same State. We believe that, approached with adequate care and planning and with adequate arrangements for local needs, consolidations can be achieved without impairing program quality.

Improving contractor performance

Similarly, we are also prepared to work with the Government to correct demonstrable performance problems. We believe that improved performance should be a permanent goal of every contractor and that poor performance can be corrected without undue disruption. But, again, an orderly and well-planned transition is critical. As with pricing, we see the development by the Government of objective, out-put oriented performance standards as the way to identify poor performance—and as the justification for their contractor changes.

Making carriers and intermediaries data processors

Finally, conversion of the intermediary and carrier role to that of a data processor, would, in our judgment be a serious mistake, leading to higher ultimate reimbursement levels and a preoccupation with form over substance. Such a concept ignores the basic nature of the work to be performed—the need for carriers and intermediaries to have established relationships within the community. They need to have knowledge about provider and beneficiary custom and practice and effective methods for dealing with them. Most important, carriers and intermediaries need to have gained the confidence of those with whom they interact.

The data processing model also ignores the importance of non-data processing practices that are vital to the efficiency and effectiveness of the program—utilization and medical review and audit and reimbursement. While advanced systems and uniform codes and methods can contribute significantly to the efficiency of these processes, the processes themselves are, nevertheless, inherently dependent on specially trained and experienced professional workers. The faults inherent in the data processing approach have, we believe, already been demonstrated by the Part B experiment in Illinois.

As with GAO, when we test the above assumptions against the experience gained so far, we conclude that, as a general proposition, a change to fixed-price competition, per se, will not achieve the result expected by the Department of Health and Human Services. Instead, we think such a change introduces a high risk of disrupting Medicare's vital processes without compensatory gains in cost.

In our view, other alternatives for change should be sought. In examining such alternatives, we recommend that first priority be given to the maintenance of program stability—the smooth and efficient interaction between Government, the pro-

viders of care and the beneficiary. We believe every contemplated change in administrative design, policy and practice should be tested for its effect on these objectives.

EFFECTIVENESS OF EXPERIMENTAL CONTRACTS

We have already spoken about the Blue Cross organizations initiated experimental Part A Medicare contract for the entire State of New York. Unlike the marketplace competitions, this contract was negotiated with the Government following an unsolicited proposal made in 1979 by the seven New York Blue Cross Plans. As indicated, we see this as a model for future contract consolidations. Its approach offers a significant opportunity for improved efficiency, including net cost reduction, without serious risk of disruption or dislocation.

Insofar as the marketplace competitions are concerned, three Part B and one Part A competitions have been carried out to date, with Blue Cross and/or Blue Shield Plans bidding on all four and winning the competition in three out of the four, as follows—

Blue Shield of Massachusetts, Inc. (BSM) was the successful bidder in 1977 for the role of Part B Medicare carrier for the entire State of Maine, replacing a single state-wide commercial carrier who voluntarily withdrew from the program. The experimental contract expired in 1980 and BSM was awarded a successor contract in June of this year. The successor contract was awarded as a result of a second experimental competition.

Blue Shield of Western New York (BSWNY) was the successful bidder in 1978 for the role of carrier for Upstate New York (47 counties). The contract took effect in 1979 and expires in 1982. This contract replaced three separate contracts, two of which were held by Blue Shield Plans and one of which was held by a commercial carrier. BSWNY was one of the two original Blue Shield contractors.

Blue Cross of Missouri (BCM) was the successful bidder in 1979 for the role of Part A Medicare intermediary for the entire State of Missouri. This contract is just now getting underway and expires in 1984.

Based on experience with these three experimental contracts, we offer the following observations:

In all three cases, the Blue Cross and Blue Shield bidders weighed various considerations in the design of their bids, including their capacity to fulfill performance requirements, their capacity to manage a smooth transition, the potential impact on their public image and, finally, unit cost.

On the matter of price, it should be borne in mind that these are non-profit bidders. They were not looking for profit. They were motivated more by their own role image as a participant in the program and with consideration for an opportunity to expand their own experience.

While the quoted unit price was lower than that which prevailed prior to the competition, the quoted price was calculated to win the competition—to a point. A price line was drawn at the point where a lower bid implied serious risk of failing the contract's performance requirements or incurring tensions with the community.

We are not giving away any trade secrets when we say that in the case of BSM and BSWNY, neither bidder has experienced a profit. In fact, in both cases the contractors actually sustained net losses in cost centers assigned to the contracts.

In the case of Upstate New York, the transfer of the old contracts to BSWNY produced significant transitional difficulty for the beneficiary population, for providers and for the contractor. There was significant adverse publicity and only through an extraordinary effort by BCWNY over a period of almost a year (including the expenditure of large sums not calculated in the contract price) has the service area been restored to normal.

By and large, these same adverse transitional experiences did not occur in the case of the Maine changeover. But, this is only because the contractor, Blue Shield of Massachusetts, and the New England Regional Office of HCFA had an opportunity to continue many of the systems and methods of the previous carrier, including adopting some of the previous carrier's medical procedure coding. This was possible for the contractor because the contract represented a fresh start within the State and BSM was not bound by the reimbursement practices of its home state, Massachusetts.

Both BCWNY and BSM have concluded that abrupt, arms-length changeovers of the kind fostered by marketplace competitions imply serious disruptions and dislocations. They see this as unavoidable under the best of circumstances. In the final analysis, it becomes a matter of degree. This conclusion is also shared by the Blue Cross and Blue Shield Associations on behalf of all of our member Plans.

THE HHS APPROACH TO FIXED PRICE

These two Plans and the Associations are also concerned about the way the D partment of Health and Human Services (HHS) approaches the concept of fixe price in actual practice. What has evolved, whether through negotiated contracts (experimental competitions, is a one-sided fixed price, imbalanced in favor of HH In short, HHS expects the contractor to accept many changes in the scope and cha acter of the work to be performed and changes in the performance standards use to measure penalties—without adjusting the price. At the same time, HHS expec the contractor to fulfill all terms of the contract, at the original price. The fact that, except for extraordinary changes resulting from modifications of law or regul tion, HHS does not seem prepared to adjust the price. Another extreme may b found in the fact that the Western New York RFP and the latest Maine RFP bot stipulated the right of the Government to modify performance criteria during th contract period—without necessarily changing the contract price. This "all for HH attitude" will not, in our judgement produce successful fixed-price contracts ove the long run. As GAO opines in their report, such an approach invites respondent to cover their bets by either hedging the price or by lowering the quality of thei product. This risks higher ultimate cost for the Government, both in administrativ expenses and the cost of beneficiary care.

FIXED PRICE VERSUS COST REIMBURSEMENT

The Blue Cross and Blue Shield associations generally accept the concept of fixe pricing for Medicare contracts—providing sufficient flexibility is included in th contract terms to recognize changes in workload and to recognize Federally initiate changes in the substantive aspects of the program or in output requirements.

The opportunities for price adjustments must be equally applicable to both pa ties. If the Government changes its requirements midstream, then so should i change the price. Similarly, if the contractor falls short of contract requirements, h or she should suffer the consequences.

In our opinion, the best general approach to fixed price in these circumstance would be a price gauged to units of output—workload—with clearly defined outpu measures built into the contract's terms and conditions. The reason we suggest thi general approach is not that we see inherent advantages in the fixed price approac compared to cost-reimbursement. Instead, we take this position at this time becaus we see the cost-reimbursement principle as having been steadily compromised b the Government's application of it to Medicare. As a result, we believe the time ha come for a reevaluation of the pricing mechanism used in Medicare contracts.

For a number of years, the contracts have, for all practical purposes, evolve toward what is now a modified, fixed-price contract. Evolution has occured as result of the Government's use of bottom-line, absolute budgets, coupled with re quirements for preclearance of any budget changes, regardless of the nature o source of the change.

In terms of its effect on the cost of administration and the prerogatives of th contractor, this agreement is now equivalent to a fixed price—but with none of th flexibility normally associated with fixed price. At this stage of the relationship be tween the parties, any assumption that the present contracts bind the Governmen to pay for whatever the contractor does is incorrect.

We are not yet prepared to suggest where performance incentives and penaltie fit into a proper pricing method, but we do believe they need to be explored. The have, of course, been included in the experimental contracts, but their influence o the cost and quality of those contracts is not clear. If they are made a permanen part of all contracts, they must be designed in a way that permits flexible and equa treatment of the parties.

In sumary, it is our position that a change in the pricing mechanism, whether i the form of fixed price or another formula, is now needed to address the imbalanc that exists in favor of the Government.

THE NOMINATION PROCESS

This has been a fundamental part of the Medicare Part A intermediary arrange ment from the beginning of the program. One of the implications of large scale com petitive bidding has been its inherent influence with the nomination of a given in termediary by one or more hospitals or other institutions. The bidding proces would determine the intermediary instead. Changeovers in contractors due to poo performance and consolidations also interfere with the nomination process, regard less of how the change is brought about.

Our position is that, although we do not believe it should override the selection out of poor performers, the provider nomination process continues to have an important role to play in the selection of qualified intermediaries. The provider has unique knowledge and experience about the requirements of the program, the character of the medical community, and most important what constitutes good intermediary practice. This valuable insite should not be ignored. Thus, we believe all providers must be consulted and their cooperation sought before a changeover is made. We see this as an important part of any changeover transition plan. If managed well, it can help avoid dislocations and tension with providers, beneficiaries and the community at large. We cannot stress too strongly the importance of this aspect of Medicare administration.

Our experience with the negotiated New York State consolidation and with similar consolidations in Tennessee and West Virginia have demonstrated what can happen where providers' interests are accounted for and where providers are consulted rather than faced with a fait accompli. In the former case, transitions are manageable. In the latter they can be traumatic. We strongly recommend the consultative approach.

MERGERS—PART A AND PART B

This subject has been raised from time-to-time by both HHS and the GAO. As with other assumptions about contractor consolidations, the assumption in this case is that the combined administration of Part A and B at the carrier and intermediary level will produce economies of scale and opportunities for the greater application of advanced data processing technology. A principal feature of this idea is that combined data bases for Parts A and B will result and that this will improve record-keeping and reimbursement and medical review at the local level.

We are not certain that these anticipated advantages can be realized through such mergers. First, there is the fact that the two aspects of the program function differently relative to the providers of care. Hospitals and institutions are organized and behave one way and physicians and other individual providers another.

Next, we call the Committee's attention to the fact that across the Medicare structure, operational A and B claims processing and related systems capable of producing the integrated processes that are sought have not been perfected. It would take both time and considerable money to produce and install such systems, particularly on such a large scale. We estimate that design of such systems alone will cost tens of millions of dollars. And the cost of installation at multiple sites would be even greater. More important, there is no way of knowing whether this speciai effort and expense will result in a significant improvement in overall efficiency.

Also, as with other consolidations, there is always the need to take cost of the changeover and its implications for disruption into account.

Finally, we note that, within the present configuration of carriers and intermediaries, there are a number of combined A and B contractors—longstanding situations where a single contractor operates both Medicare A and B on behalf of the Goverment. It must be noted that while many of these arrangements have involved central management of Parts A and B, none of them has produced the kinds of integrated process of the kinds that are sometimes talked about in discussion of the subject. In other words, experience has shown that the fundamental differences in the two Parts of the program require separate support systems.

IMPORTANCE OF PERFORMANCE STANDARDS AND CRITERIA

Throughout the presentation, we have pointed to the importance of objective performance standards and criteria in the management of Medicare and in the design of an effective and equitable relationship between the Government and the Medicare carriers and intermediaries. In fact, we believe their future refinement and use is vital to the future success of the program. They are absolutely critical to any significant improvements in Medicare administration. They can serve the mutual interest of both sides of the relationship and offer the Government a practical and workable means by which to measure comparative efficiency and performance—and by which to objectively make contractor changes.

Lest we imply that such standards and criteria are not yet in use, we would point out that they have been a part of all Medicare contracts for the past two years. We would also point out that their development has occurred as a cooperative venture between the Government and the Medicare contractors. The Government should be credited for having recognized their value and for having taken their development this far. But, despite the gains that have been made in this area, we are constrained to criticize their present basic design and the way in which they have thus far been

applied to practical situations. Our criticism, shared by all Medicare contractors, is that the present standards and criteria are not sufficiently oriented toward objective output measures, and are too numerous and detailed. These shortfalls make them less effective than they might otherwise be—than they should be.

More significant is the fact that, in their present form, they are centered too much on internal operating processes of the contractor and the way work is organized at the contractor level. This focus on how the contractor goes about his or her work discourages contractors from using their own initiative and from applying their own business success and acumen to Medicare. This approach also obscures and confuses the output measures that are currently included in the overall performance measurement package.

Despite these criticisms, we continue to believe in the essential value of performance standards and believe that they can be perfected to significant advantage for both the Government and the contractors.

SUMMARY

The Blue Cross and Blue Shield Associations agree with the conclusions of the GAO to the effect that experience with experimental price-based contracting does not demonstrate "that competitive fixed-price contracting will work successfully in Medicare."

We go further and say that rigid market-oriented contracting is simply not in the best interest of the program. The fact that the concept would apply to only 2 per cent of the program's total cost and puts the remaining 98 per cent at risk is, in our opinion, a powerful argument against a wholesale changeover in the way Medicare administration is structured.

But, at the same time, we accept the position of the Department of Health and Human Services that administrative improvements are in order, particularly in the case of marginal or poor performers and in the case of multiple contractors in given States—providing these two problems are approached with adequate planning and provision for transition from one contracting arrangement to another.

We do not believe consolidations beyond a State basis are in order at this time because of the magnitude of change required to put them in place. We do not see any cost-benefit gain from such changes as justifying the disruptions that would follow. Nor do we see an adequate capacity on the part of the Government to manage such large changeovers without serious risk to the program's ongoing operations. But, as noted, we do see circumstances where intra-state consolidations are manageable and offer some opportunities for improved efficiency.

We do not see the system as being ready for integration of Part A and Part B at the carrier and intermediary level. At the most, the concept should be considered at this time only on an experimental basis.

On the matter of the nomination process for Part A, we recommend its continuation. Thus in instances where performance dictates a change in a contractor, providers should be given the opportunity to nominate that substitute best able to maintain strong operational relationships. We see provider cooperation as being important to both the long term quality and cost of the program.

The Associations believe that, administrated even-handedly and monitored through meaningful performance standards, the concept of cost reimbursement continues to be the most appropriate approach to this kind of activity. However, we believe the principle has been erroded significantly through recent practice and that the time is ripe for the principle to be restored or for alternatives to be considered.

At this stage, we believe the number one priority of both the Government and the contractors should be the perfection of practical, output oriented performance standards. More than any other action that could be taken at this time, this one can contribute the most to an efficient, effective, mutually acceptable contracting relationship between the Government and its carriers and intermediaries.

I would close, Mr. Chairman, by emphasizing one point—our conclusion that Medicare administration is ill-suited for a price-dominated marketplace strategy should not be taken as an indication that Blue Cross and Blue Shield wishes to avoid competition. Nothing could be further from the truth. In our private business, we succeed every day in the marketplace. While community service is our mission, the success of that mission can only be realized through success in the marketplace.

Similarly, where competitions have been held in Medicare—the experimental competitions—we have been the winners in three out of four cases. We think we can continue to win if this becomes permanent public policy.

Thank you for the opportunity to testify on this important subject. We are prepared to try to answer any questions that you might have.

Senator HEINZ. Our next witness is Lester Alberthal, president of Electronic Data Systems Federal Corp.

Mr. ALBERTHAL. Mr. Chairman, we have approximately a 13- or 14-minute statement. In the interest of time, if we could have that filed in the record we would be happy to summarize, or we can do the entire thing.

Senator HEINZ. Without objection, the entire statement.

Mr. ALBERTHAL. The entire statement?

Senator HEINZ. The entire statement will be made a part of the record.

Mr. ALBERTHAL. And you would like me to summarize?

Senator HEINZ. Go ahead and abbreviate it.

Mr. ALBERTHAL. Thank you.

[The prepared statement follows:]

STATEMENT OF LESTER M. ALBERTHAL, JR., PRESIDENT OF E.D.S. FEDERAL CORP.

My name is Lester M. Alberthal, and I am President of EDS Federal Corporation. For the past 15 years, our company has served as a data processing subcontractor for twelve Medicare carriers. Two of our subcontracts are part of competitive bidding experiments in Maine and New York. We also serve as the Medicare carrier in Illinois under an experimental contract. We have learned a great deal which should be of value to this Subcommittee as it considers competitive contracting for the administration of Medicare claims.

Virtually every authority that has examined the current claims contracting process has concluded that it should be replaced with a mechanism that will infuse competition into the contractor selection process. This recommendation was made by the Perkins Committee in 1974, the Rubel Report in 1978, the President's Management Improvement Council in 1980, the Senate Governmental Affairs' Permanent Subcommittee on Investigations in 1981 and by each of the last four Administrations. We, at EDSF, based on our experience, agree with these proponents of competition.

As you know, Medicare law currently requires HCFA to award carrier contracts only to health insurance companies and to reimburse these companies for the costs of claims processing. The contracts between HCFA and these carriers are exempt from the normal competitive bidding requirements of federal procurement, and are routinely and automatically renewed. Historically, they have been subject to minimal performance evaluation. "Cost-reimbursement" of carriers, coupled with the traditional absence of any serious performance evaluation, has led to a far from perfect system.

Conventional, cost-reimbursed carriers have repeatedly been criticized for inefficiency, unresponsiveness, and lack of uniformity in policy and procedure. As an example, although HCFA has for some time required that carriers have tape-to-tape capability, carriers have been slow to offer this claims processing option. EDSF was able to offer tape-to-tape claims processing very early in the Illinois contract.

We do not suggest that all carriers are failing to carry out their responsibilities. Many are performing well. However, under the current system, they are not accountable enough for their performance and their costs. They bear no risk. Rather, the government carries it all. This fact has contributed to the growth in the cost to the government of claims processing to a staggering $700 million annually. If this trend continues unchecked, we believe that these costs will swell by 1990 to $2 billion annually. (See exhibit I.)

Substantial cost savings can be achieved by transferring some of the risk from the government to claims processors. Contractors which are at risk will hone their skills, cut the fat and red tape, and operate at peak efficiency.

We have heard that competitive bidding results in a reduction of services to beneficiaries, physicians and suppliers. EDSF's experience in Illinois demonstrates that a high level of services can go hand in hand with competitive bidding. In Illinois, we provide a multiplicity of services to beneficiaries including: seminars for senior citizens groups and clubs; training workshops for the staffs of senior citizens agencies; free speakers; educational materials; and perhaps most importantly, beneficiary aide volunteers who work directly with beneficiaries to help them file claims, answer questions and explain their rights.

We also provide services to physicians and suppliers including: regular meetings with professional societies and groups; workshops; on-site visits by field representatives; and prompt response to questions.

Thus, although costs have declined in Illinois, services have not. As any student of the competitive marketplace knows, competition occurs both in price and in service. EDSF believes that services will be enhanced through the infusion of competition into the claims processing selection process.

In addition to dispelling the notion that competitive approaches to contractor selection will reduce service, the EDSF experience in Illinois, as well as the experiments conducted to date in New york and Maine, has provided us with other insights about the benefits and difficulties that flow from competitive selection techniques. In a nutshell, the results of these experiments are clear: competitive bidding in Medicare claims contracting works. By the two quintessential criteria—carrier performance in claims processing and cost savings to Medicare—these experiments must be judged a success.

First, in each of the three states, the experimental carriers are now performing their claims processing functions quite acceptably. Their scores under Medicare's Carrier Performance Evaluation Program (CPEP) are encouraging. Under CPEP, each carrier is evaluated in accordance with performance standards in three areas—cost, timeliness and quality. In two out of these three areas, timeliness and quality, the Maine and New York experimental carriers score among the top fifty percent of all carriers. Even my own company, which got off to a rough start under its experimental contract, is in the middle ranges among carriers in terms of timeliness and quality. HCFA has not ranked the three experimental carriers in terms of its third major performance criterion, unit cost of claims processing. If it did, all three of the experimental carriers would rank within the top ten among the total group of 55 carriers. The average unit cost per claim for experimental contractors was $1.41 in fiscal year 1980 compared to a national average of $2.68 for all cost contractors. In short, the experimental carriers compare very well with conventional carriers in terms of the government's own performance standards.

Second, the experimental carriers have shown that competitive contracting saves Medicare dollars. I am not privy to the latest cost information from Maine and New York, but in a draft version of the forthcoming GAO report, which was made available to us last summer, these two projects were credited with saving the program $341,400 and $10.8 million respectively. I can speak with some confidence on the amount of money which the EDSF experimental contract in Illinois has saved Medicare. To date, the savings have amounted to $10 million in administrative costs. By the end of our contract, those savings will rise at least another $10 million to a total of $20 to $30 million. (See Exhibit II.)

Those administrative cost savings are clear. They are based on the contract price, and they are a matter of record. Are there other costs to Medicare for which we are responsible and which must be offset against these obvious administrative cost savings? We think not. We are aware of two suggestions of additional program costs resulting from the Illinois contract, but neither suggestion stands up under close inspection. First, it has been charged that EDSF has somehow "cost" HCFA the salaries and overhead of the HCFA and other HHS personnel who have been assigned to monitor the Illinois project. Yet these "costs" are precisely what one would expect as part of a large-scale experiment of this nature. These are costs which are attributable to the scope of the mandate to HCFA to conduct experiments with competitive claims contracting, and not to the competitive claims contractor itself.

It has also been charged that EDSF is responsible for some $25 million in unrecovered overpayments to physicians and beneficiaries in Illinois. This charge originated in last summer's draft GAO report. A detailed rebuttal of this claim is beyond the scope of my oral testimony today. I will only say that it is based upon a sampling method that is unsound and that GAO's conclusion is therefore speculative and unsupported. For further rebuttal of this claim, I refer the Committee members and their staffs to the relevant portions of our written submission, which we will be filing within the next few weeks.

Overall, our benefits payments under the experimental contract in Illinois have been consistent with the pattern established by the previous carriers. For example, fiscal 1978 was the last full year of operation for the prior carriers in Illinois. For that fiscal year, these carriers experienced an increase of 23.9 percent in Medicare benefit payments per Part B enrollee. For the next three fiscal years, during which EDSF processed claims in Illinois, the corresponding average annual increase per entollee was 24.8 percent. (See Exhibit III.) Our rate of increase in benefits paid is almost exactly the same as that of our predecessor, despite the fact that during our period of operations the general CPI and medical care component of the CPI both

increased faster than during our predecessor's last year. As there has been no great bulge in the rate of growth in our benefit payments, we must ask where these massive "overpayments" are hiding.

Some disruption in claims processing and payment delivery has occurred with each of the experimental contracts as the changeover to the new contractor was made. The amount and duration of the disruption has ranged from minimal in Maine, to serious in Illinois. I think we would all subscribe to the same goal: to hold any disruption of payments and beneficiary services to an absolute minimum. From our experience in Illinois, we have identified many of the causes of these transitional difficulties, and we have developed recommendations, which if implemented, would control and even eliminate many of the problems we have experienced there.

Our major conclusion is that there is a limit to the change which can be compressed into the transition period. In Maine, only the manner of contractor selection and the manner of contractor reimbursement was changed. Accordingly, disruption was limited and short-lived.

In New York, greater changes were tested. The contractor was replaced, geographic areas were consolidated, and different medical procedure coding systems were imposed. Correspondingly, in New York, several additional months were required for the carrier to overcome its transitional problems and to reach acceptable performance levels.

In the Illinois experiment, HCFA tested sweeping changes. There was a new contractor, a new method of paying that contractor, a new procedure coding system. Two incompatible procedure coding systems were converted to a new single statewide system that was unknown to providers in the state. Also, a new set of physician profiles was adopted. Two previous carrier areas were consolidated into one single area for the entirety of a large and populous state. A toll-free telephone service was provided to Medicare beneficiaries for the first time. In addition to these problems, we suffered from the self-inflicted burden of an abysmally poor choice of location for our carrier operations. As a result of our poor site choice, we encountered extreme difficulty in recruiting and retaining personnel and were forced to move a substantial portion of our claims processing to two additional sites within Illinois.

Since our rough start, however, we have improved steadily. We have learned that even uniquely difficult transitional problems can be overcome. We have also learned that many of the disruptions we experienced can be anticipated and prevented in the future. Therefore, we offer the following four recommendations:

First, the responsibility for processing claims should be transferred from the old contractor to the new one based on the date the health service is performed. This would allow the prior contractor to complete the processing of these claims which are already in the pipeline. It would prevent the prior contractor from passing delayed claims onto the new contractor.

Second, changes in medical procedure coding systems should be deferred for several months after the change-over to allow the new contractor's operations to stabilize. This brief deferral would allow the new contractor a period of time to educate both the providers and its own employees regarding the new coding system.

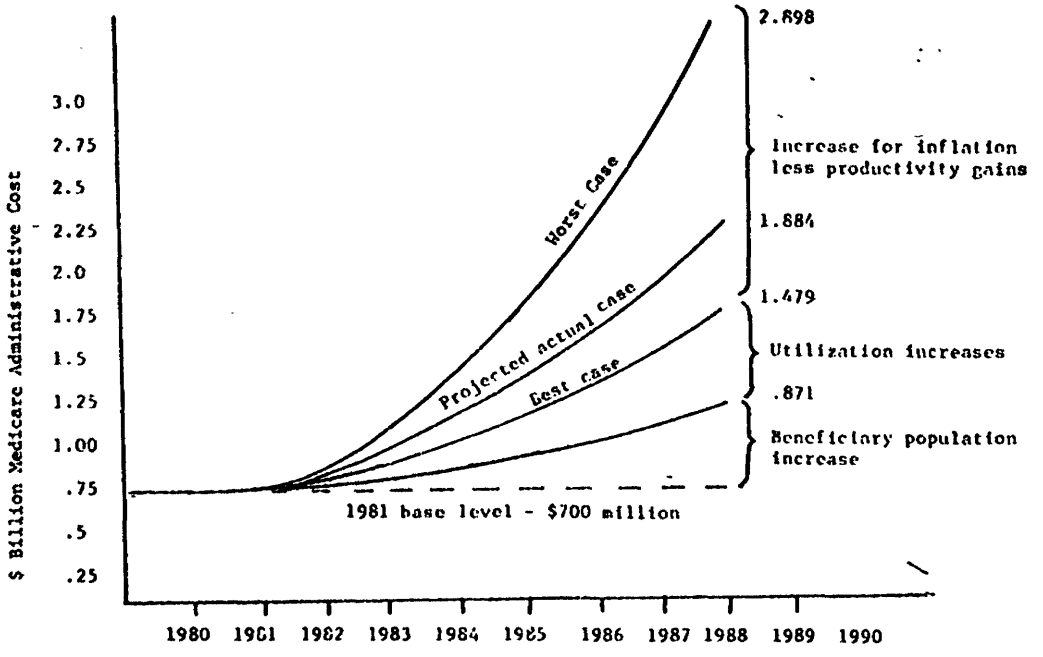
Third, novel and untested features in the Medicare program, such as toll-free telephone lines, should not be implemented until the transition period is over. Once the new contractor's operations are stabilized, its management will be able to devote full attention to implementing these new features efficiently and effectively.

Fourth, to make these contracts attractive to potential claims processors, the contracts should be awarded on the basis of a fixed rate per claim, rather than a fixed price for the total contract. We believe that the fixed-rate formula will make the risks of these contracts more reasonable, and will attract more competitors.

In conclusion, we should not forget the purpose of these three experiments: HCFA has sought to identify the problems which might arise in competitive bidding, to determine whether those problems can be solved, and to assess whether the long-term benefits of competitive bidding outweigh any short-term disruptions. This purpose has been fulfilled. The problems have been solved, or are on the way to being solved. The long-term benefits outweigh the short-term difficulties. Thus, we believe that competitive bidding for selecting Medicare claims processors should be significantly expanded. The experiments conducted thus far in Maine, New York, and Illinois have established that claims processing functions are performed and administrative dollars are saved when contracts are awarded competitively. Increased use of competitive contracting will provide HCFA an invaluable tool in assuring that the claims processing function is handled as efficiently and effectively as possible.

EXHIBIT I: PROJECTED GROWTH IN MEDICARE ADMINISTRATIVE COSTS

Medicare administrative costs are projected to rise during the 1980's from the current level of $700 million annually to almost $2 billion annually by 1990. This growth will result from the interplay of four factors: growth in the beneficiary population, increase in the utilization of medical care, the general rate of inflation, and offsetting productivity gains by Medicare claims processors. The effect of these four factors is illustrated graphically in the chart below and is explained in the text following.



Source: HCFA and SSA Data

During the 1980's, there will be an increase in the number of persons eligible to receive Medicare benefits, and in the number of persons who actually receive Medicare benefits. This growth in the beneficiary population, which itself is largely the result of an aging population, will place an additional administrative burden on the Medicare system. Using HCFA historical data, EDSF projects that the growth in the beneficiary population during the 1980's will increase the base level administrative cost for the program by $171 million. Administrative costs will also be increased by growth in the utilization of medical care, as patients require more numerous and more complex treatments and procedures. Growth in the level of utilization, sometimes called "intensity," is an historically established phenomenon. Within the Medicare framework, one measure of utilization is the number of claims submitted per beneficiary per year. Using this definition together with historical data, EDSF projects that the growth in utilization by Medicare beneficiaries during the 1980's will be responsible for an increase of $608 million in the base level administrative costs of the program. Taken together, the growth in beneficiary population and the growth in utilization of care will increase Medicare administrative costs from a base level of $700 million to $1.479 billion by 1990.

The impact of inflation and productivity gains on Medicare administrative costs during the 1980's is problematic. The general rate of inflation will drive up the costs which are experienced by claims processors. On the other hand, as claims processors become increasingly expert at their task, and as they acquire time-saving technology, their productivity will increase and the unit cost of claims processing will be lowered. Neither the general rate of inflation, nor the rate of productivity gains in claims processing, can be projected with certainty for the balance of the 1980's. EDSF believes that, in the best case, productivity gains will completely offset the

results of inflation. In this best-case scenario, with inflation and productivity cancelling each other, Medicare administrative costs at the end of the decade would rise no higher than the 1981 base level of $700 million, plus the amounts attributable to subsequent increases in beneficiary population and in utilization (i.e., a total of $1.479 billion). In contrast, a worst-case scenario would see inflation far outdistance productivity gains and drive total administrative costs for the program to $2.898 billion. Using historical trends and the best information at its disposal, EDSF believes that the impact of the general rate of inflation on Medicare administrative costs through the 1980's will be substantially offset by productivity gains. EDSF projects that inflation (less productivity gains) will be responsible for a modest additional increase in Medicare administrative costs of $405 million. As a result, EDSF projects actual growth in administrative costs to a level of $1.884 billion by 1990.

EXHIBIT II: ADMINISTRATIVE COSTS SAVINGS FOR HCFA UNDER THE ILLINOIS PROJECT

EDSF projects an administrative cost savings for HCFA of $27.2 million over the life of the Illinois experimental contract. These savings are measured by the difference between what HCFA will pay EDSF under this contract and what HCFA would have had to pay EDSF's two predecessors, Illinois Blue Shield and Continental Casualty Insurance Company, had they retained their carrier contracts. The table below sets out the data upon which EDSF bases its projection of $27.2 million in savings.

[In thousands of dollars]

	Fiscal years—				
	1979	1980	1981	1982	1983
Amounts actually paid (or to be paid) to EDSF under the Illinois contract:					
A-1: Annual	6,270	6,688	8,356	9,614	10,868
A-2: Cumulative	6,270	12,958	21,314	30,928	41,796
Amounts which would have been paid to Chicago Blue Shield and Continental Casualty:					
B-1: Annual	1,141	14,797	15,760	17,637	19,671
B-2: Cumulative	1,141	15,938	31,698	49,335	69,006
Cumulative savings to program	(5,129)	2,980	10,384	18,407	27,210

The amounts which HCFA has paid to EDSF, or which will be paid to EDSF, under the Illinois experimental contract are reflected in columns A-1 and A-2 in the table. These amounts are derived from the schedule agreed upon by EDSF and HCFA as part of the contract.

The amounts which would have been paid to Illinois Blue Shield and Continental Casualty during the fiscal years covered by the EDSF contract are shown in columns B-1 and B-2 of the table. These numbers are derived by a two-step process: first, determination of what the unit cost per claim processed would have been in Illinois had Illinois Blue Shield and Continental Casualty continued to function as the Medicare Part B carriers for the years covered by the EDSF contract; second, multiplication of these unit costs by the actual or projected volume of Medicare Part B claims in Illinois during the years of the EDSF contract. The first step, calculation of the unit costs of the predecessor carriers, is complicated by the fact that these carriers, like other carriers in the Medicare program, experienced productivity gains and lowered unit costs during the 1970's. The starting point for this calculation is the predecessor carriers' unit cost per claim for the last full year during which they had claims processing responsibility. That base figure was $8.25 per claim for FY 1978. If it is assumed that, for the period FY 1979-1983, these carriers would have continued to improve their productivity at the pre-1979 rate, then their unit processing costs for the years 1979-1983 would have been reduced to the following levels: FY 1979-$3.13; FY 1980-$3.04; FY 1981-$2.92; FY 1982-$2.82; FY 1983-$2.72. Using these unit cost figures, the second step in calculating the amount which HCFA would have paid Illinois Blue Shield and Continental Casualty is relatively straightforward. These unit cost levels, when multiplied by the claims volume in Illinois during the EDSF years, yield the amounts shown in columns B-1 and B-2 of the table. As the table shows, the cumulative administrative cost savings to HCFA

under the Illinois experimental contract were $10.4 million through the end of FY 1981, and will reach $27.2 million by the end of the contract.

EXHIBIT III: RATES OF GROWTH IN BENEFITS PAYMENTS UNDER ILLINOIS CONTRACT

The rates of growth in benefit payments under the Illinois experimental contract are consistent with the corresponding rates of growth during the last full year when EDSF's predecessors, Illinois Blue Shield and Continental Casualty, acted as carriers. The predecessors' last full year was 1977-78. EDSF's years are 1978-79 (in part) and 1979-80 and 1980-81 (in full).

The consistency in the rate of growth in benefit payment between EDSF and its predecessors is shown in three different measures: benefit dollars paid per enrollee; bnefit dollars paid per beneficiary; and total benefits paid.

1. Benefit dollars paid per enrollee.—During FY 1977, EDSF's predecessors paid $134.91 per enrollee (i.e., per individual enrolled in the Medicare Supplementary Medical Insurance Program [Part B]). For FY 1978, the corresponding figure was $167.11, leaving the predecessor carriers with a rate of increase of 23.9 percent between FY 1977 and FY 1978. Starting with the FY 1978 level of $167.11, the benefit dollars paid per enrollee have risen during the EDSF years in Illinois to $301.27 for FYD 1981. This works out to an annual increase rate of 24.3 percent during EDSF's years in Illinois.

2. Benefit dollars paid per beneficiary.—In the rate of growth in annual payments per beneficiary (i.e., per enrollee who receives health benefits during the year), EDSF again compares favorably with its predescessors. During FY 1977, the payments per beneficiary in Illinois were $256.91, while for FY 1978 the corresponding figure was $312.71. As a result, the predecessor carriers experienced a 21.72 percent increase in payments per beneficiary between these two years. Starting from a base point of $312.71 per beneficiary in FY 1978, these payments have risen to $503.47 for FY 1981 during the years of the EDSF contract. The annual rate of increase during EDSF's years works out to 19.61 percent.

3. Total benefits paid. EDSF's predecessors paid out $169,580,000 in total Part B benefits during FY 1977. For FY 1978, they paid out $213,164,000, yielding a 25.7 percent rate of increase between these two years. During EDSF's years in Illinois, there has been an increase in total benefits paid from $213,164,000 in FY 1978 to $404,076,000 in FY 1981. This growth in benefits paid reflects an average annual increase of 26.4 percent during the EDSF years.

Thus, in each of these measures, payments per enrollee, payments per beneficiary and total benefits paid, the annual rates of increase experienced by EDSF are within 1 percentage point of the rates of their predecessors. The consistency between EDSF's rates of payments increase and those of its predecessors is particularly noteworthy in light of the growth in beneficiary population, in the rate of utilization, and in the overall rate of inflation during EDSF's years in Illinois. Between 1978 and 1981, both the beneficiary population and the rate of utilization grew in Illinois. Furthermore, EDSF had higher rates of overall inflation to contend with; the CPI increased from 6.8 percent in 1977 and 9.0 percent in 1978 to 13.3 percent and 12.4 percent in 1979 and 1980, respectively. Each of these factors—higher beneficiary population, higher rate of utilization, and higher rate of inflation—placed upward pressure on EDSF's payment levels. Yet the increases in its payments levels are consistent with those of its predecessors.

STATEMENT OF LESTER M. ALBERTHAL JR., PRESIDENT, ELECTRONIC DATA SYSTEMS FEDERAL CORP., WASHINGTON, D.C.

Mr. ALBERTHAL. My name is Lester M. Alberthal, Jr. With me is Kim Hill of EDS Federal Corp. Mr. Hill is the vice president of EDS Federal and is responsible for the division that the Illinois contract is operated within, within EDS.

For the past 15 years our company has served as a data processing subcontractor for 12 medicare contract carriers. Two of our subcontracts are part of competitive bidding experiments in Maine and New York. We also serve as the medicare carrier in Illinois under an experimental contract.

We have learned a great deal which should be of value to the subcommittee as it considers competitive contracting for the administration of medicare claims. Virtually every authority that has

examined the current claims-contracting process has concluded that it should be replaced with a mechanism that will expose claims contracting to the discipline of the competitive marketplace. Conventional cost-reimbursed carriers have been repeatedly criticized for inefficiency, unresponsiveness, and lack of uniformity in policy and procedure. We believe that contractors which are at risk will sharpen their skills, eliminate waste and redtape, and operate at peak efficiency. We also believe that our experience in Illinois proves that a high level of services to beneficiaries and to providers can go hand in hand with competitive bidding.

In a nutshell, the results of the experiments are clear: competitive bidding in medicare contracting does work. By the two quintessential criteria—carrier performance in claims processing and cost savings to medicare—these experiments must be judged a success.

First, in each of the three States the experimental carriers are performing their claims processing functions quite acceptably. Their scores under medicare's carrier performance evaluation program, CPEP, are encouraging.

Second, the experimental carriers have shown that competitive contracting saves medicare dollars. For example, the savings to date to medicare under my firm's Illinois contract have amounted to $10 million. By the end of our contract we project our savings will rise another $10-plus million to a total of $20-plus million.

The GAO, in its just-released report, suggests that EDSF has somehow cost the Government $27.7 million in unrecovered benefits paid. I reject this charge categorically. It is based on a sampling method that is unsound, and it is therefore speculative and unsupported. Further, this charge is refuted by the fact that our benefit payments have been consistent with the pattern established by our predecessors in Illinois. Thus, our average annual increase in payments per beneficiary of 24.3 percent is virtually identical with our predecessor's increase of 23.9 percent during the last year of operation. Obviously, there has been no great bulge in the growth of our benefit payments; therefore, we must ask, where is this "massive" overpayment of $27.7 million, and where is that overpayment hiding?

There are likely to be problems when medicare changes carriers and changes the method of carrier selection. One of the most important lessons that we have learned is that there is a limit to the change that can be compressed into a transition period. In general, where there is the greatest number of changes tested, there will probably be the greatest disruption to beneficiary and provider services. In Illinois HCFA tested the most sweeping changes, including a new method of choosing a contractor, a new method of paying that contractor, a new procedure coding system, a first-time-ever toll-free telephone service. In addition, we were forced to change our claims processing location during midstream. Therefore, it is not surprising that the Illinois project produced the most serious disruption in beneficiary and provider services; nevertheless, after a rough start, we have improved steadily, and we have learned that even uniquely difficult transitional problems can be overcome.

To ease disruption in the future transitions, we recommend the following:

One, the responsibility for processing claims should be transferred from the old contractor to the new one, based on the date the health service is performed.

Two, changes in medical procedure coding systems should be deferred for several months after the changeover to allow the new contractor's operations to stabilize.

Three, novel and untested features in the medicare program, such as toll-free telephone lines, should not be implemented until the transition period is over.

Four, to make these contracts attractive to potential claims processors, the contract should be awarded on the basis of a fixed-rate claim charge rather than a fixed price for the total contract.

In conclusion, I suggest to the subcommittee that these experiments have effectively tested competitive bidding and that competitive bidding has met the test. We believe that competitive bidding for selecting medicare claims processors should be expanded. Increased use of competitive contracting will provide HCFA an invaluable tool in assuring that the claims processing function is handled as efficiently and as effectively as possible.

That concludes my summary statement. I would be happy to answer any questions that you have, sir.

Senator HEINZ. Mr. Alberthal, thank you very much. I do know that Senator Durenberger and Senator Dole do have some questions. I am not going to plagiarize by asking them of you. And I make the same request of you that I did of the previous witnesses, which is that you respond to the questions put to you in writing, for the record.

[The questions follow:]

RESPONSE BY LESTER ALBERTHAL TO QUESTIONS ON TESTIMONY GIVEN IN THE DECEMBER 3, 1981 SENATE FINANCE HEARINGS

1. Based on your participation in the fixed-price experiments, what do you believe to be the positive and negative aspects of fixed-price competitive contracting?

One positive aspect is that administrative dollars can be saved while the same or additional services are provided to the beneficiaries and providers. This has been demonstrated in each of the experiments. Another positive feature is that competitive contracting encourages carriers to be creative and efficient by providing freedom to utilize upgraded systems and operations. Competition also encourages new organizations to serve as carriers and intermediaries. A negative aspect of fixed-price competitive contracting is that the transition period is vulnerable to disruption if too much change is attempted. As stated in our testimony, we believe this is controllable. A second negative aspect is that unless a fixed rate rather than a fixed-price contract is used, risks to the contractor may be too great. This could restrict the number of bidders for the contracts.

2. To what extent did the HCFA regional office fail to provide assistance when requested?

We viewed HCFA, as all carriers do, as the monitoring agency and not as a supplemental resource. We do believe that more public education prior to the experiment at the regional level may have reduced some of the confusion for beneficiaries and providers. Many beneficiaries concluded that savings were being made by reducing the benefits. Many continue to believe that Medicare pays 80 percent of their medical expenses. The experiment was blamed when the provider's charge was not paid in full by the program.

3. What changes have you made in your operations based on input received from HCFA during the experiment?

Adjustments that were required to comply with various performance standards have been made. All carriers consider these routine and minor in nature.

4. In response to the GAO report you had indicated that the distribution of errors generally follows a 50-50 split between overpayments and underpayments. Your testimony indicated that you no longer hold that position. Would you explain?

In response to the GAO draft report our original objective was to verify GAO's quantification of underpayments and overpayments. We did not and do not contest the GAO's findings of payment errors in its limited sample, nor do we contest the GAO's findings that the errors in this sample were split evenly between underpayments and overpayments. However, we have been primarily concerned from the beginning with whether its methodology provides an adequate base for extrapolating to the actual amount of overpayments. Even today GAO continues to term these as "estimated overpayments" and has not been able to more specifically support the $27.7 million figure. Subsequent to our response to GAO, we conducted a number of reviews to determine more definitively the real overpayment problem. As we stated in our testimony, growth in benefit payments in Illinois has been consistent with the pattern established by the previous carriers. This point is illustrated in an attachment to our written statement. Further, as the GAO itself concluded, underpayments have been largely corrected. Hence they do not function to offset any alleged "overpayments." Since they are not offset by underpayments, these alleged "overpayments" should produce a "bulge" in EDS' benefit payments in Illinois. Yet, as we pointed out, it is precisely this "bulge" which is missing. Therefore, we concluded that, because the underpayments were corrected and because the total benefits paid have increased at the normal rate, benefit dollars have not been wasted in Illinois and the GAO's conclusions are unsupported.

5. The lengths of the contracts used in the experiments have varied. What in your opinion would be an optimum period of time for a competitive contract?

We believe the contract length of 5 years to be appropriate. This time period is adequate to encourage prospective contractors to make the financial investments needed to bid. It allows potential contractors to submit lower bids because a longer period is assured to recoup investments. Perhaps most important, this length minimizes needless turnover in the program and avoids disruption that might result from using contracts of shorter duration.

6. Should positive and/or negative incentives be used in competitive contracting?

Positive incentives should be introduced as well as negative incentives. Negative incentives encourage contractors to meet the minimum requirements to avoid penalties. However, negative incentives alone do not give the contractor encouragement to perform above the acceptable level. Positive incentives would encourage contractors to exceed average performance to reap financial benefits.

7. Do changes in the Medicare program tend to create significant problems under a multi-year fixed rate contract?

No. This is not a problem if a mechanism is provided in the contract to address significant changes in the Medicare program.

8. What should be avoided during the transition between carriers or intermediaries?

As stated in our testimony, changes in medical coding systems, changes in billing profiles and the addition of untested services should be deferred past the transition period.

9. Do you have any suggestions as to what actions HCFA and the HCFA regional offices might offer to assist those participating in further experiments?

Further experiments should utilize the assistance of HCFA regional offices to provide more education to beneficiaries and providers about the experiment itself. This should be started several months before transition and should continue through the transition period. Erroneous information caused unneeded fears for many beneficiaries and contributed to much of the confusion.

Senator HEINZ. Let me ask if you have any comments on any of the previous testimony that was given this morning.

Mr. ALBERTHAL. Not particularly at this time. We are prepared to follow up and answer any questions that the committee would have and expand our documentation to cover those.

Senator HEINZ. Well, let me thank you and our previous witnesses for having been here this morning. I think you have helped us establish a record that is very useful to the committee.

The hearing is adjourned.

[Whereupon, at 12:21 p.m., the hearing was adjourned.]

[By direction of the chairman the following communications were made a part of the hearing record:]

STATEMENT BY ROBERT C. WINTERS, EXECUTIVE VICE PRESIDENT, THE PRUDENTIAL INSURANCE CO. OF AMERICA

INTRODUCTION

This statement is submitted by Robert C. Winters, Executive Vice President of The Prudential Insurance Company of America.

Prudential was founded in 1875 as a life insurance company, and has grown over the past 106 years to become the country's largest insurer and one of its largest financial institutions with over $60 billion in assets. Prudential has been a health insurer since 1916 and today is the single largest health insurer in the country. Our group and individual health plans cover 16.1 million people in all 50 states and Canada. Total claims processed currently exceed 20 million a year with benefit payments exceeding $2.3 billion during 1980.

The Prudential has played a major role in government health insurance since the start of the Medicare Program in 1966. In New Jersey we have administered Medicare Part B (for the entire State) and Medicare Part A (for over half the institutional providers) since the start of the Program. Prudential was selected to administer the Medicare Part B Program in the State of North Carolina effective July 1, 1969. The same year, we were chosen as fiscal agent to administer the major part of the Medicaid Program for the State of New Jersey, effective with the beginning of that program on January 1, 1970. Subsequently, Prudential was designated as the Part B Carrier in the State of Georgia as of April 1, 1970. Prudential continues to fill the role as carrier, intermediary and fiscal agent for all of these Programs.

Most of Prudential's claim volume and experience is in Medicare Part B claim processing. In fiscal year 1967 our unit cost averaged $2.51 per claim. Our current Part B unit cost is $2.45 per claim. Considering the 180 percent rate of inflation over the past 15 years, a reduction in processing costs represents a significant achievement. The Part B national average unit cost was $2.69 during fiscal year 1980. This record of unit cost achievements is attributable to continuing systems improvements and the use of effective cost controls.

Equalling cost containment is the importance of quality claim processing. Prudential's Part B occurrence error rate has shown steady reduction; our New Jersey operation has one of the lowest error rates in the nation. In addition, our record of improvement in claim service is excellent. In fiscal year 1975, 53.2 percent of our Part B claims were processed in 15 days. Currently, over 90 percent of all claims are processed in 15 days or less.

Because of Prudential's Medicare contracting experience and our position as the country's leading health insurer, we feel we are well qualified to comment upon the subject matter before this Committee. Specifically, our experience in the Administrative Services Only (ASO) market has special application in this context.

Prudential has contractual "ASO" agreements with 358 group accounts under which we administer, on a non-insured basis, their health insurance benefit plans. ASO contracts are similar in nature to contracts for the administration of Medicare claims.

ANALYSIS OF COMPETITIVE BIDDING PROCESS

Problems

Prudential believes that much valuable information, applicable to the Medicare competitive bidding process, can be gained from a review of ASO arrangements. Our ASO experience suggests several problems with present Medicare bidding.

1. Bidding process.—The present request for proposal (RFP) is too complex, requires much irrelevant information, is costly to prepare and tends to discourage companies from entering the bidding process.

2. *Service requirements.*—The established service requirements are inappropriately enforced. The penalties for not meeting service objectives are unnecessary and tend to increase the cost of contracts.

3. Pricing.—The requirements for a multi-year, guaranteed, aggregate price is unrealistic and encourages conservative (inflated) pricing.

Recommendations

Several solutions suggested by practices in the private sector are recommended:

1. Bidding process.—The RFP should be divided into two phases. The first phase should be an initial request to determine which carriers are interested in bidding. It should be limited to information sufficient for HCFA to determine which of these carriers qualify for a more extensive phase 2 review.

Phase 1 should provide the carriers with background information on the contract; e.g., geographic region, number of beneficiaries covered, contract term, etc. It should set forth the deadlines for submission of information, the date of announcement of the award of the bid, and the effective date of the contract. It should also include the basic HCFA requirements for servicing the contract.

Phase 1 should request a brief questionnaire from each of the prospective bidders. This questionnaire should contain information sufficient for HCFA to decide whether a carrier has the basic qualifications necessary to participate in phase 2 bidding. Information such as current volume of claims handled by the carrier, total claim staff available to pay claims, averge claim turnaround time, degree and type of claim computerization, claim payment locations, the number of complaints filed against the company with State Insurance Departments, and a copy of the company's latest annual report should be included.

Depending upon the response in this preliminary phase, HCFA could determine the number of companies available for the more comprehensive second phase bidding. If the response proves insufficient to permit a meaningful competitive bidding, a decision could be made to continue the existing contractual arrangements.

The second phase of bidding should be more extensive and comprehensive. The focus should be on the claims payment capability of the carriers, including an on-site review by HCFA, and the actual cost projections.

While it is important to concentrate on a carrier's ability to meet the service requirements set forth under the contract, the extensive detail required by recent RFPs is unnecessary for an effective evaluation. For example, it should not be necessary for HCFA to review proposed career training and development programs, information concerning key personnel to be assigned to the project, and the description of communication channels between the contractor and the government.

The preparation and review of this information is of questionable relevance to the performance of the contract, and is unnecessarily costly and time consuming in the preparation of the bid and its evaluation.

2. Service requirements.—HCFA should establish service objectives at the outset of the contract, e.g. claim turnaround time, error ratio, etc. However, these factors should not be used to adjust the agreed upon cost of the contract during its term, but rather, should be a factor for consideration at the conclusion of the contract, to evaluate whether that contract should be renewed. Contracts should not automatically be re-bid at the conclusion of their term. Instead, a contract should be renewed, unless the in-force contractor has not satisfactorily performed during its term.

Prospective bidders should make a commitment to what they realistically expect their service results to be, but should not be penalized during the course of the contract for failure to meet those expectations.

The competitive pressure to keep a contract is sufficient incentive for a carrier to continue to provide the best possible service. When one considers the expense of the bidding process, the hiring and training of staff to meet contract obligations, and the investment in equipment, the treat of termination of the contract is a sufficient incentive for a carrier to meet or exceed its service objectives. This incentive is sufficient without penalties. The effect of the threat of imposition of penalties is only to increase the cost of the contract, as bidders seek to offset against the contingency of penalties.

3. Pricing.—The bid price should be broken down into two components: (1) a dollar cost per claim payment, and (2) a flat monthly fee recognizing administrative expenses such as overhead and profit. This could be expressed as a fee per beneficiary, downscaled as the number of beneficiaries covered increases. These fees should be guaranteed for the first year of the contract and permitted to increase during subsequent years dependent upon some predetermined index. By permitting an annual adjustment, a carrier is more likely to quote a lower initial fee if that fee is not subject to the vagaries of inflation in the later years.

It should be recognized that presently, Medicare administrative expenses account for less than 2 percent of the total Medicare cost. Accordingly, the margin for further administrative saving with that 2 percent is limited. In contrast, the potential for increased benefit costs because of cutbacks in claims control administration is relatively high. This emphasizes the importance of evaluating claims control procedures during the bidding process. There is a far greater potential for savings to the

system in effective claims control than the potentially false savings generated by cuts in the administrative budget.

Attached to our statement (Exhibit I) is a sample solicitation and quotation from a recently bid Administrative Services Only contract that provides examples of several of the points set forth above.

[Exhibit I]

ADMINISTRATION QUESTIONNAIRE

Question 1. Has many locations scattered throughout the country. Given this fact, where are your various claim offices located in relation to their operations? Please indicate which of these offices would be equipped to pay Life, Medical, A&S, Vision Care, and Dental claims.

Answer. In determining the proper claim payment facilities for Company it is important to assure that there be a sufficient volume of claims at each facility for economy and control purposes. Consideration should also be given to the establishment of a centralized banking account for use with PRU-MARC under the Minimum Premium Plan.

After review of the geographic distribution of the eligible employees and the Minimum Premium Plan banking arrangements, we believe one centralized claim paypoint will provide the most efficient and cost effective service possible. We recommend the claim payment facilities located at our Pittsburgh Group Claim Office located in Pittsburgh, Pennsylvania be utilized for the service and benefit payment of Company's health claims. Death claims would be paid out of our Central Atlantic Home Office located in Fort Washington, Pennsylvania.

Of course, we would be willing to process claims from additional payment facilities if desired. Prudential has established local group claim offices throughout the United States with major payment facilities concentrated in or around our nine regional home offices. Exhibit I outlines the locations of these group claim offices nationwide.

We would welcome the opportunity to meet with Company and discuss, in detail, their specific objectives for both localized service and cost efficiency to the payment of claims.

Question 2. Please describe your systems and procedures for paying claims to both patients and providers from the time the claim reaches your claim office through the mailing of payments and their accompanying explanations. Assume for the moment that you would be utilizing a direct type of system (i.e. claims with the exception of Life, AD&D, A&S, and Dependents Life would not require the employer to complete a portion of the form).

Answer. Medical dental claims can be paid on a direct certification basis with Prudential handling all claim matters on a one-on-one basis with each employee. Our ability to do this is contingent upon our receiving sufficient information to adequately determine eligibility. It will be necessary for Company to furnish Prudential a magnetic tape or a list containing the information required to set up an eligibility roster.

Each employee will receive a descriptive booklet outlining the Plan Benefits, as well as a wallet-size Health Insurance Plan Identification Card which will describe the benefits afforded by the coverage. Each employee will be given a supply of forms in a claim kit for use in filing claims. Instructions on how to go about submitting claims will be printed on the forms. Included on each claim form will be the address and telephone number of the Central Atlantic Regional Home Office Claim Division.

Using this system minimizes the role of Company in its claim flow. All contact with providers of medical and dental services as well as contact with the employees is performed by Prudential. Benefit checks will be sent directly to the insureds or assignees; copies can be sent to Company if desired.

Prudential has a fully developed functioning on-line computer claim systems in operation for the payment of medical and dental claims. These systems have been functioning efficiently for some years and our claim and system support staff is thoroughly familiar with its operation. Continually revised and updated, we consider both PRUTRAC and Speedental to be the most advanced claim processing systems in operation in the country. Exhibit II graphically explains the PRUTRAC system, and Exhibit III graphically explains the Speedental system.

Both PRUTRAC and Speedental utilize typewriter cathode ray tube terminals which are connected on-line to a large computer. By using a time-sharing system, each terminal user has immediate access to the computer and can, in effect, "converse" with it. The computer has disk storage capabilities which are used to store programs, employer and group plan details, claim histories, eligibility rosters, ad-

dress files, etc. Disk files also provide temporary storage for the current day's claim payment details.

When medical claims are received at Prudential, they are opened and employer eligibility is confirmed. The claim examiner than evaluates the claim, determines that it is payable, and subsequently enters pertinent data regarding the claim into the computer via the terminal. The interaction between the examiner and the computer is carried out in a conversational mode which guides the examiner and allows continuous cross-checking. The examiner has instant access to action taken on prior claims. This information plus a detailed record structure of your benefit program insures accurate claim processing.

The current day's claim details are temporarily stored in the computer. At the end of each day, this information is checked for accuracy and transferred to magnetic tape. This transaction tape is then computer processed in an overnight cycle to produce the Explanation of Benefits and check. The system produces data which is subsequently utilized by our claim accounting and statistical systems.

PRUTRAC utilizes on-line claim history records. These records provide instant access to claim data and are used by Prudential claim personnel to check past claim history when processing claims. The actual paper claim files backing up these records are available at the Prudential claim payment facility.

Prudential's philosophy has always been that the purpose of a health and welfare program is to pay benefits when due. Each claim is given the consideration we would expect to receive on our own claim. We pay no more and no less than provided by the program, making appropriate and no less generous administrative interpretations when necessary. Our claim practices are consistent with this philosophy and we are guided by the following principles:

Claims will be evaluated by trained, capable people under experienced supervision.

Benefit provisions will be applied uniformly.

Claims will be processed promptly.

Benefits are either payable or not payable; compromises are rare and involve exceptional circumstances.

Questionable claims will be thoroughly investigated and fully documented before a decision is made.

Claim decisions will be based upon factual information only.

Claim decisions will not be influenced by the amount at risk.

Where circumstance indicates, professional medical and legal advice will be sought and respected.

Claims which are not payable will, before action is taken, be reviewed by a person with greater authority than the person authorized to pay the benefit and any disputed decision will be reviewed by management.

Whenever benefits are not payable, the claimant will be given a prompt, complete explanation and told of our willingness to reconsider based upon any pertinent additional information.

As with medical claims, dental claims will be paid on a direct certification basis. The claim kit will contain claim forms with instructions for submission.

The claim form with Part 1 completed by the employee should be taken to the dentist on the first visit.

The dentist will perform an examination, recommend treatment and estimate the charges for performing the necessary services.

If the estimated fee is $300 or less, the dentist will proceed with the necessary treatment and submit the completed claim form to Prudential.

If the estimated fee exceeds $300, the dentist will submit the proposed plan of treatment to Prudential before treatment is begun. This procedure is designed so that the employee and the dentist will clearly understand what procedures are covered and how much the plan will pay before the dental work is started. The dentist's report should include: a list of dental services recommended; the charge for each service; and supporting X-rays.

If the treatment is for orthodontic services, the dentist's report should contain: a classification of the malocclusion or malposition; recommended treatment; an estimate of how long the treatment will last; and, the estimated total charge.

Prudential will review the recommended plan of treatment, indicate all parts of the treatment covered by the Dental Plan, and prepare an estimate of Plan benefits.

We will then return the estimate of benefits to the dentist. The employee and dentist can then review the estimate and the employees portion of the fee, and decide whether any changes should be made in the treatment recommended.

The dentist should proceed with the treatment agreed upon. By following the above guidelines, prompt payment of claims can be assured.

When dental claims are received at Prudential, they are opened and employee eligibility is confirmed. A claim examiner then reviews each claim, determines if it is payable and inputs it directly to the computer through one of the terminals located in the claim area. If the claim had been previously predetermined, the claim examiner verifies that the services actually rendered conform to the previously approved treatment plan. The computer compares the individual claim data to a master policy record, calculates benefits and produces a magnetic tape output containing each day's entire claim input.

The computer tape is processed on an overnight basis to produce checks, Explanation of Benefit forms, all the necessary accounting and statistical records, as well as updated individual claim histories in microfiche form for the claim examiner's future reference.

Benefit checks are generally paid directly to the employee who is then responsible for payment to the dentist. However, space is provided on the claim form to authorize benefits to be paid to the dentist.

You will find Prudential to be both flexible and innovative in developing effective claim methods which get the job done with minimal paperwork while also providing adequarte financial safeguards. We will work closely with L. B. Foster Company in developing claim procedures best suited to your particular needs.

Question 3. Please supply us with copies of the various claim forms your system would utilize for Medical, Dental, and Vision care.

Answer. Please refer to Exhibit IV for a sample of each of these claim forms.

Question 4. Describe in detail your system for maintaining patient records so as to assure completeness and accuracy with regard to claim payments.

Answer. Please refer to question 2.

Question 5. Assuming that your system would involve direct payment of claims to patients and providers, what type of updated information with regard to additions and terminations would you need from the employer and with what frequency?

Answer. Prudential's ability to properly administer claims on a direct pay basis is dependent upon our receiving sufficient and periodic information to adequately determine eligibility. The information required includes: name of employee; social security number; whether or not dependents are covered; effective date of coverage; and termination date of employment.

This information is usually provided by our larger policyholders on a magnetic tape. Our systems staff would work with L. B. Foster Company to devise a simple computer format for providing and periodically updating the information

Question 6. In terms of working days, what is your normal turn-around time for payment of the various types of claims assuming that all information is complete?

Answer. Our objective is to process 85 percent of all claims in ten calendar days. We are currently processing over 90 percent of all claims within 10 calendar days. This includes dental claims above $300 which have not been submitted for pre-determination of benefits. For pre-determinations, we expect to provide 10 day service if the claim does not require referral to our dental consultants. If the claim requires referral, turnaround will take approximately two weeks.

We would anticipate meeting our stated objectives on L. B. Foster Company's medical and dental claims.

Question 7. Please furnish us with copies of your sample payment vouchers and the accompanying explanations which would be sent to patients and providers.

Answer. Please refer to Exhibit V.

Question 8. Indicate the percentile level below which your system would consider claims to be within the range of reasonable and customary for both Medical and Dental.

Please refer to question 9.

Question 9. What methodology does your system utilize to determine reasonable and customary allowances? With what frequency is it updated? Recognizing that reasonable and customary allowances vary within different parts of the same metropolitan area, how is your system refined to cope with this?

Answer. To determine reasonable and customary benefit charge levels, the Prudential accumulates and maintains profiles derived from fee data received for benefit determination purposes from doctors and dentists across the country.

Since physician and dentist fees reflect differing costs of doing business in various parts of the country, the profile system recognized these regional differences. The country is currently divided into 243 population areas based on demographic and economic characteristics. These areas are identified by the first three digits of the zip codes. Large urban areas, such as Pittsburgh, Pennsylvania have been subdivided so as to more accurately reflect local economic conditions, while smaller areas

have been expanded beyond municipal boundaries in order to obtain a more representative cross-section of charge data.

Fee information for the most recent twelve month period is used as the basis for a Surgical Fee Guide, a Dental Procdure Fee Guide, and a Dentist Fee Guide which are the basic tools for reasonable & customary determinations. The fee guides are updated quarterly and at that time this latest information is released to all claim paying personnel. The R&C factors were last updated on Sept. 1, 1981.

Among other pertinent data, the Guide reflects for each surgical and dental procedure within each of the 243 areas the dollar value of the charge representing the 90th percentile. This charge is the one which is at least as great as 90 percent of all charges recorded in that area for a given procedure. Prudential utilizes this prevailing fee calculation procedure in its determination of the level that represents a reasonable and customary benefit.

With the advent of Prudential's PRUTRAC and Speedental computerized claim payment systems, the profile information is "on line" for the use of the claim examiner. These systems also insure that an examiner cannot exceed the reasonable and customary fee for a given procedure without the claim receiving higher technical review.

Our experience shows that Prudential's fee evaluation procedures permit us to be responsive to changing patterns of both physician's and dentist's charges and to changes in the demographic and economic makeup of communities throughout the country. At the same time, they meet the needs of policyholders, claimants and benefit providers by providing consistent benefit determination on a nationwide basis.

Question 10. What types of assistance do you provide the employer and/or employees, in terms of litigation or peer review, when a providers charges are grossly in excess of reasonable and customary allowances?

Answer. When charges for covered services exceed the customary allowance, we pay the amount determined by our surgical or dental fee profile. The difference between the fee charged and the benefit paid is shown as an ineligible expense on the Explanation of Benefits.

In those infrequent instances when our determination is questioned by the physician or dentist, we request additional information concerning the disputed item or service. Whenever our determination of a "reasonable and customary" fee for a surgical or dental procedure has been questioned, we:

(a) Request a copy of the operative notes.

(b) Ask the physician or dentist if there were any post-operative complications or extenuating circumstances which would explain his fee being higher than expected.

(c) Reevaluate the reasonable and customary surgery or dental fee.

If necessary, the Prudential utilizes the services of Medical or Dental Review Committees where such committees have been established and where experience has shown that the committees are objective in their evaluation of case situations.

We also have available our own medical department and consultants who review case situations and work at maintaining liaison with the medical community. Additionally, many of our Prudential people serve on state or regional Health Insurance Council Committees. Through their interface with local organizations, dentists, doctors and hospitals, they have achieved a cooperative atmosphere, lessening potential problem areas.

In making the reasonable and customary determination, we recognize that a doctor or dentist and his patient may agree upon a fee and we have no desire to interfere with any arrangements made. However, should the physician's or dentist's charge be greater than the prevailing rate, and the employee choose not to pay the excess, he may expose himself to possible legal action by the physician or dentist for that amount. If the provider sues the employee to collect the excess portion, Prudential, at the employee's request, will provide his attorney with the basis for our "reasonable and customary" determination. Furthermore, if we are joined in the suit as a co-defendant, we would defend our position accordingly.

Question 11. What types of claim payment information would your company be willing to provide the employer? With what frequency? Are there any additional charges for this information which were not included in your rate or retention setting process, and if so what are they?

Answer. Prudential will furnish Company with a Claim Experience Report and a Group Insurance Benefits Payment Listing. These reports are routinely furnished at no cost and are included respectively as Exhibit VI and Exhibit VII.

The computer produced Claim Experience Report will contain the premium and claim figures on an employee and dependent basis, accumulated from the last policy anniversary to the "To" date shown on the second line of the report. This report,

helpful in examining claim experience and isolating specific problem areas of claim activity, is produced monthly.

The Group Insurance Benefits Payment Listing shows each individual claim payment made under the plan. The claim payments are listed alphabetically by name of the insured employee. Pertinent details of each claim are shown. This report facilitates a review of each employees claim history, and can be produced on an annual, monthly, quarterly, or year-to-date basis.

Additionally, both the PRUTRAC and Speedental systems generate a number of other statistical reports. Reports available from the PRUTRAC system include the Reasonable and Customary Savings Report, the Health Claim Service Index Report, and the Benefit Plan Management Report which provides a summary of claim experience and the effect of deductibles, coinsurance, and coordination of benefits. Reports available from the Speedental system include the Analysis of Dental Procedures/Benefits Report, the Coordination of Benefits Saving Report, and the Report of Dental Procedure Utilization. All of the policyholder statistical reports, available upon request, are described in detail in the respective PRUTRAC and Speedental sections of this proposal.

An additional charge is made for the PRUTRAC Automatic Claim Analysis Report and the "SCOOP" (Speedental Customer Oriented Output from Prudential) reports. Each request for the PRUTRAC Automatic Claim Analysis Report will result in some inventoried costs. For each request for SCOOP reports a charge of $300 is made for the first exhibit produced. For each additional exhibit requested at the same time, the charge is $150.

As is Prudential's custom of providing quality service utilizing the latest technological advancements, we expect to install a new dental claim payment system in the fall of 1982. This advanced claim payment system, known as PRUDENT, will allow for the production of SCOOP reports at no additional cost.

California Hospital Association
1023 12th Street Sacramento, CA 95814 916/443-7401

December 18, 1981

The Honorable David Durenberger
Chairman, Subcommittee
on Health
Senate Committee on Finance
United States Senate
2227 Dirksen Senate Office Building
Washington, D. C. 20510

Subject: Hearing on Competitive Contracting for the Administration of Medicare, December 3, 1981

Dear Senator Durenberger:

The California Hospital Association (CHA) respectfully submits the following comments and recommendations for inclusion in the record of your December 3, 1981, hearing on competitive contracting for the administration of Medicare.

There are two components of this issue we would briefly like to address: Fixed-price contracts for Medicare program administration and provider nominations of intermediaries.

First, based on two years of experience with the state's Medicaid program, the California Hospital Association has very strong reservations about national fixed-price contracts for the administration of the Medicare program. In fact, while we recognize the need for cost saving measures, we reluctantly must argue against such proposals because it may further expose California hospitals to the same sort of financial damage they are suffering under the state Medicaid (Medi-Cal in California) intermediary fixed-price contract with Computer Sciences Corporation. Our arguments would center around the design of the contract and specifications of the request-for-proposal to bid: The greater the emphasis on screens and edits, the more likely the system would have a disastrous impact on providers due to excessive delays in claims payment. In California, the state obtained a highly sophisticated system for reviewing claims to prevent fraud and abuse, however, the primary purpose of the system, which is to pay claims, has been badly mismanaged.

After two years and despite CHA's efforts to make the payment system work properly, many computer programming and administrative problems continue to remain unresolved. A survey in early 1981 conducted by the accounting firm of Ernst and Whinney for CHA, shows Medi-Cal accounts receivable at 176 hospitals increased an average of 32 percent in 1980, the first full year of the contract. The report also found that hospitals were spending an average of $17,146 for clerical help and $20,693 in interest expense annually because of fiscal intermediary problems.

Hospital claims are subjected to more than 1,100 edits, and 60 percent of claims submitted are suspended before payment. The vast majority of these are the result of "system deficiencies" or the state's inability to maintain current eligibility files.

Two audit reports, prepared in mid-1980, one a state Health and Welfare/State Controllers office study and the other an Auditor General's investigation for the Joint Legislative Audit Committee, blamed payment delays on inadequate Department of Health Services management and poor computer service.

In November, 1980, Beverlee Myers, Director of the Department of Health Services, told the Commission on California State Government Organizations and Economy that among the shortcomings of the CSC contract, itself, was its "fixed-price nature" and the many levels of review any changes must go through.

In short, CHA must continue to endorse the current system of Medicare program administration. However, at the same time we recognize the cost saving potential of fixed-price contracts: The key element is equitably balancing the understandable need by the government for protection against fraud and abuse and the equally understandable need by providers for prompt claims payment. To us, an equitable fixed-price contracting system for Medicare program administration would require close negotiations by the affected parties to avoid the current inequities we have in the Medi-Cal program.

In regard to our current intermediary system, we hope that budget proposals to further reduce reasonable cost reimbursement for the intermediaries will not be accepted. Hospitals, especially in California, are experiencing growing financial hardships as a result of reimbursement restrictions. Any delays in Medicare payments could, in some instances, lead to hospital closures.

Next, we want to express our continued support for the current provider intermediary nomination process. However, we would like to suggest that the law be strengthened to give a provider's nomination more weight. Current law requires the Secretary of Health and Human Services only to take the providers nomination into consideration when selecting intermediaries--he is not bound in

any way to accept the nomination. While we would desire such an arrangement, we recognize the implications of such a mandate and, in turn, suggest that if the Secretary selects an intermediary other than the nominee, he be required to publish findings as to why he chose that particular intermediary.

Further, we also propose that hospitals be consulted during the periodic examination of the respective intermediaries. Since the outcome of this evaluation will affect the extension of the existing contract, it is essential that the provider, who is the most at risk, be asked for a performance assessment.

In closing, thank you for the opportunity to present our concerns. If there are any questions, we would be happy to meet with you or the appropriate members of your staff.

Sincerely,

John H. Ferman
Assistant Vice President
for Government Relations

JHF:dm

cc: Paul D. Ward
William Abalona

Statement of the American Hospital Association
to the
Subcommittee on Health
of the
Senate Committee on Finance
December 18, 1981

The American Hospital Association (AHA), on behalf of its more than 6,100 member institutions and 30,000 personal members, is pleased to have this opportunity to present its views to the Subcommittee on Health regarding potential changes being considered in the current contracting methods and arrangements for the administration of the Medicare program.

The Department of Health and Human Services (HHS) continues to show an interest in altering the time tested and proven Medicare-hospital intermediary process. This interest stems from a belief that the current method of awarding intermediary contracts and of permitting hospitals to nominate their intermediaries, as provided by statute, is inefficient and costly.

The Health Care Financing Administration (HCFA), argues that by changing from cost reimbursed intermediary contracts to fixed-price contracts awarded on the

basis of competitive bidding, and by eliminating the right of hospitals to nominate their fiscal intermediaries, federal expenditures for administration of the Medicare program can be reduced. HCFA supports this contention, based on results of three experiments with Part B fixed-price contracts conducted in Maine, New York, and Illinois. An AHA review of these studies finds that the HCFA arguments to modify the existing system, based solely on the results of these experiments, are not defensible.

AHA's Position

We believe that the current hospital intermediary system is working well and that alterations in contracting methods would cause needless disruptions in a system that is currently providing excellent service at a relatively low price. Further, we believe that the complexity of the Medicare program and the related complexity of the fiscal intermediary function preclude awarding contracts based solely on a price determinant. Finally, we believe that the right of providers to nominate their intermediaries must be upheld as an integral part of the current system. HCFA can and should seek refinements and improvements through adoption of a uniform claim form and paperless claims processing and by using existing legislative authority to ferret out poor performers or high cost intermediaries, without disruption of the entire contracting process.

Current Program Administration

The Medicare program is a complex entitlement program covering 28 million individuals, as of September 1, 1981. Part A benefit payments for FY 1981 amounted to $28.1 billion. HCFA administers the program with the assistance of 69 intermediaries, with current costs for program administration amounting to only 1.7 percent of total program costs. This compares very favorably to commercial insurance company administrative costs which, according to a New York State Insurance Department report, approximate 14.5 percent, and Blue Cross administrative costs, which approximate 7.3 percent.

Since the inception of Medicare, program administration has progressively become more efficient, resulting in reductions in unit costs and improvements in productivity. According to the Blue Cross and Blue Shield Associations, between 1973 and 1979, after adjusting for inflation, administrative costs were reduced by 49 percent and contractor productivity increased by almost 80 percent. We believe that these reductions in cost are attributable to the experience gained by contractors in administering the program. Certainly they are not indicators of a poorly run program in need of major modifications.

The cost reductions have been achieved despite the fact that the work of the contractors is not simply a matter of "paper-pushing" or claims payment. In addition to assuring the clerical accuracy of the claims, the intermediary

must verify beneficiary eligibility, determine coinsurance and deductible levels and lifetime reserve days, and establish that the services provided are medically necessary and of acceptable quality, etc.

In addition to their important claims processing role, intermediaries are responsible for determining the actual cost of the services rendered. Hospital services, in accordance with the Medicare statute, are paid on the basis of reasonable costs. Thus, payments made on the basis of claims are merely interim payments subject to adjustment at the end of the hospital's fiscal year. Actual cost determinations are made by applying Medicare cost finding principles to claims data and other data supplied by the hospital. The intermediary is responsible for auditing the data and making a final settlement with the hospital. Such functions require considerable understanding not only of Medicare's rules and policies but also of the particular practices of individual hospitals. Existing intermediaries have gained the expertise needed to perform this function efficiently through their long-term involvement in the program and their close relationships with hospitals.

Knowledge gained from hospital-intermediary relationships has led to subtle refinements in the administration of the program. Intermediaries and hospitals have engaged in mutually beneficial educational programs, developed workable channels of communication, and begun to develop cost saving electronic claims systems.

We believe that altering the current method of contracting would inevitably lead to major disruptions in the system. This is particularly true if contracts would be rebid on a one or two-year cycle. Long-term relationhips would be destroyed, and sophisticated software and electronic claims communications systems would be abandoned only to be recreated when a new contractor would take over.

Experiments in Part B Contracts

Service disruptions are an inevitable outcome of any change in a system as complex as that which is responsible for Medicare's contracting methods and arrangements. To date, no fixed price Medicare Part A contracts have been evaluated; however, experiments in Part B contracts may give us some indication of the impact of such changes on hospitals were the system to be disrupted.

In experimental Part B projects in New York and Illinois, contractors initially experienced high claims backlogs, poor quality assurance, and high correspondence and review levels. Of particular interest to hospitals is the impact of the new system on claims payment. In Illinois the contractor failed to process at least 75 percent of the claims in 15 days or less, as required by HCFA standards, between June 30, 1979 and June 30, 1980. If all hospital claims payments were similarly delayed, hospital cash flow could be impacted

by as much as $57 million for each day the claims were not paid[1]. In order to recover this temporary deficit, hospitals would be forced to borrow, incurring interest expense that would have to be borne proportionately by all payers, including Medicare.

Other payers' experiences with fixed-price contracts further illustrate the disruptions that can occur. In 1975, the Department of Defense's Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) awarded an intermediary contract in the Southwest based solely on a low bid. The results were poor service to providers, claims backlogs, and an increase in unpaid CHAMPUS receivables. CHAMPUS was forced to terminate its contract and return to its previous system, but not without a significant program disruption. No funds were saved, providers and beneficiaries became dissatisfied, and extensive costs were incurred.

More recently, in 1978, California Medicaid awarded a fixed-price intermediary contract to Computer Service Corporation (CSC). The result has been elimination of provider relations staff, poor service for patients and providers, and an increase in the number of days of claims processing of Medicaid

[1] Note: Assumes that $15 billion will be paid to non-Periodic Interim Payment (PIP) hospitals in FY 1982 over 260 working days.

accounts receivable--from 70 days prior to CSC implementation to 100 days currently, a 43 percent delay.

Service disruptions would be more frequent if fixed-price contracts were rebid every year or two. Hospitals and contractors just beginng to establish a viable working relationship and gaining an understanding of the system would suffer a disruption simply because a new, lower bidder would appear.

We would also point out that claims processing systems require a substantial investment in capital for such items as electronic data processing equipment, software packages, staff training and education, and production techniques. With the exception of insurance companies which already have a need to develop these systems, we believe the ability to recover capital investments could limit the number of potential companies which would be eligible to compete in a HCFA low-bid system. Over time, a potential monopoly of one or two non-insurance companies could dominate the system, since others, which would lose bids every year or two, would be unable to recover their capital investments. Creating a monopoly situation would be counterproductive to the competitive bid process. In time, the cost of all capital investments would be borne in the price of the contract HCFA would have to award the surviving company.

We believe that the Congress and HCFA must recognize the inevitable disruptions that would become part of a fixed price contracting scheme. We further

believe that the full cost of the changes to all participants--beneficiaries, hospitals, and government--must be calculated in evaluating the appropriateness of a fixed-price contract, not just the apparent low price of such a contract.

Implementation of a competitive bidding process for intermediary contracts, would ignore the non-quantifiable service component of an intermediary's responsibilities. Competitive bidding is an effective cost saving mechanism when used to purchase services that are easily measured. In purchasing services that are not easily measured, however, quality considerations must be included in the process. If they are not, quality may be replaced by a concern for the bottom line. Initial savings achieved through fixed-price contracts could well be lost if claims were processed erroneously, payments delayed, or errors introduced because providers had not been adequately educated by an intermediary in completing their claims requests. Price alone cannot ensure reliability, understanding of the program, or good working relationships with providers.

For example, HCFA estimates that the experimental contracts have saved $341,400 in Maine, $10.8 million in New York and $20.6 million in Illinois. However, performance in these experiments, according to the General Accounting Office (GAO) has ranged from satisfactory in Maine and New York to unsatisfactory in Illinois. In Illinois alone overpayments to providers and beneficiaries are estimated to be $27.7 million. In addition, no pricetag has been

estimated for the delayed claims processing, correspondence, and review activities. We believe that a cost benefit analysis in Illinois may actually show that the true costs of the fixed-price contract could well exceed those of the traditional cost reimbursed contract. In Maine we know that this is true just on the basis of the contract cost. The recently reawarded contract apparently calls for a per claim cost of 68 cents more than the national Part B average processing cost of $2.62--a 26 percent increase, making for a total of $3.30.

Nomination Process

The use of competitively bid contracts as proposed by HCFA for Medicare would eliminate the hospital's right to nominate its intermediary. This right was included in the original Medicare legislation in order to ensure acceptance and smooth operation of the program. We believe that the exercise of this right has not only achieved its original goal but also continues to ensure a well run program. As a result of this right, hospitals retain a method of commenting on intermediary performance. This is a useful check and balance on the system.

Further, we believe the nomination process has fostered the longstanding useful business relationships we mentioned earlier. This has led to stability in the system, a stability of value to beneficiaries, providers, and the federal government. To eliminate the nomination process would disrupt the system.

Conclusion

HCFA contends that it needs flexibility in managing its programs that would be provided by competively bid contracts and the elimination of provider nomination of intermediary. We concur with GAO's recommendation that such systems improvements can be made within existing legislative authority. Savings can be achieved by consolidating workloads and eliminating high cost or poor performers. Such a consolidation with the consent of the hospitals has been implemented in New York. Because it is a cooperative venture of new and old contractors, disruptions have been minimized. We therefore urge that the Congress require HCFA to use its present authority to make whatever improvements are necessary in the least disruptive manner.

We cannot overemphasize the proven effectiveness of the current system, especially in the area of audit review and settlement. Totally disrupting the system to achieve some potential savings in claims processing would not save scarce federal resources. Rather, it would create a potential for annual massive disruptions every time hospital-intermediary relationships changed. AHA remains totally opposed to any changes in the right of hospitals to nominate their fiscal intermediaries.

AHA would be pleased to respond to any questions the members of the Subcommittee may have regarding our position.

○