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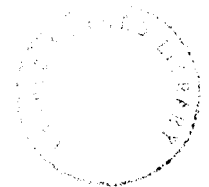
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The annexed draft of our Report is being circulated publicly by the Committee for comment.

All comments should be received no later than noon on Thursday, May 9, at the following address:

Mr. Max Perlman
Executive Secretary
Advisory Committee on Medicare
Administration, Contracting,
and Subcontracting
Room 585, East Building
Social Security Administration
6401 Security Boulevard
Baltimore, Maryland 21235

A final public meeting of the Committee to receive comments on the draft will be held as follows:

Friday, May 10, 1974 - 9:30 A.M.
Room 4131, HEW North Building
Department of Health, Education,
and Welfare
Third and C Streets, S.W.
Washington, D.C.

Any person wishing to make a statement at the meeting is requested to notify Mr. Perlman at 301-594-9134. Oral statements should be preceded by written statements filed as mentioned above.

ADVISORY COMMITTEE ON MEDICARE
ADMINISTRATION, CONTRACTING
AND SUBCONTRACTING

Charles A. Bowsher
Michael Gort
Roswell B. Perkins, Chairman

April 26 1974



DRAFT - April 26, 1974

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FOR DISCUSSION ONLY

REPORT OF ADVISORY COMMITTEE
ON MEDICARE ADMINISTRATION,
CONTRACTING AND SUBCONTRACTING

May ,1974

Statistical data and information in this draft may be subject to change before final report is issued based on validation in process.



REPORT OF ADVISORY COMMITTEE
ON MEDICARE ADMINISTRATION,
CONTRACTING AND SUBCONTRACTING

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For Discussion Only

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I. SUMMARY OF CONCLUSIONS

FOR DISCUSSION ONLY

1. The Role of Private Carriers Should be Preserved

The pluralistic system through which contracts are entered into with private carriers (both non-profit and commercial) for the administration of Part B of Medicare has distinct advantages for both Medicare beneficiaries and for taxpayers. The system should be continued.^{1/}

(a) This does not mean that the Federal Government should place blind trust in a group of privately operated non-profit and commercial carriers. A system must exist which provides incentives for high performance and a close monitoring of results.

(b) The creation and operation of Professional Standards Review Organizations (PSRO's) will not reduce significantly the functions of the Part B carriers in the immediate future. The carriers will be "consumers" of information developed by the PSRO's as to medical necessity and quality. In the longer run, it is possible that the PSRO's will take over from the carriers the function of review of medical necessity and quality.

2. There Must Be a Viable Method for Measuring Carrier Performance

The efforts to develop more refined criteria of performance of carriers should be intensified and given the highest priority.^{2/}

^{1/} See Part V-B.
^{2/} See Part V-D.



- (a) While BHI has made some progress toward assessing the administrative efficiency of carriers, much more needs to be done to improve the criteria for evaluating overall carrier performance.
- (b) The Department should enter into a research contract promptly with an independent private entity in order to accelerate the improvement of the performance criteria. Such a firm should be capable of dealing with management problems, performance measurement and incentives.
- (c) In addition to other factors, the performance criteria should take into account the degree to which the carrier performs the function of applying professional standards of medical necessity and quality.
- (d) A critical element in improved criteria of carrier performance is the development of better systems of reporting by carriers. Cost accounting information at the carrier level is not standardized to the point where comparisons can be made with a reasonable degree of reliability. HEW should consider developing cost accounting standards to remedy this.
- (e) Variations in administrative costs among carriers are at present enormous, if one considers that the Part B carriers contract to produce a standardized, if not essentially identical, service. Analysis suggests that the principal

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reason for these variations are (i) differences in efficiency among carriers, and (ii) differences in accounting practices. Further work is needed to analyze the cost differential and, as indicated below, to give the high cost carriers incentives toward greater efficiency.

3. There Must Be a Workable System for Terminating Contracts of Carriers Showing a Consistently Poor Performance.

Armed with more refined criteria of performance of carriers, HEW should pursue a policy of promoting greater competition among carriers with the objective of improving overall performance.

- (a) The Secretary's power to terminate the one-year carrier contracts should be made into an effective incentive mechanism. The Department should announce now a policy of non-renewal of contracts for those carriers consistently showing the poorest record of performance over a three-year past period. The first such period should commence as of July 1, 1973.^{1/}
- (b) HEW should announce a list of carriers in the "potential contract termination" category as early as July 1, 1975.
- (c) The present system of territorial monopoly precludes effective competition among carriers. While we do not advocate wholesale change, HEW should (i) undertake, internally or with outside consultants, a point-by-point analysis of the alleged obstacles to removal of territorial

^{1/} See Part V-F



boundaries for carriers, and (ii) develop a plan for opening up, on an experimental basis, a single territory within which at least several carriers could compete--such as an area in which a contract termination is being considered because of poor carrier performance. The lessons to be learned from an experiment in one territory would be well worth the risks of failure.^{1/}

4. Incentive Mechanisms Must Be Developed for High Carrier Performance in Addition to the Power of Contract Termination

The legislative encouragement to experimentation in the area of incentives which was enacted by the 1972 Amendments of the Social Security Act should be utilized extensively.^{2/}

- (a) HEW should immediately conduct surveys to determine the feasibility of permitting carriers with consistent records of superior performance to comply only on an optional basis with the more detailed regulatory controls imposed by BHI.
- (b) HEW should explore the feasibility of offering a flat fee per claim processed (which would be established initially at or near the level of the unit cost of the lowest cost carriers) to all carriers with demonstrated records of superior performance.
- (c) HEW should also consider a plan for financial rewards to the personnel of carriers with records of superior

^{1/} See Part V-E
^{2/} See Part V-G



performance, i.e., an award to the carrier with authorization for distribution as executive and employee bonuses.

- (d) HEW should also study the feasibility of transferring segments of the claims workload from one carrier to another--either through transfers of portions of territories or by categories of claims (e.g., all claims submitted by doctors newly engaged in practice in the territory).
- (e) HEW should disseminate more widely public information as to the performance of the Part B carriers.

5. The Consultative Role of the Carrier Should be Enlarged

Mechanisms for greater contact between top management in Government and top management of the carriers should be established.^{1/}

- (a) An annual conference of top-level executives of both HEW and the carriers should be held at HEW to discuss performance results and policy problems.
- (b) The Carrier Representative Group should be made a more effective body.
- (c) Carrier views should be solicited as early as possible in the policy-making process, since Government has entrusted to the private carriers the execution of such a large public function.

^{1/} See Part V-H

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6. HEW Should Reduce its Role in Carrier Decision-Making and Rely on its Capacity to Test Carrier Performance by Results

The most important area of decision-making by carriers to which this recommendation is pertinent is the decision as to how data processing should be performed for the carrier.^{1/}

- (a) Our conclusion assumes compliance by the carriers with clear and precise standards for soliciting subcontract bids, as recommended below.
- (b) As a necessary corollary of item 7, the decision of a carrier to perform its data processing on an "in-house" basis should not, as such, be subject to the approval of HEW. The efficiency and cost of the carrier's performance of the data processing function will be a part of the overall evaluation of a carrier's performance.
- (c) On the other hand, the delegation by a group of carriers to a jointly sponsored entity of their data processing functions should not be treated as "in-house" operation.

7. There Are Two Types of Inadequacy in Competition in the Field of Data Processing for Part B of Medicare

- (a) The first type arises from the present trend for two EDP systems, that of EDS and Model B, to assume an increasingly dominant role.

^{1/} See Part VI

- (b) The second type of inadequacy in competition concerns the options of carriers who do not wish, or are unable, to employ an in-house EDP system. For these carriers, the number of subcontractors is less than optimal for effective competition. Moreover, the precarious position of some of the subcontractors threatens to make the situation worse in the future.

8. The Government Must Take Additional Steps to Insure More Competition in Data Processing for the Part B Program

An appropriate goal is an increase in both the number of subcontractors and the number of competing EDP systems. The elements of the Government program to foster competition should include:

- (a) Improvements in the procurement process for EDP subcontracts.

--HEW should require improved specifications in the requests for proposals; should consider financial assistance to responsible bidders in order to defray the cost of developing proposals; should require carriers to make explicit the factors and weights for evaluating the proposals; and should require the carriers to improve the procedures whereby the subcontractors quote so as to facilitate comparison among proposals.

- (b) Acceleration of the decision-making process (90 days should be ample) with respect to award of EDP subcontracts; strict adherence by the carriers to announced evaluation factors.
- (c) Separation of the decision-making process within HEW as to the award of EDP subcontractors (to the extent HEW is involved at all), from the function of Model B development.
- (d) Imposition of a three-year limit on the term of all new EDP subcontracts, with annual renewals of each subcontract thereafter.
- (e) Redoubling of efforts to get EDP manufacturers and/or software houses to enter the Medicare data processing competition.
- (f) Development with Government funds of at least one new data processing system. There would be a procurement request for the development of such a system, with competitive bids. The procurement request should require that the winning contractor offer both a systems assistance option and a facilities management option.
- (g) Inauguration of financial awards (possibly utilizing procedures currently used by the National Science Foundation for research grants) for research and development in the area of Medicare EDP systems.
- (h) Announcement of policy to end Government support of maintenance of the Model B system in two stages:
 - (i) transfer of operational responsibility for interim maintenance of the Model B system to a private

contractor (selected through a competitive procurement);
and

(ii) ultimate termination of the maintenance contract when
there is adequate assurance of competition.

9. Government Must Have Access to Records of Subcontractors and
Affiliates

Not only must carriers perform cost and price analyses
before making subcontract awards, but also the Government must
have access to full financial information as to the cost and
profits involved in the subcontracting. We support the recent
move of BHI to include a contract clause in carrier contracts
which gives the Government the right to review the records of
any parent corporation or a subsidiary to any tier or a division
of the subcontractor.

10. To Minimize Charges of Conflict-of-Interest on the Part of
Carrier Officials Alleged to Have an Interest in Subcontractors,
the Department Should Consider Requiring Additional Conflict-
of-Interest Regulation of Carriers vis-a-vis Relationships with
Subcontractors

11. The Government Should Contract for an Independent Feasibility
Study to Determine the Cost/Benefits of Developing "Regional"
EDP Centers

Charles A. Bowsher
Michael Gort
Rosewell B. Perkins,
Chairman

II. PURPOSE OF THE COMMITTEE

A. Summary

We consider our purpose to be to identify the most important public policy issues involved in the present administration of Medicare, Part B, and to develop policy guidelines and recommendations for the Secretary of Health, Education & Welfare and the Commissioner of Social Security.

B. Official Statement of Functions

Secretary Weinberger's formal invitation to serve, addressed to the members of the Committee, was dated February 26, 1973. The "charter" of the Committee, signed contemporaneously by the Secretary, states the function of the Committee as follows:

"The Advisory Committee on Medicare Administration, Contracting, and Subcontracting advises the Secretary and the Commissioner of Social Security concerning broad organizational and operational matters, contract formulation, and reimbursement principles applicable to Medicare contracts and subcontracts." ^{1/}

C. Additional Background

The origins of the Committee lie in the consideration given by former Secretary Elliot Richardson and his staff in May of 1972 with respect to certain issues which had emerged in the administration of the Medicare program. The Congressional backdrop against which the Executive Branch was then examining the administration of Medicare included (a) Senate Finance Committee activity early in 1972 with respect to possible changes in the Medicare program, and (b) the reopening on May 30, 1972 of hearings on the administration

^{1/}See Appendix A for Committee Charter

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of Medicare, and particularly data processing operations, by the Intergovernmental Relations Subcommittee of the Committee on Government Operations of the House of Representatives.

In Secretary Richardson's letter of January 5, 1973, informally inviting the members of the Committee to serve, he made the following points, among others:

(1) The enactment of H.R. 1 brought about a new situation in which "the function of determining the medical necessity of services for which Medicare will reimburse will be performed increasingly over time by physician-controlled organizations". These organizations would join the carriers and the specialized data processing subcontractors in the overall administration of Medicare.

(2) "...We would like your help in reviewing our past experience and policies in the area of determining proper reimbursement of the organizations involved."

(3) Because the carriers are fully reimbursed for subcontract costs, "the Government review of the reasonableness of the cost of the subcontract becomes critical".

(4) "...The question arises concerning the extent of the Government's obligation to promote competition or alternatively to establish a yardstick against which subcontract cost can be measured (as has been done by the Social Security Administration's development of a data processing system)."

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(5) "Alternatively, or in addition, should the Government insist upon access to all the records necessary for determining the amount of profit of subcontractors and affiliated organizations in order to regulate the amount of profit?"

It should be noted that the Committee was not asked to consider, and did not consider in any direct sense, issues which might arise in evaluating or developing a program of national health insurance covering persons of all ages. Nevertheless, we recognize that certain issues which arise in connection with Medicare would also present themselves in connection with a national health insurance program for all persons.

III. SCOPE OF THE COMMITTEE'S REVIEW

A. Members

The Committee consisted of three members; a biographical summary with respect to each member appears in Appendix B. ^{1/}

The Committee set for itself a target of approximately one year of work, but an additional six months became necessary. The work was necessarily performed on a part-time and intermittent basis. No regular staff assistance was sought beyond the services furnished by staff of the Bureau of Health Insurance (BHI) of the Social Security Administration. Personnel of BHI provided invaluable service in undertaking special studies and preparing background and analytic papers for the Committee.

B. Elements of Committee Work

The basic elements of the Committee's work, and its modus operandi, consisted of the following:

(1) Study of (a) numerous background papers prepared by BHI; (b) various reports of Congressional Committees; (c) transcripts of pertinent Congressional hearings; (d) reports as to Medicare administration by the General Accounting Office; and (e) reports of certain private organizations (particularly, the Final Report of the Medicare Project of the National Academy of Public Administration).

^{1/A} fourth original member, Mr. Ronald M. Fox, found it necessary to resign on May 4, 1973, because of the press of personal business.



(2) Requests to BHI for additional analyses and special reports, which were then reviewed by the Committee.

(3) A series of 15 public meetings ^{1/}during which the study papers were discussed and the viewpoints of carriers and subcontractors were solicited.

(4) Requests for statements from various groups and hearing testimony from them:

- At the meeting held on March 9, 1973, Mr. James Naughton, Counsel to the Intergovernmental Relations Subcommittee of the Committee on Government Operations of the House of Representatives, testified;
- At the meeting held on May 31, 1973, representatives of eight carriers testified and submitted written statements;
- At the meeting held on June 13, 1973, representatives of six data processing subcontractors testified and submitted written statements; and
- Supplementary statements were submitted by one data processing subcontractor and by the Association of Blue Shield Plans at the meetings of July 26, 1973, and November 5, 1973, respectively.

(5) Occasional informal conferences with representatives of carriers and subcontractors; study of correspondence from carriers subcontractors and others as submitted.

(6) Final deliberation by the Committee, consulting with representatives of BHI and others as deemed necessary.

^{1/}See list annexed as Appendix C.

C. Certain Limitations of Scope

In describing the scope of the Committee's review it is useful to mention some of the limits the Committee imposed on itself:

(1) We have confined our focus to the relatively short-range future. Since Medicare is a field in which extensive changes appear probable or possible, such as changes in the patterns of medical care and extension of governmental programs to a wider segment of the population, it seemed useful to concentrate on the circumstances likely to exist for the next two to five years. Nevertheless, circumstances which exist in the next few years doubtless will have strong implications for the longer run.

(2) We have confined our study to Part B of the Medicare program.

(3) We have made no independent review of the functioning of individual carriers or data processing subcontractors, and thus are not in a position to comment on the administrative efficiency of particular carriers and subcontractors.

D. Commentary on P.L. 92-463

On January 6, 1973, P.L. 92-463, entitled the "Federal Advisory Committee Act", became effective. This statute was designed to require greater visibility of the functioning of Federal Advisory Committees. One of the principal provisions of the law, Section 10(a),

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was the requirement that all meetings of each advisory committee be noticed in the Federal Register and open to the general public.

The Committee fully complied with this new law. In general, the Committee found the basic requirement of the law--that the Committee do its business in public--to be viable and workable. The requirements of the Act, however, are unrealistic as applied to the actual drafting of a report. We urge that the Federal Advisory Committee Act be amended to permit drafting sessions to be private so long as a draft report growing out of such sessions is made public, followed by one or more public meetings at which all interested persons can comment on the report while still in draft form.



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IV. HISTORICAL SUMMARY OF PART B ADMINISTRATION

A. Introduction

A study of the operation of a relatively new and still evolutionary program requires an understanding of how the program developed to its present status. Accordingly, while this section of our Report may be superfluous to close followers of the Medicare program, there will be others for whom the historical exposition is essential.

The Medicare legislation, P.L. 89-97, was signed into law on July 30, 1965. This law embodied two basic parts: Part A, dealing with hospital, nursing home and related costs; and Part B, dealing principally with doctors' bills. Part B had been added late in the course of the Congressional consideration of the Medicare proposals. These programs went into effect July 1, 1966.

In designing the administrative arrangements for the Medicare program, the Congress provided for the participation of private organizations already functioning as third-party payers for health care services, such as commercial insurance companies, Blue Cross and Blue Shield Plans.^{1/} As a result, the bulk of the day-to-day operational work of the program is performed by "intermediaries" (Part A) and "carriers" (Part B). The intermediaries and carriers have administrative responsibility for receiving and reviewing

^{1/} See Section B under this Part IV

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bills from providers of health services and making payments to them.

As indicated in the Congressional Committee reports accompanying the Medicare legislation, Congress assumed that these intermediaries and carriers would be able to perform for Medicare a variety of functions and operations to which they were presumed to be fully accustomed in their normal business. However, in many respects, particularly in the administration of Part B, this did not prove to be the case. The early Medicare experience demonstrated that the largely manual claims review processes which most carriers had employed in their own business were not adaptable to the Medicare claims volumes and that it would be necessary for carriers to develop or utilize the capabilities of electronic data processing (EDP) systems.^{1/}

While some of the larger carriers were able to develop or revise their EDP systems, many were not. Because of a lack of EDP capability, some carriers concluded that outside firms could perform the EDP function more effectively and elected to subcontract the operation of their data processing to these outside firms.^{2/}

One step taken by the Federal Government to assist with their EDP operations was to design a Model System which any carrier could utilize.^{3/}

^{1/} See Section C under this Part IV.

^{2/} See Section D under this Part IV.

^{3/} See Section E under this Part IV.



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An entire new dimension to the administration of Medicare was created when Congress enacted legislation late in 1972 providing for Professional Standards Review Organizations (PSRO'S). 1/

B. Congressional Intent as to Administration

The Medicare legislation and the accompanying Committee reports reflected the Congressional decision that administration of the program was to be carried out by contracting with private organizations already engaged as third-party payers for health care services. 2/ **CONGRESSIONAL INTENT** Implicit in the choice made by Congress was the

1/
2/

See Section F under this Part IV.

The House Committee on Ways and Means Report on H.R. 6675, states:

"Overall responsibility for administration of the hospital insurance and voluntary supplementary health insurance programs would rest with the Secretary of Health, Education, and Welfare, but State agencies and private organizations operating under agreements with the Secretary and private carriers or public organizations operating under contracts with the Secretary would have a major administrative role."
(p. 43)

* * *

"Your committee's bill provides a considerable role for the participation of private organizations in the administration of both the hospital insurance plan and the supplementary plan."

The Senate Committee on Finance Report contains similar statements:

(continued on following page)



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assumption that the use of such third parties experienced in the health insurance field would represent an effective approach to administration and result in more cooperative relationships with providers of care (such as hospitals and doctors) than as if the Federal Government dealt with them directly.

Under the hospital insurance part of Medicare (Part A), cost determination and reimbursement of hospitals, extended care facilities and home health agencies are performed by contracting intermediaries. ^{1/}

(footnote continued)

"The House passed bill requires the Secretary, to the extent possible, to enter into contracts with carriers under which the carriers would perform specific administrative functions or, to the extent provided in the contracts, secure the performance of these functions by other organizations." (p. 53)

and again on page 54:

"In the performance of their contractual undertakings, the carriers and fiscal intermediaries would act on behalf of the Secretary, carrying on for him the governmental administrative responsibilities imposed by the bill. The Secretary, however, would be the real party in interest in the administration of the program, and the Government would be expected to safeguard the interests of his contractual representatives with respect to their actions in the fulfillment of commitments under the contracts and agreements entered into by them with the Secretary." (p. 54)

^{1/} Approximately 95% of the hospitals providing short-term care nominated the Blue Cross Association as their intermediary and are served under subcontracts by local Blue Cross plans.



Similarly, under the physician coverage part of the program (Part B), carriers determine reasonable charges and review and otherwise process individual bills.

As will be seen in our Report, a key decision made by the Secretary of HEW was to give the contractors under Part B responsibility for a particular geographical area; these contractors are either commercial insurance companies or Blue Shield plans. 1/

While the major responsibility of intermediaries and carriers involves the prompt determination and payment of benefit amounts, the other functions performed by these organizations are of considerable importance. Both carriers and intermediaries are responsible for the full range of professional relations activities; i.e., continuing and effective liaison with medical societies, provider medical staffs, utilization review committees and individual physicians. Carriers are heavily involved in the review and investigation of potentially fraudulent claims, in the operation of an appeals process for beneficiaries dissatisfied with decisions on claims, and in the coordination of certain program activities with State agencies and the national carrier for Railroad Retirement annuitants (Travelers Insurance Company). In addition, the carriers' beneficiary services section furnishes information to beneficiaries about the program and serves, on the local level, as the focal point for coordination with Social Security Administration (SSA) district and regional offices.

1/ With the exception of the Oklahoma Department of Public Welfare and Group Health Incorporated of New York.

Thus, although a carrier may have subcontracted its data processing, it must still perform the major responsibilities connected with the day-to-day processing and payment of claims, e.g., developing incomplete claims, determining possible over-utilization, identifying non-covered services, reconciling possible duplicate claims^{1/} and determining charges payable on claims which exceed reasonable charges.

C. Experience in the Use of Carriers
in Part B Program Administration

As indicated above the problem of adjusting the claims processing systems of carriers to the volume of bills generated by Part B of Medicare was acute.

Among the carriers selected to participate in the administration of Part B were some large organizations handling in their own business a substantial volume of claims utilizing a variety of manual and EDP systems. There were also many organizations which handled a relatively small volume of claims in their own business and which had available basically manual claims review operations on which to build Part B Medicare claims processing capacity. More importantly, none of the selected carriers had the kind of experience required to make reasonable charge determinations as stipulated by the Medicare program. In fact, for the most part, their prior experience had been restricted to the determination of appropriate charges by the application of fee

^{1/} For example, claims filed erroneously by both the doctor and the patient.



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schedules or the use of broad screens which ruled out only the payment of charges considered in excess of what they thought to be the level the great majority of physicians accepted. None had adequate data to relate their payments to what the particular physician charged his patients or to set upper limits on payment based upon a carefully drawn statistical concept of "prevailing charges" in the community.

It was recognized, therefore, that the carriers would have to move gradually from the kind of approach they used in their own business to what was required by the Medicare law.

For the first several months, the claims receipts of Part B carriers were minimal. By November 1966, however, Part B claims receipts had so increased that serious backlogs had developed. The principal attention of BHI and the carriers was directed to getting these loads under control. This was not generally achieved for at least another year because of the continuing increase in the volume of claims. ^{1/}

The early Medicare experience demonstrated that the claims review processes which most Blue Shield carriers and many commercial carriers had employed in their own business were not adaptable to the Medicare claims volumes, the complexity of the Medicare determinations, and the strict accounting required for a Government program. Moreover,

^{1/} The ratio of claims pending to receipts peaked at 97.8% in December 1966 and gradually became more manageable dropping to 54.1% in September 1967 and peaking at lower levels in subsequent years.



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BHI instructions regarding the methodology to be employed by all carriers in determining reasonable charges for physicians' services were gradually refined and made more detailed. Data as to the customary charges made by individual physicians was accumulated, both from Medicare claims and other sources, and the formulae for the derivation of prevailing charges from these customary charges was prescribed by BHI instructions.

The collection of data as to physician charges, the calculation of customary and prevailing charges, and the application of these as a measure of "reasonable charges" to the claims review process required establishment or extension of EDP systems capabilities. Improved data systems were also required in order (1) to have the capacity to detect duplicate claims, and (2) to identify situations where the physician services provided were inconsistent with normal practice and experience.

Accordingly, beginning with 1967 and following, carriers with large claims volumes undertook either to revise their EDP systems or to establish new systems. This necessitated in many instances the addition of technical staff. The unavailability of competent systems personnel in many areas made this an extremely difficult undertaking.

D. Use of Subcontractors for EDP
Systems Development and Operations

In 1966, Texas Blue Shield turned for help on Medicare data processing to the computer facility and software firm which Texas Blue Shield had been using for systems modification and



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expansion related to their non-Medicare business. That firm was Electronic Data Systems, Inc. (EDS). The EDS system began as a limited computer process in 1966, with a substantial revision at the end of 1967 and early 1968 to maximize computer utilization (thus minimizing clerical functions) and to accommodate the changes made necessary by the passage of the 1967 amendments to the Social Security Act.

In March of 1967, Rhode Island Blue Cross-Blue Shield entered into a contract with Applied Systems Development Corporation (ASDC) of Providence, R.I., for the development and installation of a claims processing system for both Part A and Part B of Medicare as well as for their regular business. The system for inpatient hospital claims, Part A, was installed in the fall of 1967, with the Part B system operative in March 1968. In addition to Rhode Island, ASDC has provided systems for New Hampshire-Vermont Blue Shield, Genesee Valley Medical Care, Inc. (Rochester Blue Shield), and Nationwide Insurance Co., Columbus, Ohio. (Nationwide has since converted to the EDS system.) The ASDC system installations all have been operated by the carriers on an in-house basis.

EDS (later, through its wholly-owned subsidiary EDS Federal, which is herein referred to as EDSF) offered systems design and processing for all phases of carrier's business, rather than for just Medicare. This capability had particular appeal to many Blue Shield plans which, with limited technical staffs, were finding it increasingly difficult to meet the demands of the volume and complexity of claims processing. Many of the commercial insurance



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companies serving as carriers, because of the size and diversity of their own business activities, had greater manpower and other resources to draw on than did the Blue Shield plans.

The EDS-EDSF approach was particularly appealing to some Blue Shield carriers because it relieved them not only of the responsibility for systems development but also of the actual operation of the EDP process with which some had had considerable difficulty. EDS provides the computer and operates the system for the carrier. Pennsylvania Blue Shield, for example, after an unsuccessful attempt to upgrade its own system, entered into a contract with EDSF effective January of 1969, to take over all the company's EDP operations. California Blue Shield entered into contracts with EDSF for all its EDP operations in 1969. Currently EDS-EDSF is serving 11 Medicare carriers processing approximately 43% of the Part B claims. ^{1/}

EDS is the only software firm presently offering a systems facilities management subcontract for a carrier's total business needs. Since 1969 competing firms (e.g., McDonnell Douglas Automation, University Computing Co., Systems Resources, Inc.) have offered this type arrangement for the Model B system, but they have no systems package available for a carrier's regular business. During this period, in those situations where a carrier might want to divest itself entirely of systems maintenance and operation, only EDS was available.

EDS
CAPABILITY/
AND
APPROACH

^{1/} In calendar year 1973, EDS-EDSI processed 42.8% of the Part B claims.

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In summary, although several carriers were able to develop reasonably adequate EDP systems to cope with Medicare loads and requirements, many other carriers found it necessary to install the Model B system or a proprietary system. In a number of instances, carriers moved to a facilities management subcontract for Medicare and for all or a part of their other business.

E. Development of the Model B System

BHI, in monitoring carrier performance, identified some carriers that had a generally effective EDP application. BHI believed that, if the best features of such systems could be shared, overall performance could be upgraded. Further, BHI believed that such sharing, if accomplished through the establishment of a complete system which would be available to all carriers, could reduce duplication of effort and cost in the development and maintenance of EDP systems.

This reasoning led to the concept of a Model B System, the design for which was begun in mid-1968 when BHI received a request for assistance from Pilot Life Insurance Co., in regard to its Medicare (Part B) system. At that time the Pilot Life system was basically manual. After a review at Pilot Life and five other carriers, BHI agreed to provide a systems team to assist with the design and installation of the system. Also, McDonnell Douglas was engaged by Pilot Life for contractor assistance. The system was designed and ready to install on June 30, 1969; but the Board of Pilot Life at that time decided to withdraw from the Medicare



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program. Therefore, the new system was operational only briefly at Pilot Life and was taken over and operated by Prudential Life, the carrier which replaced Pilot Life in North Carolina.

Subsequently, the new system was taken to Blue Shield of South Dakota and installed with a local service bureau, Data, Inc. Beginning in early 1970, BHI began a series of assisted installations of the Model B System at several other carriers (14 as of June 1972). McDonnell Douglas continued as the system maintenance contractor (under contract to BHI) throughout this period and some other contractors were also hired by BHI for specialized tasks.

In 1971, it was decided to develop an on-line version of the Model B System. This was done as a cooperative effort between Group Health, Inc. (GHI) and BHI. McDonnell Douglas was not engaged to assist with this effort. The on-line version of the Model B System was first installed, excluding the prototype system at GHI, in November 1972 at Alabama Blue Shield. There have been several additional installations at other carriers, including several conversions of the batch Model B System. At present, there is no outside contractor support for the Model B System. BHI has built up a department of about 70 people for the maintenance, enhancement, training, programming and carrier assistance of the Model B System. The Model B System is IBM equipment oriented.

F. Enactment of PSRO Legislation

1. Introduction

Our Committee has dealt only tangentially with the new element in Medicare administration--the PSRO's--since they are not

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functioning as yet. However, because of their potential significance, we are including the background information set forth in this Section F.

Public Law 92-603, which contained various amendments to the Social Security Act, became effective on October 30, 1972. One portion of this law called for the creation of a "Professional Standards Review." The 1972 legislation directs the Secretary to enter into contracts with Professional Standards Review Organizations (PSRO's), whose function will be to ensure that services rendered under Medicare and Medicaid are medically necessary, conform to appropriate professional standards, and are delivered in the most economical setting consistent with the patient's needs. Qualified organizations, the membership of which will consist of a substantial number of licensed doctors of medicine or osteopathy (usually 300 or more) engaged in the practice of medicine or surgery, will be selected by the Secretary to serve designated geographic areas.

When considered in the context of the traditional relationship of the Federal Government under the private practice of medicine, this new provision represents a remarkable innovation. In effect, Congress has caused the creation of a privately-controlled mechanism for reviewing the health care services provided to Medicare and Medicaid beneficiaries by and in health care institutions. The Congress stopped short of mandating that the reviewing organizations examine the practice of medicine in doctors' offices, but provided the reviewing organizations with the option to do so with approval of the Secretary.

The proposal for this legislation originated in the Senate Committee on Finance. It was intended to provide peer review, on a local level, of the necessity for and quality of health care services rendered to program beneficiaries as a condition of claims payment and to promote their effective, efficient, and economical delivery. The Senate Finance Committee recognized the lack of established organizations to fill this review need and indicated that ". . . in most parts of the country, new organizations would need to be developed"; however, the Committee hoped ". . . that physicians--preferably through organizations sponsored by their local associations"--would "assume responsibility for the professional review activities." ^{1/} Indeed, the legislation directs that the Secretary may designate as PSRO's, prior to January 1, 1976, only those organizations which are either professional associations (such as a State or county medical society) or "a component organization thereof."

Designation of 203 geographic areas to be serviced by PSRO's was made on March 14, 1974. At the earliest practicable date, an agreement is to be entered into by HEW with a qualified organization to serve as the PSRO for each designated area. It is anticipated that 20 or more organizations will qualify as PSRO's by June 30, 1974, enter into contracts with the Secretary and prepare to undertake operational responsibilities.

^{1/} Report of the Senate Committee on Finance to accompany H.R. 1 September 26, 1972, page 258. Volume 38, No. 244, Part II.

2. Data Needs of PSRO's.

PSRO's will be required to undertake a variety of activities based on the existence of a complex information and data system.

The principal activities requiring data support will include:

- (a) The PSRO's evaluation of the effectiveness of utilization review mechanisms used by institutions (hospitals and nursing homes).
- (b) The PSRO's assumption of selected hospital and nursing facility utilization review committee responsibilities; these review activities may involve any or all of the following types:
 - (i) Preadmission certification or prior approval programs (i.e., prospective review);
 - (ii) Review of extended durations of stay, discharge planning, and attending physicians' certifications of the need for continuing care (i.e., concurrent monitoring of inpatient care); and
 - (iii) Performance of medical care evaluation studies (postpayment retrospective review of patterns of care).
- (c) Prepayment review of exceptional Medicare and Medicaid claims.
- (d) Periodic review of provider, practitioner, and beneficiary profiles of care.
- (e) Optional review of ambulatory claims for services rendered in a variety of settings (e.g., hospital outpatient departments, emergency rooms, physicians' offices, homes, etc.) and of claims representing miscellaneous types of medical services equipment, and supplies (e.g., ambulance services, vision care, prescription drugs, etc.)

To carry out its various review activities, each PSRO will be responsible for participating in the development and application of professional norms, standards, and criteria of appropriate medical care. These will have to take into account variations in utilization patterns which may be attributable to the patient's age, sex, and operative condition. Implicit in the identification and selection of norms and standards of care is the creation of a data base for the Medicare and Medicaid populations which will be capable of affording displays of usual or average patterns of medical practice. Value judgments can then be applied to statistical representations of current practice and utilization patterns for use in postpayment retrospective review of care.

Norms and standards may also be applied to the process of prepayment claims review. It would be prohibitively time-consuming for physicians to review every single Medicare and Medicaid claim. One way suggested by the Senate Finance Committee to conserve physician review time is through automated prepayment screening of claims against exception parameters or criteria which have been determined in advance by the PSRO.

The PSRO must also bear the additional and important burden of accountability to the Secretary. The review organization will be responsible for the establishment and maintenance of a routine statistical reporting system to be based on its internal records of costs, personnel, equipment, workloads processed, etc. An obvious need will exist, particularly in the larger and statewide

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PSRO's, for computerization of the ongoing administrative functions and the periodic production of required reports to the Secretary.

The Senate Finance Committee recognized the need to establish a uniform nationwide data system as the foundation for PSRO activities. Its report accompanying the Social Security Amendments of 1972 (pp. 264-65) stated:

"The committee expects that the Secretary, in conjunction with various medical and other organizations, would assist the local professional standards review organizations through providing them with model operational guides, forms and methodology descriptions. To the greatest extent possible, standardized forms and procedures should be utilized by the local review organizations. Of course, this approach would not preclude acceptable modification and adaptation to meet local circumstances, but basic formats should be established for national usage and basic comparable data for inter-PSRO comparisons should be developed."
(Emphasis added.)

Because of the extensiveness of the required functions and activities of the new PSRO system, the comprehensiveness and uniformity of the data base will be essential elements.

Our Committee has not studied the ways in which the data needs of the PSRO's can best be met. However, in principle, we favor a system which involves the private sector, as in the present administration of Medicare, in the fulfillment of its data processing needs.

PSRO'S
IN THE
PRIVATE
SECTOR

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V. ROLE OF CARRIERS AND INCENTIVES FOR EFFECTIVE PERFORMANCE

A. Analysis of the Carrier Function

In the administration of Medicare Part B there are now 47 carriers serving designated geographical areas, usually a State or specific counties in a State, and not infrequently more than one State. Of the 47 carriers, 32 are Blue Shield Plans, 13 are commercial (for profit) organizations, one is Group Health Insurance of New York, Inc., and one is Oklahoma Department of Public Welfare. Many of these same carriers are serving as administrative agents for Medicaid, Federal Employees Health Benefits (FEHB), and the Civilian Health and Medical Program of the Uniformed Services administered by the Department of Defense (CHAMPUS).

Of the total workload, 63% is processed by Blue Shield Plans, with the remaining 37% being processed by commercial carriers. Volume of workloads and administrative costs have a considerable spread among the carriers, with the costs affected by many variables. The workload in fiscal 1973 varied from 4,992,960 claims processed by California Blue Shield (not a full-State carrier) to 128,530 claims processed by South Dakota Blue Shield.

The carrier's claims processing functions may be summarized as follows:

- (1) Receive bill from physician or beneficiary
- (2) Determine whether or not the services are covered and medically necessary. (Includes "utilization review" of individual physicians.)



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- (3) Determine the reasonable charge for the services
- (4) Determine whether the carrier has processed the claim previously
- (5) Determine whether the beneficiary is eligible for Part B of Medicare (by querying SSA)
- (6) Determine whether the Part B deductible has been satisfied
- (7) Calculate the payment due either to the physician or the beneficiary
- (8) Send a check and explanation to the physician or beneficiary, as appropriate

B. Advantages of Private Carrier Participation

Through a national or regional data processing system, and with its national network of local and regional offices, it is probable that SSA could administer the Part B program without the participation of private organizations. However, we have concluded that the advantages seen by Congress in building private carrier administration into the original Medicare statute were sound in 1965 and are sound today. Moreover, the evidence before our Committee leads us to conclude that the job of administering Medicare is being carried out with considerable success--although there is room for much improvement. A monumental task was undertaken and the basic challenge has been met by government and the private sector.

REAFFIRMATION
OF
PRIVATE
CARRIER
ROLE



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Among the reasons we support continuation of the use of private carriers (both nonprofit, such as Blue Shield, and commercial) are these:

(1) The bulk of health insurance in this country remains privately financed. The Medicare program benefits by the experience learned by private carriers in their handling of non-Medicare business. The expertise and skills of persons in the private health insurance industry should be made continuously available to Medicare, as well as techniques developed in handling private health insurance.

(2) There is far greater likelihood of innovation where numerous private organizations are employed by the Federal Government as compared with administration by a Federal agency. Total centralization and mandated uniformity would tend to stifle experimentation in the development of new ideas and approaches.

(3) Part B of Medicare is uniquely sensitive as an area of Government involvement in the practice of medicine. The physician-oriented carriers and carriers long accustomed to working with physicians are more likely to enlist physician cooperation and support than a Federal agency.^{1/} Carriers have

^{1/} In Staff Paper 8B, this argument was articulated more fully, in the following terms:

"One of the major benefits of pluralism with respect to contractors has been the opportunity and the ability of many to respond to the immediate medical community. It is generally agreed that the success of the program depends upon the continuing cooperation of individuals and institutions providing health care services, as well as the major organizations which represent health care interests at community, State, and national levels. Because of the importance



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been active and effective in developing closer working relationships with physicians.^{2/} One carrier executive states:

"Such things as utilization review are in the end as much an art as a science and require the carrier to be closely in tune with the practice of medicine, in a cooperative--not adversary--relationship, in each community served."^{3/}

(4) There are differences among localities, States, and regions in the nature and traditions of the medical service organizations and the practice of medicine. An "advantage of

1/ (continued from preceeding page)

of this cooperation, it is essential that contractors maintain a continuing awareness of health community attitudes and problems with the program. As a result of the pluralistic approach of the Medicare program, many of our contractors are in a unique position to respond immediately to these interests, concerns, and problems and, with the regional office of BHI, proceed to take immediate steps to prevent the kind of misunderstandings or dissatisfactions which, if neglected, might lead to a serious degree of noncooperation with the program. Any major move to consolidate the present system and to remove the administrative reimbursing agency one step further from the community level might seriously hamper the effective response of the medical community to the program unless the emerging PSRO's effectively deal with the professional issues and concerns."

2/ One example mentioned in testimony before the Committee is the program of annual "Medicare Workshops for Medical Assistants in the State of Louisiana" which is conducted by the carrier for Louisiana, Pan-American Life Insurance Company.

3/ Letter to the Committee from Charles W. Stewart, Executive Vice President for Government Programs, California Blue Shield, dated December 14, 1973.



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the pluralistic system is the capability of carriers to adapt to the needs of circumstances of the localities in which they operate."^{1/} Identification with the community, with resulting flexibility and responsiveness to local circumstances, are keynotes of the multi-carrier approach.

(5) The carriers have well-established facilities and procedures for direct contact and communication with beneficiaries. It would take a great deal of time and the addition of large numbers of personnel for Government to be able to create similar relationships.^{2/}

^{1/} Testimony of Mr. Stewart (see prior footnote) presented to the Committee on May 31, 1973, p. 5. He added:

"For example, the California systems in Medicaid are tailored to function with the existence of Foundations for Medical Care and the probable early appearance in our area of the Professional Standards Review Organizations."

^{2/} In Staff Paper 8B (pp. 3-4) this argument was spelled out for the Committee as follows:

"A major concern of the Congress and SSA, in addition to the need for the cooperation of the medical community, has been the response and service to the Medicare beneficiary, not only in timely processing of claims, but also in providing other necessary services. Our contractors, particularly the carriers in Part B who deal directly with beneficiaries, physicians, and other providers on a large claims volume basis, must be able to respond to written, personal, or telephone inquiries about delayed claims or requests for program information in a prompt and accurate manner. They must be able to develop promptly additional evidence in questionable claims, resolve basic and complex coverage questions and expedite delayed claims.

"When there is dissatisfaction with the determination of a claim or when a beneficiary or provider believes that the request for payment is not being acted upon with reasonable promptness, the contractor must provide an informal review and/or hearing as the case demands and as required by the program.



(6) Having a number of carriers provides an opportunity for meaningful comparison of relative performance and ranking of contractors, if the information is properly used. As we indicate below, we believe that the information as to relative carrier performance is currently both inadequate in scope and inadequately utilized. Nevertheless, the potential is there by virtue of the pluralistic system.

There are many variables in the operation of the program throughout the country (e.g., rural vs. metropolitan area; literacy rate among population; characteristics of labor market; volume of claims). These differences, reflecting regional and local characteristics, affect contractor performance. The benefit of having a sufficient number of contractors conducting essentially similar operations is that it is possible to analyze and compare costs and performance.

2/ (continued from preceeding page)

"The ability to offer personal and immediate services to the beneficiary is the 'ultimate' objective of the program, and any inability to offer satisfactory individual response is a reflection upon the program itself. The distribution of the program among 47 Part B carriers and 83 Part A intermediaries throughout the country allows each to offer these services to the community and to the individual beneficiary, maintaining SSA's traditional concern for and response to the individual. . . ."

In a similar vein, Charles W. Stewart, Executive Vice President for Government Programs of California Blue Shield, states:

"We train our people that they are dealing with a portion of other peoples's lives--often quite intimately. In the course of these dealings, we have had to learn to exercise judgment to see that the essential troika of health care (patient, physician or provider, and payer), can function in a mutually satisfactory fashion." Letter to the Committee dated December 14, 1973.



(7) A pluralistic system offers the opportunity for creating some degree of competition among carriers, and competition can be an effective force for efficiency. Many of the carriers attest to a sense of competition even under present circumstances. We are recommending several measures designed to enhance the forces of competition.

(8) As a byproduct of point (1) above, the carriers have much more at stake in their handling of Medicare business than that business alone. Irrespective of the present absence of direct competition among carriers for Medicare business as such, they are in intense competition for non-Medicare health insurance business. Accordingly, the carriers are concerned with whether they create a good or poor image with families and in the community generally through the services they provide to Medicare beneficiaries.

* * * * *

In conclusion, we believe there is a valid continuing role for the Part B carriers.

C. Objective of Highest Carrier Performance

We have stated above the advantages of private carrier participation in the administration of Medicare. These advantages, however, tend to disappear if each carrier is not given adequate incentive to do the most effective job possible on behalf of the beneficiaries of the program and the working population which pays for the support of the program. Obviously, the Federal Government should not place blind trust in a group of privately-operated non-profit and commercial carriers. A system must exist which provides incentives for high performance and a close monitoring of results.

RECOMMENDS
PERFORMANCE
INCENTIVES
FOR CARRIERS-

RESULTS
ORIENTED
MONITORING

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There are two elements in the present institutional arrangements
which combine to mitigate against an efficient result. First,
carriers are assigned territories on an exclusive basis with no direct
competition within the assigned areas. Second, they are reimbursed
on the basis of reported costs with, consequently, no financial
incentive to minimize costs. There are two policy alternatives
open to the Government, given the above constraints. One is to
devise methods that will serve as a substitute for direct competition
in providing incentives to carriers for most efficient performance--
although legislative changes might be required. The second is to
impose increasingly detailed and comprehensive regulations.

CRITICISM
OF
INCREASING
GOVERNMENT
ROLE

Generally speaking, the Government has moved primarily
in the direction of the second alternative. As a result, agreements
with Medicare contractors specify requirements for approval by SSA
of certain subcontracts and also specify what costs are permissible.
This leads to detailed regulation of carriers to the point of even
requiring, under some circumstances, prior approval for incurring
overtime labor charges. To quote BHI's Staff Paper No. 22, prepared
for the Committee, ". . .The Bureau of Health Insurance maintains
a comprehensive Contractor Inspection and Evaluation Program which
is the responsibility of its regional representatives. This program
is a continuing surveillance and assessment of quantitative and
qualitative performance of a contractor's operations covering all
aspects of his responsibilities. . . ."



The enthusiasm which the carriers have shown for the Bureau's "continuing surveillance" has been less than overwhelming. At least some of the carriers have expressed the view that the Bureau's detailed regulation approaches a type of dual management that restricts initiative and is, therefore, counterproductive. And the statistical evidence, reported below, suggests that this approach has not been successful in achieving the most economical result.

It is our belief that emphasis in Government policy should be shifted from the alternative of regulation to a policy of generating incentives for efficiency. There are four elements which are necessary corollaries to the recommended continuation of private carrier administration. These are:

FUTURE
RECOMMENDATIONS
FOR
CARRIER
ROLE

- (1) a viable method for measuring carrier performance;
- (2) a workable system for eliminating entirely those carriers showing a consistently poor performance;
- (3) incentive mechanisms for high carrier performance in addition to the power of termination; and
- (4) assurance to the carriers of a reasonable degree of freedom from Government control over carrier decision-making and administrative detail, provided that the carriers are meeting standards of adequate performance.

We shall direct our attention to each of these four areas.

D. Criteria of Carrier Performance

Central to the philosophy of this report is our belief that the performance of private carriers as participants in the administration of Medicare can be objectively evaluated.

At the present time, the system for evaluating carrier performance is inadequate. A major recommendation for this report is that the highest priority be given by DHEW, SSA, and BHI to the development of more refined criteria of carrier performance.

1. Past Efforts to Develop Part B Carrier Evaluation System

BHI has for some time been working to develop an improved Part B carrier evaluation system. Work groups which included representatives of the carriers were established and a number of conferences have been held on this subject.

There are three elements which BHI has sought to evaluate, namely (1) administrative cost, (2) timeliness (speed of processing), and (3) quality (infrequency of routine claims processing error).^{1/}

The proposed Part B carrier evaluation system defines performance as a complex comprised of these three basic elements. A carrier's performance score will be a weighted composite index determined by index numbers measuring these factors.

^{1/} On the whole, BHI's influence has been considerably greater in reducing claims processing time than in reducing the costs of the less efficient carriers. As for errors, as of the time this report was written, the "end-of-line" claims review procedure--BHI's quality assurance program based on large samples--had only recently become operational. Consequently, we were unable to analyze inter-carrier differences in the claims processing error rate.



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As indicated below, we strongly support BHI's efforts to develop these measurements. Whether a composite index is the best approach we leave to the study which we recommend be contracted out. We simply note here that weights for a composite index are generally somewhat arbitrary, so that a composite index may obscure more than it reveals. Consideration should, we believe, be given to establishing minimum acceptable standards for (1) speed and (2) the error rate. Administrative costs could then be compared for all carriers meeting the required standards with, perhaps, some allowances for carriers which are greatly above average with respect to timeliness and quality.

Before discussing the three elements more fully, we wish to emphasize that one of the most important functions of the carriers is not measured under BHI's past or proposed criteria of performance, namely, that of limiting payments made to Medicare beneficiaries to those payments which are consistent with medical necessity and appropriateness of fees. Obviously, unjustified payments are of greater economic significance to the Medicare program than administrative costs. However, the detailed analysis of inter-carrier variations in payments per claim is a complex problem that goes beyond the capacity of our Committee to examine. Numerous demographic factors have been

found to affect the demand for medical services by beneficiaries covered by Medicare. For example, on the average it appears that people in suburban areas use services covered by Medicare more intensively than people in either rural areas or in central cities. Women use services more intensively than men, whites more than blacks, and people in the South less intensively than those in the rest of the country. Variations in benefit costs among carriers, therefore, cannot, without due allowance for many factors, be used as a test of the effectiveness of carrier review of claims. Yet the problem of assessing the relative performance of carriers with respect to eliminating unjustified payments is one of paramount importance.

The extent to which carriers review claims for medical necessity varies considerably. It is safe to say, however, that none has carried the process very far. In part, this reflects the absence of generally agreed upon medical standards. Nonetheless, the potentialities of abuse are so large that the review process needs to be pressed as far as our current state of knowledge will permit.

The limited success of claims review for medical necessity appears to be reflected in the statistics. Fewer than 3% of all claims were denied (in part or in whole) for medical necessity--a figure which seems surprisingly low given the possibilities of error and the wide range and variation in utilization throughout the country.

Even if PSRO's eventually substitute for carriers in performing reviews of medical necessity under Part B of Medicare, the problem of assessing how well carriers are applying the criteria developed by PSRO's will still remain.

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We turn now to a closer examination of the basic elements of performance which BHI has relied on--administrative cost, timeliness, and quality.

(a) Administrative Cost

Administrative cost per processed claim (unit cost) is readily available and is being used by BHI as the standard unit for measuring the cost of contractor operations. The current BHI performance evaluation system computes unit cost by dividing total administrative costs by the number of claims processed. Certain adjustments made on the basis of regression analysis, discussed below, were incorporated into this computation for the September 1973 report.

Variations in administrative costs among carriers are at present enormous, if one considers that the carriers contract to produce a standardized if not essentially identical service. In fiscal year 1973, administrative costs per claim ranged from \$1.60 to \$4.04 with a mean of \$3.23 and in 1972 they ranged from \$1.57 to \$4.72 with a mean of \$3.18.

The figures we now present serve as a statistical measure of the magnitude, in national terms, of the wide variation in administrative costs. In fiscal 1972, if all carriers had costs no greater than the average of the five lowest-cost carriers, aggregate administrative costs would have been roughly \$57 million less than the actual costs in that year.^{1/} This sum exceeds one-fourth of the total administrative cost of Medicare; it happens to be roughly equivalent

^{1/} This figure would have been somewhat less if adjusted to eliminate cost variations deemed to be in the uncontrollable category.

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to total expenditures for all EDP processing (both in-house and through subcontractors) in the same year. Table 1 below shows for fiscal years 1968-72 the total administrative cost and the magnitude of the differential in aggregate costs if all carriers had costs equal to the average of the five lowest-cost carriers.

Table 2 summarizes much of the relevant information on administrative costs. Costs per claim remained relatively stable over the period 1968-73 and, when deflated by an index for salaries paid by the insurance industry, show a decline in real terms. In contrast, administrative costs per enrollee (on a national basis) rose from \$5.29 in fiscal 1968 to about \$9.11 in 1973 and, even when deflated by change in salaries, continue to show a rise.^{1/} The reason for the difference in results between costs per claim and costs per enrollee arises partly from a trend towards more frequent claims being submitted by physicians, with a larger number of claims per illness.

A key issue is the reason, or reasons, for the inter-carrier variations in costs. If we take data on costs per claim for the whole period 1968-73 (calendar years), while there appears to be some tendency for the standard deviation to decline, the decline is not consistent over time and the standard deviation for 1972 and 1973 is not very different from what it was in 1969. In short, the present framework of carrier operations, even with pressure from BHI, has not been successful thus far in causing high-cost carriers to match the record of the low-cost carriers.

^{1/} Deflated data are available only for 1969-73. The rise between 1969 and 1973 in deflated costs per enrollee was from \$6.17 to \$6.95.

Table 1.

Actual Costs and Potential Savings in Administrative Costs
If All Carriers Had Costs Equal to Average
of Five Lowest Cost Carriers, Fiscal 1968-72
(in thousands of dollars)

	Actual Costs	Potential Savings [*]	% of Actual Costs
1968	99,446	28,140	28.3
1969	118,375	26,725	22.6
1970	138,080	40,788	29.5
1971	159,890	56,990	35.6
1972	171,766	56,632	32.9

Source: Based on data from BHI

*

Based on unweighted average cost of five lowest cost carriers

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Table 2.

Administrative Costs Per Enrollee and Per Claim
Fiscal 1968-1973
(dollars)

	All Carriers Actual Dollars		All Carriers Deflated Dollars*		Costs Per Claim			
	Ratio Costs to Enrollees	Ratio of Costs to Claims	Ratio of Costs to Enrollees	Ratio of Costs to Claims	Unweighted Mean All Carriers	Lowest Cost Carrier	Highest Cost Carrier	Standard Deviation
1968	5.29	2.94	Not Available	Not Available	3.18	1.86	4.81	.73
1969	6.17	2.98	6.17	2.98	3.11	1.86	4.75	.61
1970	7.05	3.16	6.47	2.90	3.29	1.75	5.96	.76
1971	8.00	3.28	6.78	2.78	3.34	1.70	5.88	.77
1972	8.44	3.18	6.64	2.50	3.23	1.57	4.72	.60
1973	9.11	3.23	6.95	2.46	3.31**	1.74**	4.48**	.57**

Source: Based on BHI data

*Deflated on the basis of change in average salary of the carriers with 1969 as base year.

**Estimated on the basis of data for first six months.

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As is to be expected, there has been some turnover in the composition of the high- and low-cost categories. However, 11 carriers were consistently in the upper half of all carriers in terms of costs for each of the last 4 years. Fourteen carriers were consistently in the lower half in each of the same 4 years. Thus, more than half of all carriers could have been classified as either belonging to the high-cost or low-cost group for a fairly long interval of time.

Since considerable attention has been devoted in our Committee's work to EDP systems, note should be taken of the fact that the EDP system in use by a carrier is not a very important factor in explaining variations in total administrative cost per claim (EDP costs account for close to a fourth of total administrative costs for all carriers combined). For example, if we consider the two most widely used systems, Model B and the system of EDSF, we find carriers using either of the two among both the low-cost and the high-cost carriers.^{1/} As yet, therefore, the choice of EDP system has not dominated the outcome with respect to total administrative cost.

Numerous other possible explanations were given to the Committee for the observed differences in administrative costs. It was suggested, for example, that (a) some carriers had the benefit of large economies of scale, (b) that there were large regional differences

^{1/} For example, in fiscal 1973, (on an administrative cost per claim basis) two of the five lowest-cost carriers and two of the five highest-cost carriers were users of the Model B. In that same year, the fifth lowest-cost carrier and the tenth highest-cost carrier (excluding Nationwide Insurance Company, which was in the process of changing its subcontractor and had large non-recurrent costs) used EDSF as a subcontractor.

in wage levels, (c) that carriers in urban areas had much larger costs of beneficiary services, and (d) that the denial rate and reasonable charge reduction rate differed, reflecting, in turn, differences in expenditures on these functions. A closer examination of the statistical record did not support the contention that these variables contributed greatly to explaining differences in administrative costs among carriers.

Using the technique of regression analysis, BHI examined the role of 12 variables that were deemed outside the control of carriers, including all of those listed above. Only two consistently met the technical tests of statistical significance, namely, the average salary level of the insurance industry in the carrier's region and the assignment rate. Depending upon the year in question, a salary level that is 1% higher than average for all carriers can be expected to result in costs per claim that are roughly between 0.4% and 0.5% higher than average. An assignment rate that is 1% higher than average can be expected to lead to costs per claim that are roughly between 0.2% and 0.3% lower than average. A third variable, the "investigation" rate^{1/} appears to be significant in some years but not in others. Its effect on costs per claim is very small.

At one meeting of our Committee, questions were raised as to whether the investigation rate and the assignment rate were really outside the control of carriers. But, in one sense, this issue is unimportant for the three variables together explained, depending

^{1/} A claim which is "investigated" is one which is examined for any reason rather than being routinely paid.

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upon the year in question, only between 16% and 23 of the variation in unit costs. In short, the bulk of the variation among carriers apparently cannot be explained by factors outside the control of carriers.

Of some interest is the list of variables that showed no relation to unit costs, inasmuch as the analysis disposes of a number of widely-held beliefs. Most prominent among these is the view that there are large economies of scale. Neither the size of the enrolled population nor the number of claims received revealed any relationship to unit costs. Nor do differences in carrier effort expended in screening out errors appear to be correlated with inter-carrier differences in unit costs, at least if effort can be measured by the "denial rate" and the "reasonable charge reduction rate" for claims processed. Additional variables that proved useless in explaining variation in administrative unit costs were: claims filed per 1,000 enrollees, percent of population male, percent of population urban, percent of population white, and proportion of workload comprised of SSA-1490's.

It is possible that BHI may have overlooked some relevant cost factor outside the control of carriers. However, if there are no other explanations, large differences in unit costs among carriers would appear to be attributable to one or both of two sources, namely (1) differences among carriers in efficiency, and (2) differences in accounting practices, particularly with reference to the proportion of a carrier's costs allocated to its Medicare business.^{1/}

^{1/} It should be noted that BHI performs an annual audit of carrier costs including overhead allocation. While BHI audits the carriers annually,



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Whatever the explanation, very large differences in administrative costs attributable neither to superior quality of service nor to so-called noncontrollable variables reflect an unacceptable situation if it continues for a long time. Some corrective measures are recommended in this Report.

(b) Timeliness

Until late 1973 timeliness of processing was based on the number of weeks work on hand, claims processed per man-day, and the percentage of claims pending over 30 days. These indicators were incomplete, since they reflected only a single measure taken at a fixed point in time.

1/ (continued from preceeding page)

puzzling variations in direct costs remain after audit. For example, for July-Dec. 1973, of the carriers using the Model B system, the carrier with the lowest administrative costs per claim used 17.3 full-time equivalent employees per 100,000 claims. The ~~highest~~ cost carrier using Model B employed 35.6 full-time equivalent employees per 100,000 claims. The numbers of claims they processed were of the same order of magnitude and the higher cost carrier had a higher assignment rate, which should have reduced its labor cost. In fiscal 1972, once again restricting the observations to users of Model B, the lowest cost carrier used 23.5 full-time equivalent employees per 100,000 claims; while another carrier used 41.4.

It is of course possible that these differences result from differences in efficiency. But it is important that it be ascertained that they do not result from mere differences in judgment and/or arbitrary procedures in the allocation of costs between the Medicare and the other business of carriers.

The information derived from analyses such as the foregoing is one of the advantages of a pluralistic system. The problem now is to utilize this kind of information to greater effect.



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In September of 1972, SSA developed a new reporting system to determine claims processing time. The new reporting system provides the number and percentages of claims processed in specific time categories--15 days, 30 days, 60 days, and 90 days. Additionally, the number of claims pending for these same periods of time will be reported. The initial reports of the results of the new reporting system were issued on November 5, 1973, in a BHI report entitled "Quarterly SMI Carrier Claim Processing Time Report, January-June 1973". SSA replaced the old method of reporting timeliness of processing with the new procedure in its evaluation report issued for the October-December 1973 quarter.

(c) Quality

In the area of quality, BHI, with the assistance of the carrier work group and the Office of Research and Statistics, has developed an end-of-line sample claims review system. The nationwide end-of-line claims sample system will provide uniform performance data needed to permit comprehensive and accurate comparisons of carrier performance. Previously, BHI used query reply reject rates and reasonable charge data as subjective indicators of the quality of processed claims. The new system is expected to be a major step forward in improving the qualitative evaluation of carrier performance.

The system will measure processing quality in two ways: (1) the monetary amount of carrier overallowances and underallowances will be determined, and (2) the incidence of specific

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types of processing errors will be determined. The system will furnish to carriers and BHI regional offices specific management information to take corrective action on error situations. Performance indices will be developed based on the dollar over-allowances and underallowances as well as the frequency of error occurrence.^{1/}

It is anticipated this system will become part of the carrier evaluation during the first part of fiscal year 1975.

2. Current Status of Evaluation Reports

At the present time, in order to evaluate the performance of a given carrier, BHI utilizes a wide range of information. There are a variety of periodic statistical reports summarizing quantitative factors of carriers' operating experience, as well as an annual evaluation of individual carriers which incorporates qualitative aspects of operations. These reports, in their present form, are not sufficient for the purpose of assigning clear and objective rankings to carriers based on appropriately adjusted carrier costs and on quality of service. But the enormous volume of available information suggests that what is needed most is a major improvement

^{1/} The procedural aspects of the new system have been highly automated via computer programs (provided by SSA) to minimize program administrative costs as well as to assure appropriate consistency in the quality review procedures and reports data. The program has two distinct phases: The Phase I program determines the number of sample claims which are to be drawn from each class of adjudicated claims and will identify the individual claims in each claims class which are to be reviewed for claims adjudication quality. The Phase II program extrapolates the performance quality data provided by the carrier processing quality reviews to cover the carrier's total population of adjudicated claims.



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in the analytical tools for using the data that already exists if the objective of evaluating carriers is to be achieved in an adequate way.

(a) Quantitative Reports

Ongoing statistical data are reported in the following reports:

- (1) SMI Carrier Workload Report published monthly shows the number of claims received, processed and pending.
- (2) DCO Monthly Workload Report lists by carrier receipts, clearances, pending claims, weeks work on hand, percent of claims pending over 30 days, investigation rate, assignment rate, payment rate, and denial rate, along with national and regional totals. In addition, the report ranks highest and lowest carriers in selected performance categories and is also used in the Quarterly Performance Indicators discussed below.
- (3) Report of Carrier and Intermediary Reject Data is published monthly and evaluates performance in the area of query transmissions. A composite mean performance is determined in each of five error categories and those carriers in each category which exceed the mean by the highest percentages are listed. This report is also used in the Quarterly Performance Indicators.
- (4) Quarterly Report on SMI Carrier Reasonable Charge and Denial Activity summarizes carrier activities in reasonable charge reductions and claims denials. National trends are analyzed and the amount of reductions and denials are shown by carrier.
- (5) Quarterly Report on Overpayment and Duplicate Charge Activity summarizes the status of Part B claim overpayment workloads and provides information on how overpayments were resolved in the quarter. The duplicate charge activity section summarizes carrier activity in detecting duplicate charges.
- (6) Supplement to the Quarterly Report on Overpayments and Duplicate Charge Detection Activity, published quarterly, summarizes national, regional, and carrier performance by cause of overpayment and by method of discovery.



- (7) Quarterly Report on SMI Carrier Appeals Activity summarizes carrier activity in the area of claims reopenings and revisions, reviews and hearings.
- (8) Quarterly SMI Claim Processing Time Report is a newly-instituted report which summarizes data on the time required by carriers to process claims. As the report is refined, the data will be utilized in the Quarterly Performance Indicators.
- (9) Analysis of Intermediaries' and Carriers' Administrative Costs, published quarterly, contains workload, administrative costs, manpower, benefit payment data, and related indices. This report is also used in the compilation of Quarterly Performance Indicators.
- (10) Part B Carrier Performance Indicators is published quarterly and contains quarterly and annualized data. This report arrays performance in a format which treats five functional areas of information:
 - (a) Weeks work on hand
 - (b) Percent of claims pending over 30 days
 - (c) Unit cost per claim processed
 - (d) Claims processed per man-day
 - (e) Query reply reject rate.

This last report (Part B Carrier Performance Indicators) is, for present purposes, a most important one. In establishing broad ranges of performance, the average (i.e., mean) level of performance is determined in each of the above five areas, (a) through (e). Carriers are then ranked in one of five broad groupings using degrees of deviation from the standard deviation from the mean. The best and poorest performance carriers can be determined in each of the functional areas. For the purpose of these indicators, the mean is an unweighted average of carrier performance and does not reflect the respective workload volumes. However, computation of both the mean and the standard deviation excludes extremes of either favorable or unfavorable performance.



A composite indicator is not determined, but carriers whose performances exceed one, two, or more standard deviations and are, therefore, excluded in the computation of the mean, can be identified for the relevant category of performance.

The present performance indicators do not encompass quality-related factors which reflect the effectiveness of carriers' operations in many areas of claims review. Only data which can be quantified are included, and no consideration is given to such factors as quality of performance, complexity of the operations, systems changes, or the effect of the business environment in which the carrier functions.

(b) Qualitative Reports

A qualitative analysis of individual carrier performance is available in the Annual Contractor Evaluation Report (ACER) prepared by the BHI regional office for each contractor in its region. The ACER is a reflection of all regional office contractor review and evaluation activities conducted throughout the specific period preceding the issuance of the report. The report sets forth the regional office findings, conclusions, recommendations, and evaluation of the adequacy of performance during the specified period of time in each operating area; i.e., claims process, coverage and utilization safeguards, program reimbursement, EDP operations, beneficiary and provider services, carrier management, and fiscal management.

The preparation of the ACER incorporates all information, including statistical indicators and onsite reviews of



carriers' operations, that the Bureau has with respect to the contractor evaluated. The ACER is a comprehensive statement and represents the Bureau's formal evaluation of a carrier's performance. This report is made available to the public upon request.

3. Additional Work Needed

There is general agreement among carriers and BHI that much more needs to be done to improve the criteria for evaluating carrier performance.^{1/} While BHI has made steady progress, its staff needs outside assistance for the purpose of making more rapid advances.

Our Committee has concluded that HEW should enter into a research contract promptly with an independent entity in order to accelerate the improvement of the performance criteria. Such a firm should be capable of dealing with management problems, performance measurement and incentives. The contracting firm selected might require the services of one or more subcontractors, particularly in dealing with problems of medical necessity and the related problems being confronted by the PSRO's. In particular, we believe an immediate program is urgently needed to bring into the performance evaluation criteria the carrier's ability to apply professional standards of medical necessity and quality (to the extent they have

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^{1/} A staff paper of the National Association of Blue Shield Plans states, for example:

"Ideally an evaluation system should provide for the carriers certain basic assurances that the system is objective and it provides reliable and constant measures in which both contractor and the Government can independently know and arrive at the same conclusions on carrier comparative performance standings. The nature of the present system does not fulfill this objective."



been developed). Moreover, we believe that an independent organization could bring about a degree of carrier confidence in the results which BHI could not achieve.

In the Report we shall not seek to raise all of the questions which should be examined by a consulting entity. However, we shall mention a few problems to which the contracting firm should address itself.

(a) Accuracy

Perhaps the most important question relating to measurement of carrier performance is how the performance criteria can be made to reflect the accuracy of program benefit payments, i.e., whether the correct amount of money has been paid to the right person. For example, this would entail such matters as correctly determining coverage, screening out aberrant-appearing situations for further investigation and identification of excessive utilization.

Some of these problems are, of course, ones with which the PSRO's are supposed to deal. Ultimately, probably the test of carrier performance in this area will be closely geared to its capacity to be an effective consumer of the outputs of the PSRO's. However, it may be years before the PSRO's are producing vital utilization review data for Part B services, and particularly those rendered in doctors' offices. Thus, the carriers should be urged to perform this function as effectively as possible until the PSRO's take over. Protection of the taxpayer's interest requires that ways be devised to assess the effectiveness of the present carriers,



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whether through PSRO's or otherwise, in reducing waste of program funds.

(b) Cost Variation

In relation to costs, criteria need to be developed as to what constitute tolerable deviations from the accepted norm.^{1/} Clearly one would have to allow for differing circumstances that carriers face, to the extent that these differences affect costs and are also outside the control of carriers (e.g., regional differences in wage rates). But the question that needs to be resolved is what constitutes unacceptable performance once the data on costs have been adjusted for sources of variation that are outside the control of carriers. In this respect, two principles must be considered. First, before penalties are applied, unacceptable performance should be manifest for several accounting periods since poor performance in one period may be attributable to non-recurring forces. Second, small deviations from the norm established by the more efficient carriers should not result in penalties in the performance rating. Fear of being downgraded for minor deviations from the norm would serve as a disincentive to experimentation and may lead to excessive uniformity among carriers. Accordingly, penalties in the performance rating are appropriate only for significantly higher than target costs. Quantitative criteria are needed as to what will be considered a "significant" deviation from the norm.

^{1/} Needless to say, the Committee does not mean to encourage carriers toward developing similar costs or cost estimates. Obviously, collaboration among carriers should not extend to pricing policies and practices.



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(c) Timeliness

In relation to timeliness of processing claims, has too much emphasis been placed on this factor? It has been suggested by the National Association of Blue Shield Plans that:

The performance term 'timeliness' should be used very sparingly. The program should perpetuate a new connotation of 'inventory control', in which the performance standards defining the term would focus on the overall workload, and the performance objective would measure how well the carrier processed the bulk and controlled the exception claims."¹

(d) Quality

In relation to the quality of a carrier's processing of claims, we believe that the primary responsibility for applying relevant tests should remain with the Bureau of Health Insurance. However, in devising standards and criteria, as distinct from evaluating individual carriers, the advice and suggestions of carriers should, of course, be solicited.

4. More Effective Carrier Reporting

A critical element in improved criteria of carrier performance is the development of better systems of reporting by carriers. It would appear from the data presented to the Committee that the cost accounting information at the carrier level is not standardized to the point where comparisons can be made with a reasonable degree of reliability. This was acknowledged by the Government representatives after reviewing Staff Paper No. 3 and was confirmed by several industry representatives.

¹/ Memorandum accompanying letter to the Chairman dated December 19, 1973.

