92d Congress
2d Session

CONFIDENTIAL COMMITTEE PRINT

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MEDICARE AND MEDICAID

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COMMITTEE ON FINANCE
UNITED STATES SENATE
RUSSELL B. LONG, *Chairman*

MAY 31, 1972

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE
78-624 WASHINGTON : 1972

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Following earlier committee discussion of an amendment proposed by Senator Hansen, the Committee suggested the Social Security Administration work with the staff in developing a suggested amendment designed to encourage and reward efficiency and economy on the part of Medicare's administrative agents.

In preparing the proposal for the committee, discussions were held with representatives of all of the different types of carriers and intermediaries. The recommendation outlined below, in large part, takes into account the views expressed by those organizations. The staff and the Social Security Administration believe the recommendations represent a reasonable approach toward instituting an incentive payments program consistent with the legitimate interests of the carriers, the program, and the public.

Proposal

It is suggested that Title XVIII be amended to establish an incentive award system to provide program carriers (and eventually intermediaries) with financial incentives toward achieving maximum quality of performance in service to beneficiaries, compatible with program objectives and requirements.

An important step in achieving an effective incentive payment system would be to provide that only carriers meeting minimum standards of effectiveness participate in administration and that the areas of work assignment be consolidated as necessary to secure areas of such a size that makes optimum effectiveness possible. The carrier evaluation system has the following objectives:

1. Establishing performance criteria for all parties involved in the administration of the program;
2. Establishing a mechanism whereby carriers are evaluated principally on the basis of end results achieved, rather than the process used in meeting the performance criteria;
3. Establishing that the intent of carrier evaluation is basically related to levels of performance rather than on the precise procedures used to perform the work; and
4. Establishing a means for rewarding those who have used talent and resources well resulting in high quality performance.

Incentive Awards Board

The Incentive Awards Board would be appointed by the Secretary. It would have five members, including the Commissioner of Social Security, who would serve as Chairman; the Director of the Office of Management and Budget; and three non-Federal members, selected by the Secretary from among persons with skills and knowledge indicative of an ability to objectively assess the quality of the administration of Medicare, and who are not associated with contractors with the program. The non-Federal members would serve staggered three-year terms, and could be reappointed.

The function of the Board would be to review the performance of Part B carriers, to identify carriers whose performance had been superior, and to recommend to the Secretary those carriers which should receive awards and the amounts of such awards. Staff support for the Board would be furnished by the Bureau of Health Insurance, including ongoing development and application, to the extent feasible, of objective measures of carrier performance, evaluation of carriers on the basis of these measurements, and the collection of objective and subjective information pertinent to the determination of carriers whose performance had been superior. A main function of the Board in making recommendations for awards would be to weigh the relative importance of each of the various objective and subjective measures of performance in relation to overall performance in achieving program objectives and carrier responsibilities.

Under another amendment to H.R. 1, the Secretary is directed to routinely release Bureau of Health Insurance reports evaluating program carriers, together with the carriers' comments on the evaluations. These would be made available to the Board, along with any other evaluative material and carrier comments prepared for purposes of the incentive amendment.

Basis for Evaluating Carriers

Carriers would be evaluated on the basis of performance in meeting contractual obligations, in accordance with program objectives and standards, with respect to the following basic criteria which would be included in the statute:

Quality of service to beneficiaries;
Effectiveness of service to providers and practitioners;
Timeliness, completeness and accuracy of claims handling;

Administrative cost would be a consideration also, taking into account the relationship between those costs and the carrier's performance toward achieving the preceding three principal objectives of the contractual relationship.

To the extent possible, evaluation of carrier performance would include those aspects capable, in whole or in part, of objective measurements, but it is recognized that important areas of carrier performance are not susceptible totally to objective measurement; thus the evaluation task will also be judgmental. In developing both quantitative and qualitative measures, a basic concern, of course, will be to reward a carrier for efficiencies or savings achieved without detriment to high quality performance; this avoids rewarding a carrier for high performance in one factor if that performance was achieved at the expense of other factors, and avoids rewarding carriers on the basis of misleading and non-comparable data. Measurements will be structured so as to enhance comparability among carriers of the factors being measured, so as to assure that a carrier's performance relative to that of other carriers would be measured fairly. In this context, the Board may request of the Secretary, and apply such information and other data as it believes appropriate and necessary to full and fair evaluation of both objective and subjective aspects of performance.

In addition, every effort would be made in measurement to primarily emphasize end results, rather than process, so that the procedures used to perform the work would not be controlling in the determination of incentive payments. The intent of the incentive payment evaluation is not to require uniform operating procedures,

but to encourage a continuing high level of performance with regard to carrier responsibilities. It is believed that this can be achieved without discouragement of innovation and development of alternative methods of operation where it is demonstrated that these approaches further the fulfillment of the general criteria previously outlined.

Specific results to be measured and matched against performance standards related to achievement of the carrier contract objectives would include, among other factors: the proportion of claims which take excessively long to be processed and the duration of delay; the degree to which questionable patterns of practice are identified and acted upon; the quality of service and the degree of cooperation with PSRO's; the accuracy with which charges above allowable amounts are identified and the accuracy with which such charges are reduced to allowable levels; the degree to which the need for professional relations contact is identified and the extent and effectiveness of follow-up, for example, correcting the failure of physicians to comply with the obligations involved when they take on an assignment; the degree to which claims for non-covered items or services are identified and denied; extent of control over necessary administrative costs; the extent to which beneficiaries are informed of their rights to appeal when claims are denied and the speed and effectiveness with which appeals are acted upon; and, the service to beneficiaries who submit incomplete claims in arranging to have the claims completed properly.

Incentive Payments

Under the proposal total incentive payments in a year could not exceed 5 percent of aggregate administrative costs of carriers for that year. (In fiscal 1973, that 5 percent would total an estimated $10 million with the amounts rising in subsequent years.) The maximum amount payable in any year to a single carrier may not exceed 10 percent of the total award fund in that year. Since, in the initial stages of the incentive program, objective measures of carrier performance will be relatively limited and imprecise, it is expected that, at least at the outset, total payments recommended would be less than the total amount permitted by the amendment.

In determining the incentive payment to any individual carrier, the Board would be expected to consider the extent to which the carrier (defined as the carrier and its subcontractors, if any) achieved over-all program objectives for Part B administration; the degree of improvement in the carrier's performance; performance compared to that of other carriers; size of the carrier load (that is, the number of beneficiaries serviced by the carrier); and the degree of impact the carrier's performance had on over-all program administration and costs.

To be eligible for an incentive payment, a carrier would have to be found to have met the essential standards of program performance established in accordance with Title XVIII as modified by this amendment.

The proposed incentive payment procedure would measure a carrier's over-all performance, taking into account both "plus" and "minus" factors relative to other carriers, but changes in the carrier's own performance would also be taken into account. Any incentive payment payable to a carrier would be considered, for tax purposes, to be income related to health insurance business.

Report by Secretary

It is recognized that the task of fully implementing a successful carrier incentive payment system is difficult, and that some elements of the system, particularly the development of objective qualitative performance measures, will take time. It is expected, then, that the incentive system will be refined over time, and desirable modifications identified. These modifications, to the extent no change in the statute is needed, would become effective at the beginning of the next year, and no changes would be made in the performance standards during the year. The Secretary would be required to allow adequate lead-time (of not less than 3 months) to carriers in preparing to comply with any changes in performance requirements proposed for a given year from those applicable to the prior year. He would also be authorized to implement a related program of incentive payments for Part A intermediaries when feasible, and to explore the possibility of establishing a concept which might recognize superior performance by relating payments to carriers and intermediaries on the basis of the number of beneficiaries served in a given carrier or intermediary area.

Under present law, the Secretary is required to submit to the Congress an annual report on Medicare. Under the proposed change, the Secretary would include in his annual report an analysis of the status of the incentive payments program, modifications made and proposed in perfecting it, and such legislative recommendations as he believes would improve the incentive system.

This proposed amendment is suggested in lieu of the provision of section 222 of the House-passed bill that would authorize experimentation with incentive payments to carriers and intermediaries.

2. Carrier Flexibility Under Medicare Subcontracts

Another objective of Senator Hansen's amendment was to provide carriers with complete discretion to subcontract functions where they believed it would improve performance.

The staff, at the direction of the Committee, has developed a proposal which we believe significantly enhances carrier flexibility in subcontracting coupled with reasonable safeguards assuring accountability. Additionally, the suggested amendment contains a provision designed to maintain the confidentiality of a subcontractor's trade secrets.

Present Law

Medicare Subcontracts

When the Medicare program was enacted in 1965, little attention was given to the use of subcontractors in the performance of administrative responsibilities under the program. Rather, it was generally contemplated that insurance companies would serve as carriers and intermediaries and would perform whatever administrative functions were necessary to implement Medicare. Over the years, however, the use of subcontractors—particularly in the automatic data processing field—has become more common. Yet, there are no specific provisions in the Medicare statute governing the relationship of subcontractors either to the prime contractor (the carrier or the intermediary) or the Government. What direction there is consists of regulations of the Social Security Administration, indicating the conditions which must

be included in subcontracts. The Social Security Administration reserves the right to veto a subcontract if, in its opinion, the subcontract is not in the best interest of the program.

Other Committee Amendments to H.R. 1

Amendments Agreed to

During consideration of H.R. 1, the Committee on Finance has added to the bill two provisions dealing specifically with Medicare subcontracts. The first of these provides that subcontracts may not be entered into for periods longer than the prime contractor continues to serve as a Medicare carrier or intermediary. Generally, carriers operate on a year-to-year contract basis; their contract is renewed automatically unless it is specifically terminated by the Secretary. Despite this short-term nature of prime contracts, some carriers have negotiated subcontracts on relatively long-term basis, thus requiring automatic continuation of the subcontracts if the prime contracts are renewed.

The second Committee amendment requires that subcontractors provide access to the financial books, records and related data with respect to their performance of a Medicare subcontract. Under this amendment, financial information and related data with respect to the subcontractor, and all corporations related to the subcontractor, which have a role in the performance of the subcontract must be consolidated and made available to the Secretary of the Department of Health, Education, and Welfare.

Proposal

Today, flexibility can be limited because of the approval power of the Secretary over subcontracts. It would appear to the staff that if the incentive award system is to operate effectively, carriers should be permitted substantial discretion and latitude to select subcontractors of their choice for assistance in performing their responsibilities under Medicare. Accordingly, it is recommended that if the subcontractor is qualified, and has the capacity to assume the responsibilities required under the subcontract, then the carriers' selection pursuant to bona fide competition and open bidding should not be disapproved by the Secretary, except for good cause. For example, if the subcontract involved an excessive delegation of responsibility, the Secretary should remain empowered to disapprove it. Indeed, such a subcontract should bring into question the carrier's capacity to continue to serve under the Medicare program.

Similarly, if the plan for operation under the proposed subcontract does not appear consistent with program objectives of service to beneficiaries and providers and timeliness, completeness and accuracy of claims handling, authority to disapprove it should not be withdrawn from the Secretary.

Effective bidding procedures would include reasonable notice of subcontract availability to prospective bidders and opportunity to adequately and equally prepare and submit proposals based upon written specifications. In the event proposals submitted vary from the carrier's written specifications, the Secretary would determine whether the variation was reasonable (in terms of consistency with program requirements); and if so, he would further determine the reasonableness of cost differentials attributable to the variation. Reasonable variations from the written requirements would not negate

a finding that the subcontract was let under conditions of bona fide competition in open bidding.

To avoid disclosure of trade secrets of a subcontractor related to formula, patterns, devices, data processing systems or a compilation of information used in his business, and which may provide him an advantage over competitors who do not know or use such elements, a requirement of confidentiality would be imposed upon the Secretary.

For example, his examination of specific elements of the process employed in a data processing system and the costs thereof, would be limited to an initial evaluation of the system proposed by a new subcontractor or at the time of contract renewal, except where he is requested to examine the process by the contractor and the subcontractor. This would not preclude periodic evaluation by the Secretary of a carrier's operation—including the subcontracted portion—through introduction of test claims. If the need should arise for a subsequent examination of a subcontractor's system in order to determine possible points of defective processing or the costs of providing services under such system, the Secretary would request the Comptroller General or Inspector General to examine the system, but would not make the examination himself. The Comptroller General or Inspector General would, in turn, advise the Secretary as to any defective points in the system, accompanied by such recommendations as they might have for correction. The Secretary may also request such examinations, generally by the Comptroller General or Inspector General, but at not less than 12-month intervals.

It is further suggested that language implementing the earlier decision of the Committee authorizing access to subcontractor costs be incorporated into this Medicare subcontracts amendment, if approved. Access to subcontractor costs, as previously approved, would provide the Secretary, the Inspector General, and the Comptroller General with authority to examine permanent financial records and books of the subcontractor and related organizations, relating to subcontracts aggregating $25,000 or more. Prime contractors would be required to include an access to financial records clause in any subcontract.

The Comptroller General and Inspector General would, of course, also be required to observe confidentiality with respect to trade secrets as outlined above.

3. Payments to States Under Medicaid for Installation and Operation of Claims Processing and Information Retrieval Systems

CLERK's NOTE: This section was previously considered by the Committee and passed over so that it might be evaluated in the context of other proposals relating to claims information systems.

Problem

Many States do not have effective claims administration or properly designed information storage and retrieval systems for their Medicaid programs and do not possess the financial and technical resources to develop them.

House Bill

Authorizes 90 percent Federal matching payments toward the cost of designing, developing and installing mechanized claims processing and information retrieval systems deemed necessary by the Secretary.

The Federal government would assist States with technical advice and development of model systems. Federal matching at 75 percent would be provided toward the costs of operating such systems.

Change From 1970 Senate Provision

Similar to both the House and Senate-passed versions of H.R. 17550, except that the House has added a provision to provide 90% matching for 2 years (up to a total of $150,000 annually) for the development of cost determination systems for State-owned general hospitals.

Proposal

The staff agrees with the thrust of the House bill that States should be permitted to develop suitable data processing capacity of their own. However, we believe the situation in many States may be such that they would be unlikely to have the volume of Medicaid work, by itself, needed to operate a computer system efficiently and economically. We believe it is not necessary at the present time to provide for separate, independent Medicaid computer systems in each of the 50 States as the House bill contemplates.

Accordingly, the staff suggests modification of the House provision so as to:

(1) Authorize regional or multi-State Medicaid data processing systems (with the voluntary agreement of the States concerned) rather than State-by-State systems, unless the Secretary finds that a system for a single State would be more feasible, economical, and efficient than a regional system. Consideration would be given to the fact that, while a smaller State may not have sufficient Medicaid volume to justify an independent computer operation, Medicaid claims processing, in conjunction with other State data processing may be feasible and efficient.

(2) Require that the design of any such new systems, to the extent feasible, be compatible with Medicare data processing requirements so as to permit expansion of the system, if necessary, where suitable carrier or intermediary performance is not available.

The intent of this staff suggestion is not to create excess capacity (as the House bill seems to encourage), but to foster a system of a siege capable of functioning economically and of expansion to assist in Medicare administration, if that became necessary.

4. Excessive Profits Under Medicare Subcontracts

In a previous meeting, the Committee tentatively approved an amendment authorizing recapture of profits under a subcontract which aggregated $100,000 or more. The determination would be made by the Secretary under a procedure similar to price redeterminations applied under procurement contracts by the Department of Defense. No determination or recapture would be authorized where the subcontract was let under an effective competitive bidding procedure.

In order to assure itself, that the amendment would be utilized equitably, the Committee requested that the staff prepare and submit to it proposed Committee Report language explaining the provision. That draft language follows:

"Excessive Profits Under Medicare Subcontracts"

Background

Under present law, carriers are reimbursed on a cost basis for their administrative activities in the Medicare Program. What financial incentive there may be to carriers to participate in the program today is considered to flow from factors such as the following: (1) the carrier performs a number of functions and incurs a number of costs in its own activities that it shares with Medicare—e.g., the salary of executives—and the cost to the carriers is reduced by this so-called "piggy backing"; (2) the increased scale of operation that occurs when Medicare is included permits use of data processing equipment and other cost-saving measures in both Medicare and non-Medicare business which might not be economical on the basis of non-Medicare business alone; and (3) the increased public contact and direct mail from the carrier to the public may have a favorable effect on sales of private insurance to those it serves in its Medicare capacity.

The use of private carriers was expected to produce cost advantages for the Medicare program as well; it too would gain from the sharing of costs and from the expertise carriers had developed in the handling of health insurance claims before Medicare was enacted.

Additional key factors motivating private health insurers to undertake Medicare administration on a costs basis was to forestall direct Government operation and, in the case of for-profit insurers, to prevent the non-profit Blue Cross and Blue Shield plans from taking over completely as carriers and intermediaries.

While the results in a fair number of cases have been generally along the lines predicted, Medicare experience shows that there has been considerable variation in cost of operation and expertise from one carrier to another. From the beginning of the program, the Medicare program has exerted considerable pressure on carriers, and especially on the poorer administrators, to improve their performance. Some have successfully improved their effectiveness within their own organizations. Others, preferring not to expand their own operations, but seeking the benefit of economies of scale, have contracted out much of their data processing. However, the subcontractor in these instances is not bound by the contracts which prevent carriers from earning a profit on their Medicare operation. To the contrary, he enters into the subcontract precisely with the profit motive in mind.

Problem

Thus, when a subcontractor performs a service for a carrier, a profit element enters the picture which would not be permitted if the carrier performed the service directly. However, the program may gain from the subcontract and should be willing to pay a reasonable profit if the total cost to the program is reduced and overall carrier performance improved.

In the ordinary case, free and open competition between subcontractors would be expected to produce a subcontract price which would include no more than a reasonable profit for the successful bidder. But, if the service being sought is one in which there is little keen competition, the question may be fairly raised as to whether the price to the program and the profit to the subcontractor are equally fair. For instance, the fact that the price to the program is below the cost which would have been incurred by the carrier if he had performed the

services directly may be an insufficient test because the carrier involved may be one of the poor performing carriers. In such a case, an alternative way of reducing costs, such as substituting a better carrier for the poor one, may be a more satisfactory solution. In addition, costs are not always a desirable measure of adequate performance since a high-cost carrier may be doing a very effective job of auditing claims and challenging submitted bills on the basis of their not being medically necessary or their not being covered by the program. Thus, although his processing costs may be high because of his greater efforts, the amounts paid out in benefits by this sort of carrier may be relatively less as compared to other carriers and his overall performance may be quite good.

Basically, in the absence of bona fide competition and bidding, there is a need to establish safeguards to prevent excessive profits from being paid in the first place, as well as the matter of retroactive recovery.

There is also the related problem—even in a competitive situation—of a bidder submitting an artificially low bid in order to "buy in" the business. Obviously no excessive profits inure to him initially, but renewals of such contracts—where competitive bids are not generally solicited—may lead to pricing involving an excessive profit situation.

Committee Amendment

While the Committee agrees with the concept that a carrier seeking to upgrade its performance by subletting part of the administrative work associated with its duties as a carrier should be permitted to do so, it does not believe that profit-making subcontracts should be allowed without some reasonable assurance that the profits will be reasonable and not exorbitant.

Accordingly, the Committee has added to the bill a new provision designed to assure that subcontractors which benefit under the Medicare program may realize reasonable, perhaps even large, profits with respect to their work, while at the same time assuring that the Medicare program will derive additional benefits from increased efficiency of the subcontractor which may be directly related to its Medicare operations. In effect, the Committee amendment provides for a redetermination of the subcontractor's contract price in the event the Secretary of Health, Education and Welfare determines the contract which might involve an excessive profit was not let or renewed under effective bidding procedures described in the discussion of "Carrier Flexibility Under Medicare Subcontracts."

The existence of an excessive profit involves the exercise of good judgment, and cannot be determined by applying strict statutory language. Consistent with this subjective approach, the determination should not involve or result in a profit based solely on the principle of a percentage of costs. Subcontractors who sell at lower prices and produce at lower costs through good management (including conservation of manpower, facilities and materials) and close control of expenditures should have these factors recognized more favorably in a determination of excessive profits than those who do not.

Such a diligent subcontractor should not, in effect, be penalized by having the profits growing out of his diligence reduced (through a price redetermination) to the level of less efficient subcontractors who demonstrate little concern for cost savings through administrative controls.

In evaluating a particular subcontractor's performance, the Committee anticipates that the Secretary will make comparisons with

prices and costs of other subcontractors engaged in substantially similar operations and also with the costs incurred by carriers in performing "in-house" substantially the same services as the subcontractor.

The reasonableness of profits, or the presence of excessive profits requires qualitative judgments of subjective criteria—matters generally not susceptible to objective measurements. Some of the factors which the Secretary should take into account in determining whether subcontractors' profits are excessive include the following: (1) reasonableness of costs and profits with particular regard to production and normal earnings; (2) the subcontractor's net worth with particular regard to the amount and source of private and public capital employed; (3) extent of risk assumed including the risk passed-on in the form of contingency allowances in the overall price; (4) character of the business including the extent of subcontracting with respect to the Medicare program as contrasted to similar services performed under private contracts or subcontracts; and (5) such other factors, the consideration of which the public interest and fair and equitable dealing may require.

Similarly, it would be expected that the Secretary would give favorable recognition to a decrease in costs per unit of production between years as compared with other subcontractors or carriers performing substantially the same services when their operations are reasonably comparable. In addition, in determining the efficiency of a subcontractor, the success he may achieve in reducing the per-beneficiary costs of benefits paid must be given favorable consideration provided these reductions are not made at the expense of accuracy and effectiveness in claims processing or in marked reductions in assignments accepted by physicians. The claim-reduction rate would be another factor indicating the efficiency of a subcontractor in performing his work under the Medicare program.

In determining reasonableness or excessiveness of costs and profits of a subcontractor for a given year the Secretary would make comparisons with the subcontractor's costs and profits in previous years and with current costs and profits of other subcontractors performing substantially similar services or with the costs of carriers incurred with respect to the perforance of similar services. Of course, uncontrollable variations of labor, material or other costs must be taken into account as must variations in physician or other provider charges in different geographic areas.

Where Medicare subcontracts enable the subcontractor to increase his services without equivalent increases in his costs, decreased unit costs result and the government should normally share this benefit in the form of more favorable prices. However the subcontractor may establish that factors relating to the increased volume such as added risk assumed or added investment of capital entitle him to claim a larger share of the benefit resulting from the increased volume.

In addition, the determination of whether profits are reasonable or excessive in any year should involve the consideration of losses in prior years resulting from nonreoccuring costs which relate to services performed in the year under review. Thus, labor costs and overhead may be high in the early years because of inexperienced labor or testing, changing and improving the methods of performance. These circumstances can be present under a long-term contract and can also be equally present in the case of a series of two or more short-term

successive contracts which are similar. A profit which may appear excessive when viewed in isolation, may be quite reasonable when placed in a long-range perspective.

In determining reasonableness or excessiveness of profits the Secretary would give more favorable consideration to a subcontractor who is not dependent upon government or carrier direct or indirect operating or capital financing (including any such financing of the development or maintenance of data processing systems). In these latter cases, it would appear that the subcontractor's (or carrier's) contribution tends to involve lesser risks and in such a case his profit must be considered accordingly; other things being equal, the profit in such a case should be less than in a situation where the subcontractor assumes risk and bears responsibility for the total operations required by his subcontract.

An additional factor relates to the extent of risk assumed by the subcontractor in performing work for the Government under his subcontract. For example, in some cases, a substantial degree of risk may be found in the temporary sacrifice of civilian markets to competitors in order to accept more Medicare work. In other cases Medicare subcontractors may assume risk by guaranteeing their price and their performance and this factor should be given fair recognition. Thus, a fixed-price contract without escalation or similar protection may involve a risk that the cost of labor or material may increase to the detriment of the subcontractor. The Secretary would give special consideration to evidence of a risk through actual realization of losses incurred by the subcontractor in performing subcontracts in other years similar to those under audit.

Finally, in weighing the extent of the risk assumed by the subcontractor, one whose initial prices were calculated to yield a reasonable profit and who revises such initial prices downward periodically when circumstances warrant, would be given more favorable treatment than another subcontractor who does not follow such a practice.

The Committee believes that these criteria, judiciously applied, will provide effective subcontractors with profits adequate to the role they play in helping to moderate the costs of the Medicare program yet not allow virtually unlimited profits under a program which, when it was enacted, did not contemplate the use of profit-making enterprise in its administration. The approach suggested by this Committee amendment represents a fair resolution of the issue which has developed in the last few years.

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