MEDICARE CONTRACTING FOR ADMINISTRATIVE SERVICES: COMPETITIVE ALTERNATIVES

Staff Memorandum

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This analysis was prepared by Darrell Hollonbeck of the Human Resources and Community Development Division of the Congressional Budget Office, under the supervision of Nancy M. Gordon and Paul B. Ginsburg. The study was essentially complete as of April 1983, but was delayed by Mr. Hollonbeck's extended illness. In order to avoid further delay, the study is being released now without updating. Please bear in mind that the text and numbers are correct only as of April 1983. Questions regarding the analysis may be addressed to Nancy Gordon on 226-2669.

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SUMMARY

In fiscal year 1983, Medicare contractors are expected to process 280 million claims and provide reimbursement for benefit payments totaling more than $56 billion. The federal government uses contractors to perform four types of activities:

- Process claims promptly and accurately;
- Design and implement claims review procedures to ensure that payment is provided only for reasonable and necessary medical services;
- Maintain good relations with the health-care provider and beneficiary communities; and
- Adjudicate beneficiary appeals arising from insufficient reimbursement or denial.

Medicare will pay approximately $800 million, or 1.4 percent of total program costs, for these services.

BACKGROUND

When Medicare was enacted, profit and nonprofit health insurance corporations were selected by local providers of health-care services to serve as Health Insurance (HI) contractors--known as intermediaries--and Supplemental Medical Insurance (SMI) contractors--known as carriers. When more than one contractor has been approved for a local area, individual providers can chose among them.

Contractors are generally reimbursed for all costs associated with their Medicare activities. In fiscal year 1982, however, an unusually tight appropriation led the Health Care Financing Administration (HCFA) to reimburse contractors for only part of the expenses above budgets negotiated at the beginning of the year.

Theoretically, cost reimbursement perpetuates insufficient and ineffective management practices. Under such a payment system, contractors are not encouraged financially to implement cost-efficient managerial practices. Indeed, in some circumstances, the system encourages contractors to shift expenses from their private business to Medicare. Differences in managerial efficiency across contractors contribute, in part, to variations in the average cost of processing a claim (unit costs). In fiscal year 1982, HI claims processing costs varied between $2.79 and $7.35 per claim; SMI unit costs varied between $1.91 and $3.92. Some contend that the recent departure from cost reimbursement that has been forced by budget stringency has increased efficiency significantly, however.

Another criticism of the current system is that the method used to evaluate contractors' performance may overemphasize low administrative costs and exclude other activities designed to limit the total benefits paid by the program. In effect, small reductions in administrative costs may be achieved at a much larger cost for benefits that should not be reimbursed by

Medicare, since too few resources may be devoted to medical utilization reviews and other costly activities that reduce payments for unnecessary or duplicative services. While the evaluation system used to measure contractors' performance examines these so called "benefit-safeguard" activities, this assessment focuses primarily on the existence rather than the effectiveness of these activities. As a result, contractors differ considerably in the resources they devote to ensuring accurate benefit payments.

COMPETITION AND THE FIXED-PRICE CONTRACT

The competitive award of Medicare administrative contracts, used in conjunction with a fixed-price contract, has been proposed as a mechanism to encourage cost-efficient management by contractors. The introduction of market forces in awarding contracts could force competitors to adopt managerial improvements that would increase efficiency and could reduce outlays for Medicare's administration.

Because Medicare's administrative costs constitute only 1.4 percent of total program costs, however, such a reduction in administrative costs might not significantly reduce total Medicare outlays. Attention focused exclusively on administrative costs could encourage contractors to reduce resources for benefit safeguard activities and for those activities that provide a high level of service to the beneficiary and provider communities. In addition, the quality, accuracy, and promptness with which claims are

processed could be reduced during the transition to contractors winning the competitively awarded contracts.

Under demonstration authority, HCFA has implemented seven competitively awarded, fixed-price contracts. Valuable information was obtained from these experiments with which to assess the impact of competition on several aspects of the Medicare program:

- o Administrative costs,
- o Total benefit payments, and
- o The promptness of claims processing.

These effects are discussed in the following sections.

Administrative Costs

When several competitors participated in the contract solicitation, Medicare payments to contractors were reduced by approximately 10 percent relative to the projected costs of continuing with the incumbent cost-reimbursement contractor. In solicitations that drew few bidders, however, bids were considerably higher than the projected costs of the incumbent contractor and, in one competition, the solicitation was withdrawn because of the high price of the only bid.

Recent solicitations have produced few competitors, clouding the otherwise significant potential of competition to reduce administrative

costs. This reluctance to bid on the part of potential contractors may reflect the recent uncertainties about the cost-reimbursement system--under which some costs have not actually been reimbursed. In essence, contractors may see small potential gains and large potential losses associated with the fixed-price contract.

Benefit Payments

The impact of competition on total benefit payments is unclear, since in the three states where data are available the differences between amounts paid under the demonstration projects and those projected under the previous system varied considerably. Moreover, cost data submitted by fixed-price contractors were insufficiently detailed to determine if the level of resources expended for benefit-safeguard activities affected the level of benefit payments or if this variation resulted from other factors. This issue remains a primary concern with the fixed-price contract for, as discussed, the differential allocation of resources for benefit safeguards could easily more than offset any administrative efficiencies induced by competition.

Another discouraging finding is that fixed-price contractors consistently and significantly increased the rate of erroneous payments and, because overpayments exceeded underpayments, expenditures increased unnecessarily. This inaccuracy may also have affected numerous individual beneficiaries who may have had to absorb underpayments made by the contractor.

Timeliness of Claims Processing

Contractors were, in most circumstances, able to maintain the promptness with which claims were processed by incumbents. In the one situation, the average processing time doubled, however, creating massive dissatisfaction and complaints among providers and beneficiaries.

OPTIONS

This report analyzes three options to modify the existing system for the award of Medicare contractors. The discussion is limited to SMI contractors because of the current lack of data from the HI demonstration projections. The first alternative would use competition to select all contractors and reimburse them through fixed-price contracts. The second would substitute competition only to replace contractors with high administrative costs and also use fixed-price contracts. The third option would use competition cost-reimbursement contracts to replace those contractors with repeatedly high levels of erroneous benefit payments or with ineffective procedures to safeguard benefit payments. The budget impact of each alternative for fiscal years 1984 to 1988 is shown in Summary Table 1.

SUMMARY TABLE 1. BUDGET IMPACT OF COMPETITIVE OPTIONS, FISCAL YEARS 1984-1988 (In millions of dollars)

	Alternative 1 a/	Alternative 2 b/	Alternative 3 c/
Administrative Costs	270	-30	130
Benefit Payments	390	150	-370
Total	660	120	-240

SOURCE: Preliminary CBO estimates.

NOTE: Positive sign denotes increased expenditures.

a. Competition to award all contracts (using fixed-price reimbursement).

b. Competition to replace high-cost contractors (using fixed-price reimbursement).

c. Competition to replace contractors performing poorly on benefit-safeguard activities (using cost reimbursement).

Competition to Award All Contracts (Using Fixed-Price Reimbursement)

This option would award all Medicare contracts on the basis of competitive procurement. Contractors would be reimbursed at a rate based on a fixed price for a designated period of time or for some predefined unit of work determined at the time of contract award. The transition to competitively awarded, fixed-price contracts would occur over four years beginning with fiscal year 1984.

Under this alternative, total program costs would increase by $40 million in fiscal year 1984 and by $660 million over the period of fiscal years 1984 to 1988. Administrative costs would account for $270 million of the five-year rise. Although competition theoretically would reduce program administrative costs relative to the cost-reimbursement system, the limited interest in competition among potential bidders, the small savings obtainable from those contractors that are currently performing efficiently, and the significant transition costs would actually raise them.

Benefit payments would also increase--by $390 million over the period--because of increased error rates. Higher error rates would raise outlays since overpayments tend to exceed underpayments. This estimate assumes that the results of claims review would be about the same as under current law, because fixed-price contractors would devote roughly the same levels of resources to benefit safeguard activities. (This assumption is consistent with the mixed claims-review experience of the demonstration projects.)

Moreover, the implementation of the competitive fixed-price contract would require 14 SMI solicitations per year; the continual monitoring and technical assistance necessary to maintain the functioning of the overall system would tax the oversight capabilities of HCFA, unless central and regional staff were increased substantially. Lastly, this option would disrupt the contractors' operations for three quarters.

Competition to Replace High-Cost Contractors (Using Fixed-Price Reimbursement)

In contrast to the first alternative, the second would limit competition to those territories currently served by contractors with consistently high administrative costs. The selective use of competition is intended to replace high-cost performers while minimizing the potentially disruptive and costly effects of competition on contractors' performance.

This alternative would increase total program costs by $20 million in fiscal year 1984, during which the initial solicitations would be awarded and transition activities would occur. Over the period 1984 to 1988, this alternative would raise total program outlays by $120 million--the net effect of lower administrative costs but higher benefit payments.

The option would reduce administrative costs by $30 million over the five years when 14 contracts would be awarded competitively. These savings are limited, in part, by the large transition costs associated with the establishment of facilities and operations in the new territory. Consequently, savings might be expected to increase in future years. Since incumbent cost-reimbursement contractors with low administrative costs would be retained, they would have incentives to invest in new technologies and other cost-efficient management strategies in order to achieve future efficiencies and avoid competition for their contracts.

Benefit payments would increase by $150 million between fiscal years 1984 and 1988, because of higher error rates, however. As in the first option, fixed-price contractors are assumed to continue roughly the same levels of benefit safeguard activities as their cost-reimbursement predecessors. In spite of these activities, erroneous benefit payments would rise more than offsetting the administrative savings realized by the selective application of competition.

Competition to Replace Contractors Performing Poorly on Benefit-Safeguard Activities (Using Cost Reimbursement)

This alternative would introduce competition in the award of Medicare administrative contracts to eliminate those who perform poorly on benefit safeguard activities. Contractors would be replaced by competitors with the demonstrated capabilities to implement innovative and cost-efficient activities designed to improve the accuracy of benefit payments to eligible individuals. Performance on the payment-deductible error rate or some other measure that objectively embodies this payment-safeguard orientation would serve as the most important selection criterion. As under the current system, the contractor would be reimbursed for the actual costs of performing administrative activities.

In fiscal year 1984, this option would save $7 million; between fiscal years 1984 and 1988, total program outlays would be reduced by $240 million. The higher level of safeguard activities would reduce benefit

payments by $370 million over the five-year period, but raise administrative costs by $130 million. Some uncertainty is associated with the estimate of benefit payment reductions, however. While the General Accounting Office (GAO) has estimated that benefit safeguard activities return $7 for each $1 spent, it is not known at what point diminishing returns would set in.

This approach would have the additional advantage that it would serve as a stimulus for all contractors to implement effective benefit reduction activities in order to avoid the competitive process. This effect is not, however, included in the estimate of federal savings.

CHAPTER I. INTRODUCTION AND OVERVIEW

The Medicare program contracts with private health insurance organizations to perform activities related to the payment of benefits. These contractors establish rates of reimbursement, verify program eligibility, establish medical necessity, and reimburse claimants for medical expenses. At the inception of Medicare in 1966, contractors were nominated by local provider organizations and approved by the Health Care Financing Administration (HCFA)--the federal agency responsible for administration of the program. This nomination process resulted primarily in the selection of Blue Cross and Blue Shield affiliate organizations. Reimbursements for administrative services are expected to exceed $800 million in fiscal year 1983.

Contractors are reimbursed for all costs associated with the administration of the program within annual budgets negotiated with HCFA. Each contractor submits an annual budget based on HCFA's projections of the claims volume within the contracting district. In submitting this budget, the contractor retains discretion over the managerial practices and assumptions that are used to perform the claims processing and associated services. Should actual costs exceed the negotiated budget, the contractor can request supplemental funding and, pending HCFA approval, receive reimbursement for these expenses. In fiscal year 1982, however, contractors were not fully reimbursed for expenses incurred above the negotiated budget because of HCFA's financial constraints.

The current system is thought to perpetuate costly and ineffective management practices. By reimbursing contractors for costs incurred, it fails to create incentives for contractors to execute their administrative functions as efficiently as possible. Moreover, the administrative discretion afforded contractors in establishing annual budgets may thwart HCFA's efforts to eliminate inefficient practices and to reduce the program's administrative costs.

In addition, there is concern that the dearth of incentives to implement utilization review and other activities that ensure payment only for reasonable and necessary medical services may cause Medicare benefit expenditures to be higher than necessary. Coupled with recent reductions in the growth of administrative funds, the emphasis on low administrative costs in assessing contractor performance may seriously affect the ability of, and incentives for, contractors to implement costly procedures designed to avoid erroneous expenditures for benefits. Although these procedures are more expensive than other administrative functions, the savings in correct benefit payments should far more than outweigh their costs.

Competition in the selection of contractors has been proposed as a mechanism to induce greater efficiency in the delivery of administrative services while maintaining or improving performance. Competition could be implemented in conjunction with a fixed-price contract, under which the contractor would be reimbursed for a predetermined sum of money based on

a fixed period of time or a fixed unit of work. This contract form could reduce administrative costs by introducing market forces into the selection of contractors and the profit motive into the contractors' operations. Alternatively, a negotiated cost-reimbursement contract, such as used now, could be retained in a competitive setting. Competition could also be implemented in concert with strategies such as consolidating territories or combining administrative responsibility for the two parts of Medicare--Hospital Insurance (HI) and Supplementary Medical Insurance (SMI)--to eliminate duplicative activities and reduce administrative costs.

Three competitive options are analyzed here:

- Competition in the award of all contracts, with reimbursement on a fixed-price basis.
- Competition used only to replace high-cost contractors, with reimbursement on a fixed-price basis.
- Competition used only to replace poor performers on benefit safeguard or operational performance measures, with reimbursement on a negotiated cost-reimbursement basis.

Chapter II provides background information on program administrative costs and discusses the concerns with the existing system. Chapter III describes the perceived advantages of competition and its likely effects on administrative costs, operational performance, and level of expenditures for benefits. The results of several competitive fixed-price demonstration projects are also reviewed. Chapter IV discusses three specific options.

CHAPTER II. THE CURRENT PROGRAM

The Medicare administrative system, relatively unchanged since the inception of the program, has important implications for the cost of the program. Direct outlays for outside contracts for administrative services will exceed $800 million in fiscal year 1983; moreover, the claims processing activities performed by these contractors influences the amount spent for Medicare benefits--expected to be about $57 billion in 1983.

The first section of this chapter describes the current system used to purchase claims processing and associated administrative services. The next section discusses the costs associated with Medicare administration. The last section examines concerns with performance under the existing system.

THE ADMINISTRATION OF THE MEDICARE PROGRAM

The Medicare program contracts with private health insurers to perform all activities related to the payment of benefits. Medicare Health Insurance (HI or Medicare Part A) contractors--called intermediaries--process claims for hospital and other institutional health-care services and determine the amount of reasonable and necessary costs to be reimbursed by Medicare. Medicare Supplemental Medical Insurance (SMI or Medicare Part B) contractors--called carriers--process and reimburse claims for medical

services performed by physicians and other health professionals, verify program eligibility, adjudicate appeals, and establish reasonable and customary charges for reimbursement. 1/ Medicare contractors are currently either Blue Cross and Blue Shield organizations or commercial health insurers. In some circumstances, health insurers subcontract with data processing firms for some claims-processing functions.

The use of contractors in the Medicare program was initiated to expedite the development of a system to distribute benefits. This system was designed to process and provide payment for the large volume of claims that was expected at program implementation, to obtain managerial and technological experience and expertise, to maximize the cooperation and involvement of the provider community in the program, and to control administrative costs. Large numbers of organizations were selected to function as intermediaries and carriers to ensure the smooth operation of the program at its inception, to reflect regional and within-state differences in the practice of medicine, and to provide ample numbers of contractors so that, over time, contractors with high administrative costs or poor performance could be replaced, thereby providing the highest quality of service.

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1. There are currently 74 HI intermediaries and 40 SMI carriers. Some individual contractors, most frequently the commercial health insurance corporations, serve multiple states or multiple partial-state areas.

One of the contractors' major responsibilities is to limit payment to reasonable and necessary services and to prevent program fraud and abuse--often referred to as benefit-safeguard activities. Through hospital audits, HI contractors verify that costs allocated to Medicare are derived from the provision of services to Medicare patients. Similarly, SMI contractors conduct a review of claims to establish the medical necessity of an individual claim and to identify potentially abusive patterns of practice.

Medicare contractors are reimbursed for all expenses incurred in the administration of the program within annual budgets negotiated with HCFA. Each annual budget is negotiated on the basis of a HCFA estimate of the work for the year derived from a projection of the claims volume, the purchase of new technologies or systems to improve efficiency (productivity enhancements), other systemic or administrative changes desired by HCFA, and the expected rate of inflation.

If the actual costs are larger than the negotiated budget because of inaccurate estimates of volume, changes in Medicare legislation affecting contractor work or responsibilities, postage increases, or other additional expenses, contractors can request supplemental funding. They receive reimbursement for costs in excess of the negotiated budget, if funds are available. As discussed in the next chapter, fiscal year 1982 represented the first year in which contractors were not reimbursed for all costs in excess of their negotiated budgets. Budgeted funds not used are returned to HCFA.

Although HCFA must approve each contractor's budget, the contractor has considerable discretion in the administration of the program, thereby creating potential differences in administrative efficiency. The internal managerial assumptions that underlie the budget submission are determined by the contractor. Without direct control over these assumptions and the resultant management practices, HCFA may be relatively powerless to eliminate administrative costs it believes to be excessive.

Contractors are audited periodically using federally defined Generally Accepted Accounting Procedures (GAAP). The audit verifies that contractor costs are attributable to Medicare activities. Medicare activities, which are distinct from private business activities, are directly charged to Medicare. Costs for activities that are shared with private business activities are allocated according to approved accounting procedures. Allocated costs may include items such as space, utilities, personnel hiring and training, retirement pensions, senior staff and other management time, computer hardware, or use of computer time.

THE COST OF MEDICARE ADMINISTRATION

The total cost of Medicare administration was $1.2 billion in fiscal year 1982. These costs are divisible into three distinct categories and functions:

- HCFA central office and regional office costs for program oversight—$160 million;

- Social Security Administration (SSA) costs for individual eligibility determination, data storage, and data processing--$370 million; and
- Contractor costs for program administration and implementation--$711 million. 2/

Throughout this paper, "Medicare administrative costs" refers exclusively to contracted services.

Currently, Medicare administrative expenses constitute 0.69 percent and 3.15 percent of the HI and SMI program costs, respectively. As a share of total costs, both rates have been decreasing over the last decade, during which expenditures for benefits increased rapidly relative to the growth in administrative costs. 3/

Although costs for Medicare administrative services have increased, on average, more than 13 percent annually since 1973, the total cost of administering the program has increased only slightly when adjusted for inflation. In fiscal year 1973, contractor costs were $308 million; expressed in 1982 dollars, they were $612 million, compared to actual costs in 1982 of $711 million. This represents a real growth rate of 1.6 percent over the ten-year period.

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2. Funds for contracted administrative activities are appropriated from the HI and SMI trust funds by the Congress as part of the Department of Health and Human Services discretionary budget.

3. Between fiscal years 1973 and 1982, administrative costs increased 130 percent, whereas expenditures for benefits increased 444 percent.

During this decade of almost constant real administrative costs, the number of HI and SMI claims increased by 142 percent and 227 percent, respectively, so that the cost per claim (unit cost) decreased dramatically (see Table 1). Claims-processing costs dropped from $4.82 to $3.03 per claim for HI contractors and from $3.23 to $2.10 for SMI contractors. Adjusted for inflation, the unit cost in 1982 was less than one-third the cost in 1973 for both HI and SMI contractors.

This reduction in unit cost is attributable primarily to the automation of the claims-processing activities, and is likely to continue. New technologies, such as the electronic submission of claims, direct electronic payment to physician and hospital accounts, and telephonic transmission of beneficiary deductible and coinsurance status, will further reduce the need for manual labor in claims processing.

The reduction in administrative unit costs also reflects the economies of scale that have been achieved through increasing the number of claims processed by each contractor. Given the existence of a functioning system, each additional (marginal) claim processed should be cheaper than those proceeding it, within limits. In some cases, these economies of scale have been realized through the consolidation of territories and the reduction of the number of contractors. 4/

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4. HCFA has been moving toward the establishment of one HI and one SMI contractor per state. HCFA is also experimenting with the integration of HI and SMI administrative responsibilities in one comprehensive contract.

TABLE 1. MEDICARE ADMINISTRATIVE COSTS PER CLAIM (By fiscal year, in dollars)

Fiscal Year	Health Insurance (Medicare Part A)	Supplemental Medical Insurance (Medicare Part B)
1973	4.82	3.23
1974	4.83	3.23
1975	4.72	3.21
1976	4.29	3.12
1977	4.57	2.98
1978	4.08	2.86
1979	4.07	2.82
1980	4.17	2.74
1981	3.86	2.67
1982	3.03	2.10

Because of budgetary restraints in fiscal year 1982, the Congressional appropriation for contractor expenses was inadequate to meet program administrative responsibilities. HCFA responded in four ways. First, it released administrative contingency funds and diverted funds from benefit-

safeguard activities to claims processing and other legally required activities. 5/ Second, it reviewed contractor administrative responsibilities and relaxed many processing and beneficiary service requirements. 6/ Third, it directed contractors to identify and implement methods to improve management efficiency. Finally, HCFA reimbursed contractors 90 cents for each one dollar of expenses incurred above their negotiated budget. 7/

The fiscal year 1982 funding shortage demonstrated that contractors could no longer be guaranteed that they would be reimbursed for all incurred costs. As a result of the limitation on administrative funds, contractors suggest that managerial efficiencies were forced into the system, but they also argue that no further efficiencies are possible. In their view, further reductions in administrative costs, whether achieved under a negotiated cost-reimbursement or a competitive fixed-price contract, would seriously affect the quality and timeliness of services provided and cause serious reductions in benefit-safeguard activities, increasing benefit expenditures.

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5. In order to prevent reductions in benefit-safeguard activities in future years, the Congress responded by appropriating an additional $45 million for HI and SMI benefit safeguards for fiscal year 1983 and for each succeeding year until 1986.

6. These program standard changes, called the Medicare Administrative Reform Initiatives (MARI), were estimated by HCFA to save $63 million in fiscal year 1982. Additional savings should be realized in future years, but amounts are not known.

7. This policy may have contradicted Medicare legislative authority that requires contractor reimbursement for costs, but it was necessary because of the appropriated ceiling on contractor expenditures.

Others believe that the limitation of administrative funds resulted in relaxed performance standards rather than managerial efficiency on the part of contractors. They maintain that until contractors are more directly financially responsible for operations, managerial inefficiencies will be continued.

PROBLEMS WITH THE CURRENT SYSTEM

Critics identify several weaknesses in the current contractor system, including, among others, the lack of incentives for cost-effective management and for implementation of policies that realize technological and economic efficiencies, the potentially high costs derived from the allocation methods used to determine rates of administrative reimbursement, and the limited incentives for contractors to expand activities designed to limit payment to services that are medically necessary.

Costly Management Practices

The system of cost reimbursement lacks incentives for cost-effective management and may thereby perpetuate expensive, inefficient management practices. Once chosen, a contractor is virtually guaranteed to continue indefinitely the role of carrier or intermediary.

Although overall Medicare unit costs have been decreasing steadily, there appears to be considerable variation in the management efficiencies

of individual contractors. These differences are partly reflected in differences in the unit cost of claims processing. For example, in fiscal year 1981, HI contractors' costs for claims-processing activities ranged between $2.79 and $7.35 per claim. 8/ SMI contractors ranged between $1.91 and $3.92 per claim. These differences remain, even after estimated economies of scale are taken into account.

This measurement of contractor performance may be insufficiently specific to identify whether management is efficient, however. Besides economies of scale, cost per claim is sensitive to factors such as assignment rates, provider or beneficiary mix, unexpected fluctuations in claims volumes, differential expenditures for benefit-safeguard activities, and the purchase of systems or technologies by individual contractors to streamline operations, all of which may mask the effects of good or bad management.

Costly Allocation Procedures

Medicare's cost-allocation procedures may result in payments to contractors that are too high. These procedures distribute corporate expenses among the various business "products" and, in doing so, ensure that each product absorbs its portion of corporate expenses for accounting, tax, and pricing purposes.

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8. The HI values exclude audit activities. If audit costs are included, HI unit costs range from $3.66 to $8.80.

Medicare may be absorbing disproportionately high levels of corporate expense for space and pension plans, in particular. The charge to Medicare for space can be determined using an average cost per foot for all corporate-owned and rented space. Expenses for new corporate skyscrappers, headquarters, or other space can be included in this computation which, in general, could produce a space rental cost higher than the cost of renting the actual space used for Medicare activities. Similarly, wage differences and the low probability that Medicare workers will continue employment with the contractor until they retire, relative to workers in other lines of corporate businesses, may create larger contributions by Medicare to corporate pension plans than necessary to provide retirement benefits for processors of Medicare claims.

Structural Economic Inefficiencies

Program administrators have been criticized for their reluctance to use existing legislative authority to consolidate territories or employ other structural modifications to reduce program administrative costs and improve program management. The consolidation of territories to achieve greater cost efficiencies was pursued only after frequent criticism by outside groups. Critics suggest that another structural change, the movement from costly central city processing to less costly rural localities, has not been implemented because the contractor and health-care provider communities have often criticized HCFA for such relocations in the past.

Possibly Excessive Benefit Payments

Expenditures for Medicare benefits may be higher than necessary because of the incentive in the contractor performance system for rapid processing times and low claims processing costs. These incentives discourage the establishment of effective systems and procedures to ensure that benefits are paid only as current law intends. 9/ The computation of a unit cost to assess contractor performance includes costs for both claims processing and benefit-safeguard functions and is considered heavily in the assessment of contractor performance. In contrast, performance evaluations place little emphasis on the effectiveness of the benefit-safeguard activities. The assessment criteria merely note whether the required processes are in place.

Studies indicate that the limited emphasis on benefit safeguards in the evaluation system leads to less attention to reducing Medicare expenditures. The General Accounting Office (GAO) has testified that the use of prepayment utilization reviews are particularly effective in reducing benefit payments. These reviews are conducted before payments are made to providers to assess the appropriateness of a claim relative to individual medical and claims history. It is estimated that while such reviews reduce

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9. Benefit-safeguard activities for HI and SMI constituted 23 percent and 4 percent of administrative costs, respectively, in fiscal year 1982.

benefits by $7 for each one dollar expended, 10/ they appear to be underused and are implemented unevenly. A forthcoming study by Abt Associates also concludes that additional allocation of resources for reviews reduces benefit expenditures. 11/ This finding suggests that if contractors devoted additional resources to benefit safeguards, expenditures for benefits by the federal government would be substantially reduced.

Possible Conflict of Interest

A conflict of interest may exist for many contractors whose own business operations are intimately involved in the Medicare program. Hospital expenses disallowed by Medicare are frequently borne by other third-party payers. Contractors interested in their own financial viability as private health insurers may directly or indirectly encourage the allocation of hospital costs toward Medicare, thereby raising Medicare payments and lowering their own.

Exclusion of Data Processing Firms as Prime Contractors

The legislative restriction that Medicare contractors be nonprofit or commercial health insurance organizations excludes the use of other firms,

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10. Testimony by Gregory Ahart, Director, Human Resources Division, General Accounting Office, June 15, 1982, before the Subcommittee on Health, Committee on Ways and Means, House of Representatives.

11. This analysis used six years of data to compare contractors with each other and to compare the same contractor over six years. An estimate of the relationship between expenditures for benefit safeguards and benefit expenditures is available in the final report which is expected later in 1983.

such as data processors, as Medicare prime contractors. This restriction was imposed because of the perceived importance of the skills and experience necessary to maintain beneficiary and provider relations, to conduct hospital audits, and to review claims for medical necessity.

As claims processing becomes an increasingly automated procedure, data processing firms may become more important in the design and implementation of new systems to reduce administrative costs. Although the data processing industry is expanding its role in the processing of claims for Medicare, this involvement is limited to subcontracts. Their exclusion as prime contractors may add unnecessary administrative costs because an additional firm must act as an intermediary between the government and the data processing firms.

Sluggish Technological Advancement

The current cost-reimbursement system may slow the adoption of technological advancements, because of the need for HCFA to finance the design and implementation of new systems or other productivity enhancements. Critics have charged that HCFA has been slow to finance improved methods of claims management, such as the greater use of sophisticated electronic transfer systems (paperless systems) and other "state of the art" technological improvements.

CHAPTER III. COMPETITION IN THE SELECTION OF MEDICARE CONTRACTORS

One way to address the concerns with the existing system is to introduce competition in the award of Medicare administrative contracts. The use of competition would base contractor selection on an assessment of bidder capabilities rather than on nomination by the provider community. Under a competitive procurement, HCFA would identify the work to be performed, solicit proposals from the contractor community and other potential bidders, and evaluate the proposals based on preestablished selection criteria. These criteria could include some combination of the contractor's performance on other contracts (experience), the adequacy and responsiveness of the bidder's plan to perform the required work (technical merit), and the proposed cost.

Competition could also be used in conjunction with a system of reimbursement based on the establishment of a fixed level of reimbursement rather than the reimbursement for all expenses incurred. This amount of reimbursement would be established at the time of the award of the contract. The contractor would receive this sum of money regardless of the costs incurred in the performance of contractor responsibilities. 1/

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1. Several variants of the total-sum, fixed-price contract could be used. The first--a fixed-price-per-claim contract--would permit (continued)

Alternatively, contractors could compete on the basis of their historical cost performance on other contracts, but continue to be reimbursed for their actual costs. Although this system would not make contractors financially liable for their management practices and decisions, it would introduce competition in the award of contracts, would award them to those contractors with demonstrated abilities to implement cost-effective management procedures, and would provide contractors with incentives to be efficient so that they could win future competitions.

The remainder of this chapter will examine the direct impact of the competitively awarded, fixed-price contract on administrative costs and then turn to the indirect effects on the quality and timeliness of services

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1. (continued)
contractors to bid without many of the contingency costs that they include to compensate them for large fluctuations in claims volumes. This contract form could be further modified to require contractors to bid varying unit costs based on the level of claims received. HCFA would issue work orders (called task orders) to the contractor as claims were received. If few claims are received, unit costs would be higher; if the volume of claims increased, unit costs would decrease reflecting the efficiencies of scale of the larger volume. Some suggest that contractors might be able to manipulate the volume of claims and thereby increase their reimbursement, however.

Another type of contract format--a fixed-price-per-beneficiary or a fixed-price-per-beneficiary-month--would reimburse contractors for the number of beneficiaries in the contract area. This contract format would eliminate the uncertainties resulting from variations in the number of beneficiaries. Contractors would be encouraged to implement procedures to reduce the volume of claims, such as increasing the number of services included on one claim, to reduce their own costs. These efficiencies could reduce total administrative costs for the federal government.

offered to the provider and beneficiary communities. This discussion will examine both the theoretical arguments and data from several demonstration projects that awarded Medicare administrative contracts through a competitive, fixed-price contract procedure. In Chapter IV, both the competitive fixed-price and the competitive cost-reimbursement contracts are discussed as alternatives to the existing system.

COMPETITION AND ADMINISTRATIVE SAVINGS

Competition appeared to reduce Medicare administrative costs in demonstration projects when the contract solicitations generated several bidders; when few bids were received, however, the administrative costs were increased relative to the previous cost-reimbursement contract. In all demonstration projects, the fixed-price contract increased administrative costs in a four-to-nine month transition period during which the existing cost-reimbursement contractor maintained ongoing claims processing activities and the fixed-price contractor simultaneously established the new managerial and technological systems in the contract area. After the initial year, however, contract administrative costs were, on average, between 15 and 20 percent lower than costs projected under the cost-reimbursement contract.

This impact of competition on costs must be interpreted with one general caveat, however. Although competition produced mixed results in reducing administrative costs for individual solicitations, the existence of competition may have focused attention on the reduction of administrative costs and may have served as an intangible stimulus for all cost-reimbursement contractors to minimize administrative costs in order to avoid competition. Although the cost estimates from individual solicitations may not indicate significant savings from competition, the indirect and unmeasurable effects of competition on all contractors may have reduced the total cost of program administration during the period of the demonstration projects.

In recent competitions, however, few bids to perform administrative activities have been submitted. This decline of contractor interest in competition is expected to continue in the near future, making large administrative savings from competition unlikely. It is thought to reflect contractor perceptions of the large financial risk and limited financial gains because of declining reimbursement under the current system, as well as aspects of the procurement process in the award of contracts.

The following section examines the theoretical mechanism by which administrative costs might be reduced under a competitive award and the aspects of the procurement process that would encourage and discourage

potential contractors from entering competition. This section is followed by a detailed discussion of the results the competitively awarded, fixed-price demonstration projects and the possible implications of these findings for other competitive situations.

Potential Effects

When implemented with a fixed-price contract, competition has the potential to provide a superior or comparable product at a lower cost. Including cost as a selection criteria for contractors would place greater emphasis on cost-efficient management than the current system. Contractors might be forced to direct more attention to the level of work and the management strategies that they would employ to meet defined performance standards while remaining competitive. These market pressures might ultimately reduce Medicare administrative costs.

Competition might force contractors to consider one or more strategies to reduce administrative costs. First, management could improve the overall productivity and performance of its existing labor force. 2/ Second, new technological systems could be implemented to streamline

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2. Managerial strategies that could improve performance and reduce costs using existing resources include financial incentives to increase worker productivity, advancement programs to encourage worker longevity and superior performance, creative use of worker schedules, ongoing training to provide skills necessary for high productivity, limited use of overtime, or targeted recruitment based on characteristics of workers identified with good and extended work tenure.

administrative operations and reduce labor costs. "State of the art" and other less radical modifications to contractor systems, such as the subcontracting of data processing activities or automation of correspondence, when appropriate, could significantly improve the overall efficiency of an existing system.

Third, contractors could bid on only the incremental costs associated with expanding existing managerial and claim-processing systems for Medicare services, rather than on the costs derived from allocating the fixed costs of production proportionally to Medicare and private business claims. This marginal cost pricing policy could considerably reduce Medicare contract costs. 3/ Fourth, contractors could reduce labor costs by establishing the base of operations in rural locations or other areas with cheaper labor and lower overhead costs.

Competition could provide a mechanism through which other administrative initiatives might be implemented. Many changes could be achieved

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3. This argument for competition assumes that the existing system for private business claims processing could be easily modified and expanded to accommodate Medicare claims. Regulations on contract specifications that create dissimilarities between Medicare and private business claims might violate this assumption, however. Examples of the types of restrictions in existing fixed-price contracts include requirements for a specific claims format and billing and coding systems, or the limitation on the location of claims-processing activities.

using the existing provider-nomination system, such as consolidation of territories to achieve greater economies of scale, introduction of new technologies, improved performance standards, or the integration of HI and SMI administrative systems. Competition might aid such changes by eliminating some of the resistence that has been expressed by the contractor and provider communities to implement such changes under the existing system.

In addition, contractors outside the specific area subject to competition might try to improve their performance in order to prevent the competitive award of their contract and the challenge by competitors with superior capabilities.

On the other hand, the perception of limited financial advantages of the contract might discourage many potential bidders, possibly negating the intended impact of competition on administrative costs. The fixed-price contract would not guarantee "no loss" and, unlike the existing system, the contractor would have to weigh potential financial gains relative to potential losses to determine the appropriate use of corporate assets. 4/

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4. Efficient organizations are in a position both to bid lower costs to obtain the contract and to gain from it, and may also realize more financial gain since they need not transfer all of the gains from their greater efficiency to the government by lowering their bids to their actual costs.

While many of the indirect and nonfinancial incentives for participation would exist, potential financial loss might be weighed most heavily. 5/

Such a reluctance to bid might result, in part, from assigning the total financial risk for fluctuations in claims workload to the contractor as required by the total-sum, fixed-price contract. Competitors might choose not to compete, since they would be unable to bid the full value of contingency costs for unanticipated events for fear of being underbid, and disinclined to exclude these costs because of possible financial losses.

The relative emphasis given to each of the selection criteria might also affect the number of bidders. Although bidders do not formally state their willingness to compete prior to the submission of proposals, the contractor community is aware of other firms that may enter the competition and, in general, their standing relative to these others. 6/

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5. The nonfinancial advantages of the Medicare administrative contract include: the positive product affiliation of the contractor's private business with the Medicare program (especially for Medigap, the private, supplemental medical coverage for non-Medicare reimbursed expenses); the additional leverage in negotiations with providers when implementing general corporate policy; the testing of new claims-processing procedures and technologies prior to use with private business; and the financial stability which may be achieved when Medicare constitutes a large proportion of contractor's total business activity. Other reasons for participation include corporate goodwill and an interest in influencing general Medicare policy to safeguard the contractor's own business interests.

6. This awareness, in part, comes from a bidders' conference in which potential contractors are gathered to clarify aspects of the contract solicitation collectively.

Potential bidders would assess their corporate strengths and weaknesses relative to the selection criteria, and, more importantly, to other firms they feel are likely to compete. 7/ Firms feeling that they are noncompetitive might not compete because of the costs associated with proposal development.

The perceived advantage of a competitor on technical merit and experience or the perception that there will be few other competitors might increase the price of the bid. Conversely, a larger number of bidders or the perception of a "tight" competition might reduce the cost bid by each competitor, reducing the value of the contract award to competitors. This administrative cost reduction is desirable for the federal government, if performance on other key measures can be maintained.

Actual Experience

Since 1977, HCFA has initiated seven competitive, fixed-price contract demonstration projects for the selection of Medicare contractors. 8/

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7. The points assigned to the selection criteria--experience, technical merit, and cost--determine the relative advantage of one firm over another. High points for cost, for example, would generate interest from firms with limited experience in the field but whose costs are low, for example, because of having adopted new technologies. Alternatively, high points for experience might encourage those firms with good and extended performance on other contracts, thereby excluding or discouraging inexperienced firms.

8. The seven competitions have included six territories; one fixed-price contract area, Maine, was recompeted at the conclusion of (continued)

The demonstrations have implemented only total-sum, fixed-price contracts. Each contract has been awarded to provide administrative services for a three-to-five year period. These contracts have included liquidated damage clauses in which substandard work reduces contractor payment. The most recent contracts have also incorporated financial incentives for performance that exceeds specified standards. 9/

The competitive fixed-price demonstrations have produced mixed results in reducing administrative costs. 10/ When measuring differences between the actual fixed-price and a projected cost-reimbursement contract price, half the demonstrations realized administrative savings and half increased administrative costs (see Table 2). In one instance, however, the

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8. (continued) the first contract. Bids for an eighth solicitation, the recompetition of the Illinois SMI contract, have been received and are being reviewed by HCFA.

9. Payments for administrative services involve three major cost functions: transition costs required to design and establish all systems in the contract territory, operational costs, and negative costs for liquidated damages. Liquidated damages will not be included when determining administrative savings in CBO estimates of administrative cost savings as poor performance cannot be predicted, should not necessarily be anticipated in future procurements, and merely represents an inferior product, not an actual savings.

10. Administrative cost estimates derived from the competitive fixed-price contract assume the comparability of contractor responsibilities under the cost-reimbursement and the fixed-price system. It should be noted, however, that contractors under the existing system are expected to perform all activities requested by HCFA; contractors awarded business under a competitive fixed-price arrangement are bound only by the language and requirements of the contract and additional work or changes in responsibilities require contract negotiations and modifications.

TABLE 2. ESTIMATED ADMINISTRATIVE COST SAVINGS FROM COMPETITIVE FIXED-PRICE CONTRACTS

Area	Type	Estimated Savings a/ (Dollars in thousands)	Savings as Percentage of Projected Costs	Number Competitors	Other Potential Explanatory Factors
New York	SMI	10,591	34	6	Consolidating 3 territories into one
Illinois	SMI	10,873	25	5	Consolidating 2 territories into one very large territory
Maine I	SMI	739	13	5	Minimal changes; no consolidation
Maine II b/	SMI	-1,306	-30	2 c/	Minimal changes; no consolidation
Missouri	HI	-1,844	-35	2	Consolidating 5 territories into one
Puerto Rico	HI/SMI	Now awarded because of high bid	--	1	Consolidating HI/SMI
Colorado	HI/SMI	Not available	Not available	1	Consolidating HI/SMI

a. Negative sign denotes additional cost to federal government. Estimated for the entire period of the contract.

b. The Maine I fixed-price contractor was awarded a second fixed-price contract in the recompetition of the Maine II contract and the continuity of staff and operations was maintained.

c. Initially, three competitors; one withdrew bid.

competitive fixed-price bid was so high that the contract solicitation was withdrawn by HCFA.

The administrative savings that have been realized occurred after the first year of fixed-price operations. During the first year, the costs of establishing program operations were substantial and offset any administrative efficiencies. 11/ These costs were incurred partly because of the necessity to maintain the cost-reimbursement contractor to process claims while the fixed-price contractor established new operations during the transition period. Cost increases for claims processing during the first year were, on average, more than 30 percent greater than those which would have been experienced by the incumbent contractor. In subsequent years, however, costs were reduced considerably, producing an average, net, overall savings of approximately 10 percent for the SMI fixed-price solicitations.

Number of Competitors and Administrative Savings. The level of competition, as measured by the number of competitors, significantly affected the administrative costs of contracts awarded under the competitive fixed-price process. In solicitations with multiple bidders, the

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11. Transition costs will be incurred by all contractors regardless of previous Medicare administrative experience because of the need to establish new operations, hire and train a new staff, develop a new computer system, and perform other developmental activities in a new site.

cost of the contract was considerably lower than the projected costs of the incumbent contractor. Solicitations involving one or two bidders demonstrated significant increases in administrative costs or were not awarded because of high bids. The behavior of the incumbent cost-reimbursement contractor paralleled that of other competitors: incumbent contractors reduced fixed-price cost per claim below cost-reimbursement rates when large numbers of contractors participated in the solicitation; with limited competition, the fixed-price cost per claim increased.

Strong contractor interest in competing for Medicare contracts was observed in the initial solicitations. Competitors included Blue Cross/Blue Shield affiliates from the state of the contract, Blue Cross/Blue Shield affiliates in other states, commercial health insurers with other Medicare experience, and, in one solicitation, a data processing firm.

In recent competitions, only one or two competitors have entered each competition. These competitors represented primarily the local incumbent Blue Cross/Blue Shield affiliates (see Table 3). It appears that while some incumbents may be willing to compete for their existing territory under current conditions, Blue Cross/Blue Shield affiliates and commercial health insurance corporations may be uninterested in expanding their responsibilities beyond their current areas.

TABLE 3. NUMBER OF COMPETITORS BY TYPE

Area	Calendar Year Awarded	Local Blue Cross/ Blue Shield Affiliate	Other Blue Cross/ Blue Shield Affiliate	Commercial Health Insurer	Data Processing Firm	Total Number of Competitors
Maine I	1977	1	2	2	0	5
New York	1978	1	0	5	0	6
Illinois	1978	1	0	3	1	5
Missouri	1980	2	0	0	0	2
Colorado	1980	1	0	0	0	1
Maine II a/	1981	0	2	1 b/	0	2
Puerto Rico	1982 c/	1	0	0	0	1
Total		7	4	11	1	23

a. The Maine I fixed-price contractor was awarded a second fixed-price contract in the recompetition of the Maine II contract and the continuity of staff and operations was maintained.

b. Withdrew bid.

c. Contract not awarded.

In addition to the general factors mentioned above, lack of interest may have reflected losses to contractors in the early fixed-price contracts 12/ and the recent ceiling on payments in cost-reimbursement contracts. The latter has led the contractor community to be uncertain about future involvement in the Medicare program even under a cost-reimbursement arrangement. Because the price bid for a competitive contract is based on the efficiencies derived from the expansion of existing operations, contractors might be unwilling to bid for additional contracts if they are considering curtailing or discontinuing their Medicare participation. This concern is voiced particularly among commercial health insurance corporations.

Generalizing from the Experience

The results of these demonstrations must be interpreted with great care when predicting future administrative savings or costs, because of unique aspects of the demonstrations. First, in several instances, structural and methodological changes included in the demonstration contract may have, by themselves, affected the contract's cost. In several demonstrations, considerable economies of scale may have been realized through the consolidation of territories. These economies may have led to overstated estimates of the savings realized from the competition alone.

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12. GAO estimates of contractor bids relative to work required indicate a financial loss by the contractor on the Maine I and New York SMI fixed-price contracts. The Illinois demonstration was estimated in 1981 to have cost the contractor $8.9 million over the $41.8 million awarded for the contract.

Second, estimates are necessarily based primarily on the Maine I, New York, and Illinois demonstrations, which produced the greatest administrative cost savings. The Missouri data provide only the transition and early operational costs, Colorado has yet to be implemented, and Puerto Rico was withdrawn because of the high bid. Early projections of administrative costs indicate high costs for these later demonstrations; the withdrawal of the Puerto Rico solicitation may, in particular, contradict the savings trend of the earlier competitions.

Also, some contractors may have underbid in an attempt to acquire the territory for corporate territorial "positioning" in the advent of the passage of a National Health Insurance plan, the regionalization of Medicare contractor responsibilities, or other Medicare fixed-price contract solicitations. To the extent that this occurred, "savings" could be only a transitional phenomenon.

COMPETITION AND ADMINISTRATIVE PERFORMANCE

The administrative performance of a contractor can be measured on three representative program dimensions: the timeliness of claims processing, the accuracy with which benefits are paid to eligible program participants, and the rigorousness with which the contractor reviews claims to ensure they are reimbursed for medically necessary services. The assessment of the accuracy of benefit payments--the payment deductible

error rate--measures the rate of reimbursement relative to individual coinsurance, program deductible, and eligibility status; the review for medical necessity compares a submitted claim to a medical record to establish the appropriateness of the claim. Contractors retain considerable discretion over the allocation of resources and the stringency of the review of claims to verify medical necessity. Differences in payments resulting from differences in the standards and policy interpretation of individual contractors on medical necessity reviews are not considered errors and are excluded from the payment-deductible error rate.

In the demonstrations described above, fixed-price contractors experienced temporary disruptions in the timeliness and accuracy with which claims were processed relative to the incumbent contractor. The period of disruption on the timeliness measure was relatively short; contractors generally achieved the incumbent's standard within a year after the assumption of responsibility.

Fixed-price contractors were less successful at accurately determining and reimbursing claimants for medical expenses. Initial payment error rates for fixed-price contractors were more than double those of the incumbent and remained high for almost two years. This increase in the payment error rate affected beneficiaries and providers of health-care services and, because overpayments exceeded underpayments, increased the expenditures for the program's benefits.

Lastly, the average benefit paid to each enrollee remained, on average, slightly below the expected payment for the demonstration site population. Payments to beneficiaries varied considerably in each of the three demonstrations, however. The implication of this variation in benefit payments for future competitions is unclear and the adequacy of resources devoted to benefit safeguards that were allocated under the fixed-price contracts remains unresolved.

The next section examines the effects of competition on contractor performance; this analysis focuses exclusively on the SMI contractors because data are not yet available from HI demonstration contracts. After a description of the measures that are used to evaluate contractor performance, potential positive and adverse effects of competition on contractor performance are discussed. The last section describes the actual experience under the demonstration projects.

Measurement of Administrative Performance

The **timeliness of payment** measures the speed with which the contractor processes and pays for a claim submitted by an individual or an institution. One measure of timeliness is the average number of days reported by the contractor to process a claim. Technological advancements have reduced the time required. Currently, an average carrier processes a claim with 11 days after receipt.

Delays in the payment of claims may create unnecessary cash flow difficulties for institutions and economic hardships for beneficiaries who may have paid for medical and hospital expenses from household assets prior to submitting the claim for reimbursement. Serious delays in payment have increased complaints and inquiries to the contractor by Congressional representatives and by beneficiaries in the past.

The **accurate payment of benefits** ensures that benefits are targeted to beneficiaries as intended in the authorizing legislation and the implementing regulations, at levels which are consistent with established reimbursement procedures. A measure assessing the number of payments made inaccurately is called the payment-deductible error rate. 13/ A large error rate appears to increase benefit payments, since overpayments have exceeded underpayments. 14/

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13. The payment-deductible error rate computes the dollar value of overpayments, underpayments, payments to those ineligible for the program, and payments based on inaccurate deductible and coinsurance information. Only errors attributable to the carrier are included in this measure. The error rate is determined from a review of a sample of claims dispensed by the contractor.

14. Since overpayments exceed underpayments by 16 percent, an additional one dollar paid inaccurately would increase program expenditures by 16 cents.

Lastly, the **benefit paid per enrollee** measures the average value of Medicare services provided for each enrollee. 15/ This ratio serves as a benchmark to measure significant changes in the level of payments to beneficiaries among contractors or across several years for a specific contractor. Changes in the ratio may reflect many factors outside the contractor's control, or they may reflect variation in the allocation of resources to activities to establish the medical necessity and medical appropriateness (prepayment utilization review) for claims and to prevent practices by providers that are excessive or abuse the Medicare system (postpayment utilization review). 16/ Some analysts are concerned that apprehensions about Medicare competitive bidding may have acted as an incentive for all contractors to cut benefit safeguards to avoid competition for their contracts and that, if competition were implemented, carriers would attempt to find ways to lower these activities even further.

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15. This ratio is defined as the total dollar value of benefit payments for a year divided by the number of beneficiaries in the same geographic area.

16. Differences among contractors may reflect differences in reasonable and customary charges among areas, differences in medical practice affecting the number of medical visits and claims for a population, seasonal variations affecting the regional incidence of illness, greater preventive practice, or other factors contractors cannot control.

    Stringent benefit safeguard activities require staff time and resources and delay payment because of the time necessary to review and verify manually the medical appropriateness of a claim.

Potential Effects

A competitive system to select contractors based on key performance indicators might provide one mechanism to improve overall contractor performance. Through the elimination of poor performers and subsequent replacement with good performers, the quality of services might be improved.

In order to ensure adequate performance on timeliness, payment-deductible error rate, and other key measures, demonstrations of fixed-price contracts have included financial sanctions (for example, liquidated damages) that reduce contractor reimbursement when performance fails to meet specified standards. These financial sanctions create incentives for contractors to maintain consistent and quality performance. Under the current system, contractors are chastised for poor performance through the routine publication of contractor performance data, but are not directly financially liable for their performance.

Although intended to improve performance, competition might actually create selection and implementation difficulties that would adversely affect contractor performance. First, HCFA might have difficulty in specifying important criteria for consideration. Actual contractor performance might involve programmatic intangibles that might be difficult to describe objectively in the solicitation or to evaluate technically from the

bidder's proposal. These intangibles include important aspects of service delivery such as beneficiary and professional relations, appropriateness of correspondence, and for HI contractors, the adequacy and thoroughness of hospital audits.

Second, an emphasis on cost in the selection criteria might inadvertently affect program performance. If cost was the single most important consideration for selection, bidders might be forced to bid low and thereby lessen the possibility of good performance during program implementation.

The emphasis on administrative cost in the selection criteria might be especially important for the measure of benefit paid per enrollee. The selection of low-cost contractors to replace those who have historically demonstrated high administrative costs may inadvertently eliminate contractors with more benefit-safeguard activities, thereby producing an unintended increase in benefit payments, which could far outweigh any savings in administrative costs.

Third, performance might suffer during transitions. A new contractor with no Medicare administrative experience or an existing contractor in a new area might undergo a period of adjustment or difficulty when implementing the systems required to perform the contract's responsibilities.

Fourth, although financial sanctions have been instituted to ensure adequate performance as measured by certain criteria, the assessment of competitive contractors' performances on safeguard activities, like those under the cost-reimbursement system, focuses primarily on the existence of the activity, or process, rather than its effectiveness. This system may be insufficient to ensure that contractors implement the most effective and extensive activities to limit payments to those intended by law. In particular, the periodic replacement of HI contractors under a competitively awarded system could have serious, although unexplored, consequences for the continuity of staff, the quality of audits, and ultimately the level of HI benefits that are paid. Audits would probably be performed by inexperienced auditors—a responsibility requiring one to two years of supervision and training before independent audits can be performed. This function is of special importance in view of the increasing sophistication of hospitals in realizing the maximum reimbursements from Medicare.

Actual Experience

In the competitive demonstrations to date, fixed-price contractors initially have experienced a difficult period after assuming Medicare responsibilities, but then have achieved performances at least as good as those of the previous incumbents, as measured by the criteria described above. 18/

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18. Note that the information in this report only covers the period through April 1983.

Average Processing Time. The four fixed-price SMI contractors demonstrated somewhat mixed success in providing benefits in a timely fashion. Two contractors (Maine I and New York) provided benefits as quickly as the incumbent contractor within one quarter after taking responsibility. The Illinois contractor, however, required five quarters to match the incumbent; and, after three quarters, the Maine II contractor has not met these standards as of the last reporting period--the third quarter of 1982 (see Table 4). Fixed-price contractors that experienced difficulty during the initial year reported that they required more than twice the national average number of days to process a claim.

TABLE 4. AVERAGE PROCESSING TIME OF FIXED-PRICE SMI CONTRACTORS

Area	Number of Quarters to Equal Incumbent Contractor	Number of Quarters to Equal National Average
Maine I	1	1
Maine II a/	4 or more b/	4 or more b/
New York	1 c/	1
Illinois	5 c/	5

a. The Maine I fixed-price contractor was awarded a second fixed-price contract in the recompetition of the Maine II contract and the continuity of staff and operations was maintained.

b. Contractor has not equalled incumbent or national average as of the third quarter of 1982.

c. Compared to the weighted average for incumbents.

The initial period of disruption suffered by the worst performer, Illinois, produced considerable difficulties for the beneficiaries, public officials, and the contractor. Beneficiary reaction prompted an investigation by the Subcommittee on Health of the House Ways and Means Committee. The contractor was forced to devote scarce top level management resources for public relations activities, responses to Congressional inquiry, and other time-consuming activities to respond to the public and to appease critics.

While the difficulties in maintaining processing times may be attributable, in part, to aspects peculiar to the inexperience of HCFA and the contractors in managing a transition, it seems likely that a new contractor can expect some temporary disruption of service while hiring and training a new staff. 19/

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19. The initial slow processing times in the demonstrations were created partly by the large numbers of backlogged claims inherited from the incumbent, complicated revisions and integration of disperate provider codes inherited from multiple cost-reimbursement incumbents when contractor areas were consolidated, insufficient testing of modified systems prior to their implementation, and differences in levels of reimbursement based on new reimbursement codes prompting beneficiary requests for appeals.

    In some of the earlier demonstrations, considerable change in contractor operations or revisions in computer systems was implemented; in later demonstrations, minimal change was introduced at the point of transition and desired changes were phased in over the period of the contract. This "phase-in" policy might reduce the duration and intensity of the demonstration project difficulties. In spite of this change, however, some difficulty is expected as contractors experience low productivity and poor performance during the transition period.

After completing this transition period where low performance was experienced, however, fixed-price contractors have repeatedly demonstrated superior performance relative to the national average. In fiscal year 1982, the three fixed-price carriers reported an average processing time of 9.4 days; the national average for all carriers was 10.4 days.

Payment-Deductible Error Rates. Fixed-price SMI contractors also required considerable periods of time to match incumbent payment-deductible error rates. In all cases, more than one year elapsed before contractor performance equalled the incumbent; in two cases--Maine I and Illinois--more than two years passed (see Table 5).

Fixed-price contractor error rates were 70 percent higher than incumbent rates over the period of the demonstration, and rates in the first year more than doubled incumbent rates. Compared to national averages, however, payment deductible error rates for fixed-price contractors equalled the average for cost-reimbursement contractors in the July 1981 to June 1982 period. The projected performance of incumbents was considerably below that level.

TABLE 5. PAYMENT DEDUCTIBLE ERROR RATE OF FIXED-PRICE SMI CONTRACTORS

Area	Number of Quarters to Equal Incumbent Contractor	Number of Quarters to Equal National Average
Maine I	11	2
Maine II a/	6	0
New York	4 b/	3
Illinois	10 b/	11

a. The Maine I fixed-price contractor was awarded a second fixed-price contract in the recompetition of the Maine II contract and the continuity of staff and operations was maintained.

b. Based on weighted average of incumbents during last quarter of cost-reimbursement contract.

Benefits Paid Per Enrollee. Although overall performance on the benefit per enrollee measure matched the projected growth over the demonstration period, the performance by individual contractors varied considerably. In New York, benefits per enrollee were more than 20 percent lower than expected; in Maine, payments were equal to projections; in Illinois, payments were 20 percent higher than projected.

Several explanations exist for the change in the average payment under demonstration contractors. First, because of the consolidation of

territories, the implementation of the demonstration contract required a recomputation of rates of reimbursement based on the integration into one rate of the reimbursement coding systems for several cost-reimbursement contractors. The reasonable and customary charges may have been unavoidably adjusted upward or downward because of this recomputation and thus have affected the cumulative benefit payments.

Second, this growth may reflect routine fluctuations in annual payments among contractors. Historic contractor data suggest some variation in the measure by individual contractors across several years.

Conversely, the replacement of high cost contractors with less expensive fixed-price contractors may reflect the allocation of fewer resources to benefit-safeguard activities by fixed-price contractors. Because these contractors do not submit expenditures for specific administrative functions, a direct determination of resource allocation is not possible.

Unfortunately, these demonstration data do not adequately resolve the concern that fixed-price contractors might be encouraged to reduce the resources allocated to benefit-safeguard activities, thereby increasing expenditures for benefits. To mitigate such an effect, HCFA could implement the competitive fixed-price contract with strict contractual provisions and sufficient levels of monitoring to ensure the required use of cost-effective benefit-safeguard activities by contractors.

CHAPTER IV. PROGRAM ALTERNATIVES

This chapter analyzes three alternative methods of awarding Medicare administrative contracts. Each would award administrative contracts based on competitive processes rather than on the nominations of contractors by provider communities. Two options would use a fixed-price contract; the other would maintain a cost-reimbursement arrangement and emphasize potential performance in the selection process. The three alternatives are:

- Alternative A--competition in the award of all contracts, with fixed-price reimbursement.
- Alternative B--competition limited to replacement of administratively costly contractors, with fixed-price reimbursement.
- Alternative C--competition to replace contractors performing poorly in benefit-safeguard activities, with cost reimbursement.

Under each option, selection of contractors would be based on three criteria: technical merit, experience, and cost. The projected cost of the current system (the baseline) is provided in Table 6.

Each alternative is examined by using the following criteria:

- The administrative cost for contractor services,

- o The level of payments for benefits, 1/ and
- o The timely execution of administrative functions.

TABLE 6. PROJECTED SMI BASELINE OUTLAYS FOR FISCAL YEARS 1984-1988 (In millions of dollars)

Costs	1984	1985	1986	1987	1988	1984-1988 Total
Administration	530	560	590	630	660	2,970
Benefits Paid Correctly	20,080	23,220	26,810	31,130	36,090	133,330
Net Paid in Error	80	90	100	110	120	500
Total Outlays	20,690	23,870	27,500	31,860	36,880	140,800

SOURCE: Preliminary CBO estimates from SMI administrative data.

NOTE: Details may not add to totals because of rounding.

To minimize difficulties during transitions between contractors, it is assumed that any alternative to the current system requiring the transfer of responsibility from one contractor to another would be implemented in

1. Because neither the existing system nor the proposed alternatives put the contractor at financial risk for the level of expenditures for benefits, this discussion will focus on the limited, incremental improvements that might be realized through the selection of contractors who have performed well on benefit-safeguard activities.

conjunction with uniform processing, billing, diagnostic, and provider identification codes. 2/

The estimated effects of competition in this chapter are limited to SMI contractors. HI demonstration projects have not yet provided sufficient data to permit an assessment of the impact of competition on their administrative costs and, more importantly, on contractors' performance.

COMPETITION IN THE AWARD OF ALL CONTRACTS, WITH FIXED-PRICE REIMBURSEMENT

This alternative would modify the existing legislative authority to require that all Medicare contracts be awarded through competitive bidding. Contractors would be reimbursed at a rate determined when the contract was awarded, based on a fixed price for a designated period of time or for some predefined unit of work. The selection criteria would emphasize the cost proposed by the bidder; technical merit and contractor experience would be included to exclude poor performers. The transition to a completely competitive system would occur over four years beginning with fiscal year 1984. One quarter of the contracts would be subject to competition each year; contracts that currently have the highest unit costs

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2. Differences in these basic administrative procedures reflect contractors' preferences. These differences are costly and burdensome at the time of the transition because providers must modify their systems to accommodate these changes. Differences between systems also limit the collection of meaningful utilization and cost data in the Medicare program.

would be offered first for competitive bidding. Because of the emphasis on administrative cost control, CBO has assumed that winning contractors would devote fewer resources to preventing errors in benefit payments, thus raising federal benefit costs.

This alternative would increase overall Medicare outlays by $40 million in fiscal year 1984 and by $660 million between fiscal years 1984 and 1988 (see Table 7). The cost increases would reflect both higher administrative costs and more benefits paid in error. By introducing the greatest change into the program, this option would also expand HCFA's administrative responsibilities significantly. Fourteen SMI contracts would be awarded each year. 3/

Impact on Administrative Costs. This alternative would increase administrative costs by $40 million in fiscal year 1984; total additional costs through fiscal year 1988 would be $270 million. This additional cost would represent a 9 percent increase over projected administrative costs under current policy.

Higher administrative costs are expected to result from a small number of bidders. As experienced in the demonstration projects, the

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3. One option to reduce this number of competitions would be to consolidate the responsibilities of groups of contractors and gradually reduce the number of contracts.

TABLE 7. BUDGETARY IMPACT OF UNIVERSAL APPLICATION OF COMPETITION IN SMI, WITH FIXED-PRICE REIMBURSEMENT, FISCAL YEARS 1984-1988 (Changes to the baseline, in millions of dollars)

	1984	1985	1986	1987	1988	Total
Administration	40	20	70	80	60	270
Benefit Payments	0	40	70	110	170	390
Net Budget Impact	40	70	130	190	230	660

NOTES: Positive signs denote an increase in expenditures compared to the baseline presented in Table 6. Details may not add to totals because of rounding.

cumulative effect of competition without sufficient bidders would be an increase rather than a decrease in administrative costs. To apply competition universally, as proposed under this alternative, would require 14 competitions per year--a number far exceeding any observable interest in competition by potential contractors in the recent demonstrations.

In essence, some savings could be achieved in those areas where current contractors have high costs, but these would be offset by increased costs for those operations that are currently performing efficiently and effectively.

Impact on Benefit Payments. Benefit payments would rise because of an increase in the dollar value of payments made in error. Erroneous payments would increase almost 80 percent between 1984 and 1988 compared with current policy. The net impact of overpayments and underpayments would be to increase the program's cost by nearly $400 million over the period.

Of all alternatives presented, the universal application of competition is most subject to concern about the allocation of resources for benefit-safeguard activities. The universal conversion of the system to fixed-price contracts would tax the abilities of HCFA to monitor contracts and to oversee the activities of the new contractors. Without sufficient monitoring, contractors could easily reduce benefit-safeguard activities, thereby increasing benefit payments.

Impact on Timeliness of Benefit Payments. Contractors would experience, on average, three quarters during which performance would be adversely affected because of difficulties inherent to the transition.

COMPETITION LIMITED TO REPLACEMENT OF ADMINISTRATIVELY COSTLY CONTRACTORS, WITH FIXED-PRICE REIMBURSEMENT

This alternative differs from the first in that competition would be limited to areas where contractors have consistently had high administrative costs. The transition would begin in fiscal year 1984 and, over the next four

years, one-fourth of the contractors in the quartile with highest 1983 administrative costs would be replaced each year.

The selective application of competition would represent an incremental change from the existing system. If this approach was found to increase administrative costs or benefit payments based on the experience of the initial years, the policy could be discontinued or curtailed. Its incremental nature is, in fact, a major advantage of this option, because of the uncertainty about the long-term impact of competition on administrative cost, benefit payments, and administrative performance. A gradual transition to this system might also prove to be a more manageable task for HCFA in monitoring transition and operational activities.

This option would increase net outlays by $120 million over the period 1984 to 1988 (see Table 8). Although it would reduce administrative costs by $30 million, payments made in error would increase by $150 million.

Impact on Administrative Costs. By limiting the situations in which competition would be employed, this option would differ from the first alternative in several ways. First, the possible loss of territory through competition could stimulate more cost-efficient management among all incumbents.

TABLE 8. BUDGETARY IMPACT OF LIMITED COMPETITION IN SMI, WITH FIXED-PRICE REIMBURSEMENT, FISCAL YEARS 1984-1988
(Changes to the baseline, in millions of dollars)

	1984	1985	1986	1987	1988	Total
Administration	20	0	0	-10	-40	-30
Benefit Payments	0	10	20	50	70	150
Net Budget Impact	20	10	20	40	40	120

NOTES: Positive sign denotes an increase in expenditures, compared to the baseline presented in Table 6. Details may not add to total because of rounding.

Second, the selective application of competition would reward incumbent contractors for good performance. The opportunity to retain their contracts would encourage effective management strategies, long-term productivity investments, and technological innovations by incumbent contractors.

Third, by limiting the number of competitions, more bids could be expected in each case. Only four competitions would be held annually, if competition were targeted toward the gradual elimination of the lowest quartile of performers. Competent contractors with an interest in expanding territorial responsibility would be more capable of bidding, because their "home" territory would most likely not be subject to competition.

Impact on Benefit Payments. On the other hand, benefit payments would increase because of a higher error rate. The higher rate of benefit payments made in error would increase program expenditures by $150 million between 1984 and 1988 compared to current policy (see Table 8).

Impact on Timeliness of Benefit Payment. Some temporary disruption in the performance of the competitive, fixed-price reimbursement contractors would occur. Because of the limited number of competitions per year, however, it is possible that HCFA, based on their demonstration experience, would be able adequately to monitor and direct these transition operations.

COMPETITION TO REPLACE CONTRACTORS PERFORMING POORLY IN BENEFIT-SAFEGUARD ACTIVITIES, WITH COST REIMBURSEMENT

This alternative would hold competitions to award Medicare administrative contracts to replace poor performers with others that demonstrate superior capabilities. Awards would be based upon ability to improve the accuracy of benefit payments for eligible individuals. The contractor's performance on the payment-deductible error rate or some other measure that would objectively embody this payment-safeguard orientation would serve as the most important criterion for selection, although an assessment of the technical merit of each proposal would also be included. The cost proposal would be assessed to establish the general acceptability, reasonableness, and justification of the expenditures that were identified. As under the current system, however, the contractor would be reimbursed for

the actual cost of performing administrative activities. The net budgetary impact of this proposal would be $10 million in additional outlays in fiscal year 1984, but $240 million would be saved over the 1984-1988 period (see Table 9).

TABLE 9. BUDGETARY IMPACT OF COMPETITION TO REPLACE CONTRACTORS PERFORMING POORLY ON BENEFIT-SAFEGUARD ACTIVITIES, WITH COST REIMBURSEMENT, FISCAL YEARS 1984-1988 (Changes to the baseline, in millions of dollars)

	1984	1985	1986	1987	1988	Total
Administration	40	20	30	40	10	130
Benefit Payments	-40	-60	-70	-90	-100	-370
Net Budget Impact	10	-50	-40	-50	-90	-230

NOTES: Positive sign denotes increased expenditures, compared to the baseline presented in Table 6. Details may not add to totals because of rounding.

Impact on Administrative Cost. Administrative costs would increase by $130 million over the five-year period, but more emphasis on benefit safeguards and a reduction in the error rate would reduce benefit payments made inaccurately by $370 million (see Table 9).

Increased administrative costs would reflect increased resources for benefit-safeguard activities. Contractors chosen for replacement probably would have low administrative costs because of their previous limited use of resources for benefit safeguard-activities. Their replacements would spend more money on benefit-safeguard activities, resulting in higher administrative costs. In addition, the emphasis on this performance indicator for contractor replacement and contract award might increase the cost of benefit safeguard-activities by all incumbents.

Impact on Benefit Payments. This option would pursue opportunities to reduce expenditures for benefits by eliminating payments for duplicative, medically unnecessary, or medically inappropriate services, or to ineligible persons. Currently, an additional dollar for benefit-safeguard expenditures is estimated to return seven dollars in reduced benefit payments. By basing contractor selection on benefit-safeguard activities and, thereby, removing the financial incentive to minimize these activities, this alternative would cut total outlays for the Medicare program significantly.

Impact on Timeliness of Benefit Payments. Because of the limited number of contracts undergoing competition at any one time, HCFA would probably be able to monitor these contracts successfully. The period of temporary disruption would probably not exceed two or three quarters for each new contractor.