

February 1997

DEFENSE HEALTH CARE

Dental Contractor Overcome Obstacles, but More Proactive Oversight Needed



**Health, Education, and
Human Services Division**

B-276142

February 28, 1997

The Honorable Steve Buyer
Chairman
The Honorable Gene Taylor
Ranking Minority Member
Subcommittee on Military Personnel
Committee on National Security
House of Representatives

The Honorable Joel Hefley
The Honorable Walter B. Jones, Jr.
The Honorable Charles W. Norwood, Jr.
House of Representatives

In 1985, the Congress authorized the Department of Defense (DOD) to establish a dental benefits program for eligible family members of active duty members who could no longer be accommodated on a space-available basis at military dental clinics. Today, the TRICARE Active Duty Family Member Dental Plan (FMDF) is a large dental insurance program covering over 1.8 million beneficiaries and allowing up to \$1,000 annually per person for a wide range of dental services. From February 1996 through July 2001, the FMDF will be administered nationwide for DOD under a \$1.9 billion contract with United Concordia Companies, Inc., and its parent company, Highmark, Inc., both of Camp Hill, Pennsylvania.¹

Concordia experienced a difficult and protracted takeover from the incumbent FMDF contractor, DDP*Delta.² Until February 1996, DDP*Delta had been the only nationwide FMDF insurer, and dentists and beneficiaries alike had grown accustomed to DDP*Delta's management of the program. DDP*Delta's unsuccessful legal action protesting DOD's contract award to Concordia caused a 6-month delay in Concordia's takeover and generated negative publicity that Concordia has had to surmount. In addition, congressional concerns were raised early on about whether Concordia was administering the FMDF in such a way as to ensure the satisfactory

¹Concordia is the legal entity acting as the prime FMDF contractor. Concordia's parent company as of December 1996 is Highmark, Inc., after its original parent company, Pennsylvania Blue Shield, merged with Blue Cross of Western Pennsylvania. Highmark has an agreement to participate as an interdivisional affiliate providing various services in support of the contract, such as information systems, internal audit, training, and business experience.

²From August 1987 through January 1996, the FMDF was administered and underwritten by DDP*Delta, representing Delta Dental Plans in 50 states.

delivery of dental care nationwide. Of particular concern were the amounts Concordia paid to dentists, the number of participating dentists, and the timeliness of claims processing and restrictiveness of coverage.

In response to these concerns, House Committee Report 104-563 (accompanying H.R. 3230, Fiscal Year 1997 Defense Authorization Act), in addition to a joint request from Representatives Joel Hefley; Charles Norwood, Jr.; and Walter Jones, Jr., directed us to evaluate several issues regarding the program. Specifically, we were required to determine whether (1) Concordia's fee allowances for participating and nonparticipating dentists are appropriate, (2) Concordia has established an adequate network of participating dentists, (3) Concordia's claims processing and marketing efforts meet contract requirements, and (4) DOD is meeting its oversight responsibilities to ensure that Concordia complies with contract requirements.

To do our work, we obtained actuarial assistance from the Hay Group and reviewed regulations, contract provisions, and bid protest records bearing on Concordia's fee schedules and network. Concordia has used two sets of fee allowances for participating and nonparticipating dentists since starting work as the FMDP plan insurer: (1) initial fees from February through July 1996 and (2) revised fees since August 1996. We analyzed Concordia's fees and charge data for 26 frequently incurred services between February and June 1996. To evaluate the adequacy of Concordia's network, we compared the frequency of services needed by beneficiaries with the number of participating dentists nationwide and at 21 military bases. To evaluate Concordia's claims processing timeliness, we analyzed its computerized claims records for February through September 1996. We also reviewed Concordia's policy to limit payments for certain treatments to less costly alternatives to determine whether it was consistent with regulations and the contract, and we compared Concordia's marketing activities with contract requirements. Finally, to evaluate DOD's oversight of Concordia, we assessed the current level of effort at DOD headquarters in Washington, D.C., and at the TRICARE Support Office (TSO) in Aurora, Colorado. For additional discussion of our scope and methodology, see appendix I.

Results in Brief

Concordia has overcome numerous start-up problems and is now performing the task areas we reviewed within the contract's requirements. DOD, however, has not yet taken a proactive role in overseeing the contract

and thus far has not acted to assure itself and the Congress that the contractor is performing as required.

Regarding fee appropriateness, neither applicable regulations nor the contract establish how Concordia's fees should be set nor whether or when they should be revised. Thus, while contractually required to pay dentists at certain fee levels based on "prevailing charges" (or less when billed charges are lower), in effect, Concordia is left to determine whether its fees are appropriate and whether and how such contractual requirements are met.

Our analysis of Concordia's fee-setting methods showed that its initial February 1996 fees were based on less up-to-date charge data than were its revised August 1996 fees. Lacking actual charge data experience, Concordia based its initial fees on 1993 and 1994 industry data, the most current data available when it submitted its January 1995 contract bid. After the 6-month delay in the contract's start, Concordia used these same fees to reimburse dentists during the contract's first 6 months. In August 1996, Concordia revised many of the fees on the basis of its actual claims experience during the first 6 months. Although not required to do so, Concordia could have elected to update its initial fee schedules by using a trend factor reflecting the estimated 1994 and 1995 dental charge increase, thus making them about as up to date as its August 1996 fees.³ Had it done so, Concordia would have paid an estimated \$2.5 million more in fees nationwide to dentists during the contract's first 6 months. Concordia used up-to-date dental charge trends in projecting the program's premium revenue rate increases over the contract's 5-year period.

In the geographic areas we reviewed, Concordia has ample numbers of network dentists within 35 miles of beneficiaries' residences—one of two access standards. Moreover, we estimated that, if optimally located, Concordia would need only about 7,300 dentists to meet the 1.8 million beneficiaries' likely demand for dental services. As of November 1996, Concordia's network included almost 45,000 dentists. At two remote military base areas, however, there are not enough dentists available for Concordia to develop an adequate network. In a third area, Camp Lejeune Marine Corps Base in Jacksonville, North Carolina, nearly all dentists have declined to participate in Concordia's network, for which DOD is now considering several remedial interventions. Data were not available in time with which to evaluate compliance with DOD's other access standard—that

³Recent dental charge increases have been fairly consistent at 5 to 6 percent per year.

beneficiaries obtain an appointment with a participating general dentist within 21 days. Concordia and DOD, however, plan to survey beneficiaries about the timeliness of their appointments.

Although tardy during the early months of the contract, Concordia data indicate that it is now processing dentists' claims for payment within required time limits. Also, Concordia had been processing nonparticipating dentists' claims somewhat slower than participating dentists' claims, but now is meeting the required time limit for both groups. And Concordia's data on processing predetermination claims⁴ show that it is now meeting the established time limit. Concordia's "optional or alternative treatment" policy allows payment for a less costly treatment instead of a more costly treatment (removable denture instead of a fixed bridge, or amalgam filling instead of a crown). While questioned by some dentists, Concordia's policy is permitted under the regulations and contract when such alternatives meet acceptable dental standards. Finally, Concordia's marketing activities meet requirements.

Even though the fixed-price contract places the greatest risk on Concordia, DOD's oversight, generally relying on contractor self-reporting, does not provide DOD adequate assurance that the contractor is performing as required. To date, DOD has not conducted a contract performance evaluation nor independently verified Concordia's data. Responding to our concerns, DOD officials told us they plan to conduct a performance evaluation in the summer of 1997, but they have not yet defined what the evaluation will entail. Also, the Deputy Assistant Secretary for Clinical Services recently proposed, among other changes, creating an oversight and advisory role for TRICARE regional dental officers regarding FMDP beneficiary appeals.

Background

The Congress established the FMDP in 1987 as a basic benefit program for the eligible dependents of active duty members of the seven uniformed services in the 50 states, the District of Columbia, Puerto Rico, Guam, and the U.S. Virgin Islands.⁵ The program is administered by TSO through the insurer, Concordia, as a fixed-price, fee-for-service contract. Thus, Concordia is "at risk" to pay all administrative and benefit costs for dental

⁴Predeterminations authorize coverage, including the amount the beneficiary will have to pay, for proposed dental services.

⁵10 U.S.C. 1076a authorizes the Secretaries of Defense, Transportation, and Health and Human Services to administer the Active Duty Dependents Dental Plan for the Army, Navy, Air Force, Marine Corps, Coast Guard, and the Commissioned Corps of both the Public Health Service and National Oceanic and Atmospheric Administration. The program was expanded to Canada in 1995.

services provided under the contract. Initially, the dental plan benefits specified by the Congress and administered by DDP*Delta provided only basic coverage with a strong preventive focus. In 1993, the Congress expanded the authorized benefits, effectively restructuring the dental plan into a comprehensive program comparable to many plans offered to private sector employees (covered dental benefits are shown in table II.1).

Participation in the FMDP is through voluntary enrollment by the active duty member, whose monthly premium is paid in advance through a payroll deduction. Single and family enrollment options are available under defined circumstances. Family members who are eligible for FMDP coverage are spouses and unmarried children under the age of 21 (or under age 23 if in college and financially dependent). The FMDP benefit year runs from August 1 through July 31, there is no deductible, and the yearly maximum benefit payment is a total of \$1,000 per family member for all services except orthodontia (which has a separate lifetime maximum of \$1,200 per family member). The monthly premium cost is shared by the government (60 percent) and the active duty member (40 percent). On the basis of the premium rate projections in its final bid, Concordia's FMDP premiums are automatically increased at an average rate of 5.7 percent each year to account for rising dental charges and other costs. (See table II.2 for FMDP premiums, 1995-2001.)

Family members may receive dental care from a dentist of their choice but will save money, time, and paperwork if they use Concordia dentists participating in a developed network. Participating dentists are those who have signed contracts with and accept Concordia's fee allowances in full for covered services, and they cannot charge family members for any difference between their usual fee and Concordia's allowance (other than the applicable cost-share amount). In addition, participating dentists file claims and accept payment directly from Concordia.⁶ Concordia's fee allowances for reimbursing nonparticipating dentists are lower than those for participating dentists, and nonparticipating dentists can bill the family members the balance of payment between their usual charge and Concordia's fee allowance. This may lead to higher out-of-pocket costs for family members.

Concordia's succession as the FMDP contract insurer was delayed 6 months following the unsuccessful bid protest by the incumbent contractor, DDP*Delta. In February 1995, after TSO awarded the contract to Concordia

⁶With the family member's permission, nonparticipating dentists can file claims and accept payment directly from Concordia.

for the 5-year period August 1, 1995, to July 31, 2000, DDP*Delta filed a protest of the award with GAO.⁷ The protest triggered a delay in Concordia's performance. It also caused DOD to allow DDP*Delta to continue performing under its contract and to modify the Concordia contract to change the period of performance to February 1, 1996, through July 31, 2001. In June 1995, GAO denied the protest, upholding DOD's contract award to Concordia. DDP*Delta next sought a preliminary injunction against DOD's proceeding with Concordia as its contractor by filing suit in the U.S. District Court in the Northern District of California. In February 1996, the court denied DDP*Delta's injunction request and upheld DOD's contract award to Concordia. While the legal challenges played out during 1995 and 1996, Concordia and DOD encountered considerable negative publicity that raised congressional and public concerns about Concordia's ability to administer the FMDP. Among other impacts, the fallout from the publicity impeded Concordia's recruitment of dentists to join its network. DOD and Concordia responded to the criticisms in part by citing substantial cost savings—\$112 million—to the government and beneficiaries as a result of awarding the contract to Concordia instead of DDP*Delta.

No Regulatory or Contractual Criteria for Judging Fee Appropriateness

While Concordia is required to pay dentists at certain fee levels (or less when billed charges are lower), neither the regulations nor the FMDP contract specify how such fees should be set, such as on the basis of "prevailing charges" during a certain period of time, nor whether or when fees should be reviewed or revised. As a result, the regulations and the contract provide no assurance that fees paid are appropriate. We found, moreover, that Concordia's initial February 1996 fees, which were based on prevailing charges in 1993 and 1994, were less up to date than its August 1996 fees, which were based on Concordia's own charge data during the first 6 months.

Both DOD regulations and the FMDP contract have general requirements that the insurer pay participating dentists at a level that provides financial incentive for them to participate, when compared with the maximum fee level paid to nonparticipating dentists. Concordia established a maximum

⁷The Competition in Contracting Act of 1984 (31 U.S.C. 3551 et seq.) allows bidders to seek relief from GAO when they have reason to believe that a federal contract has been awarded improperly or illegally, or that they have been unfairly denied a contract. GAO considers the facts and legal issues raised and issues a decision. GAO may sustain, deny, or dismiss the protest.

fee level at a certain percentile⁸ in its final offer for participating dentists, which is considered proprietary and thus is not discussed here. For nonparticipating dentists, regulations and the contract require a maximum fee level equivalent to the 50th percentile of prevailing fees charged by dentists for similar services in the same region.

Concordia's Initial Fees Less Up to Date Than Its Revised Fees

To determine initial fees, Concordia developed separate fee allowance schedules for participating and nonparticipating dentists that encompassed 192 dental procedures grouped in seven regions. These fees, used to reimburse dentists during the contract's first 6 months, were based on 2-year-old insurance industry data on charges submitted by dentists. Concordia used this method because it lacked its own charge data experience with which to develop initial fees, so it used pooled industry data from 1993 and 1994. Also, the delay in the contract's start date, caused by DDP*Delta's unsuccessful bid protest, made the initial fees even less current. Furthermore, Concordia was under no regulatory or contractual obligation to adjust or trend the initial fees, such as through the use of a trend factor based on historic annual dental charge increases.

Concordia revised its fees in August 1996. After 6 months of program experience, Concordia used its own charge data to adjust its fee allowances for many procedures, and it increased to 16 the number of fee allowance regions from the 7 regions used in setting initial fees. Our actuarial analysis showed that the revised fees are substantially higher (about 10 percent, on average) and conform with more recent charge practices. Lacking sufficient charge data, however, Concordia did not revise fee allowances for the less frequently billed services, which account for more than half of the 192 dental procedures in each of its schedules. Thus, such fees remain based on prevailing 1993 and 1994 charge data, now 2 to 3 years behind the trend.

Although not required, had Concordia's initial fees been based on more up-to-date charge data, the company would have paid out more in maximum allowances to dentists during the contract's first 6 months. For example, recent dental charge increases have been fairly consistent at 5 to 6 percent per year. Approximating the effect of applying a 5-percent 1994 through 1995 dental charge trend increase to Concordia's 1993 through

⁸The use of percentiles, rather than averages of charges, is an established practice for setting health care fee allowances. The reason is that use of a percentile, such as the 50th percentile, ensures that 50 percent of the claims will be at or below that charge amount. When using averages, a few outliers (very high or very low charges by a few dentists) could result in a fee schedule that covers substantially more or less than the desired percentage of claims from all dentists.

1994 industry charge data, we estimated that such additional payments would have been \$2.5 million. Concordia used such dental charge trends in setting the beneficiary and government premium increases for the contract's 5 years. Moreover, for the first year's premium (originally August 1995 through July 1996), Concordia used a 1993-to-1994 base period. Then it adjusted the base for estimated annual increases in dental use and charge practices through February 1996. Concordia established annual premium increases through July 2001, the life of the contract, on the basis of projected period increases in dental charges and other factors affecting costs. In discussions with us, Concordia officials said that trending fee allowances, rather than using empirical claims experience, could inappropriately inflate the program's costs because some dentists submit bills at the maximum allowable charge. They also said that the insurance industry does not trend fee schedules and uses a baseline period that may be 1 to 2 years before the fee application period, and thus what Concordia did is consistent with industry practice. In contrast, however, they also said that projecting dental charge and related costs for purposes of setting future-year premium rates is financially appropriate when bidding on a fixed-price contract.

Not Clear Whether and How Concordia Would Update Fees in Future

Concordia officials told us that they planned to review their fees every 12 to 18 months throughout the contract, but are under no regulatory or contractual obligation to do so, nor are they obligated to make modifications. Concordia and DOD officials told us that the contract provides Concordia the flexibility to develop and change fee allowances in the manner it sees fit. Also, Concordia and DOD officials said that as long as sufficient numbers of dentists accept its fees and participate in Concordia's network, the company in effect has satisfied the program's requirements. We question, however, whether such an interpretation recognizes the regulatory and contractual requirements stating that the contractor should cap its provider fees at certain percentiles based on prevailing rates within a region. Hypothetically, a contractor could unfairly enhance its profitability by holding dentist fee increases below historic trends while enjoying premium increases that more closely track projected dental charge trends during the contract's option years. Also, paying fees based on out-of-date dental charges could lead to higher out-of-pocket costs for beneficiaries electing to use nonparticipating dentists (when such dentists bill them for the balance of their full charges). But unless DOD establishes how such requirements are to be met, the contractor in effect is allowed to determine compliance and fee appropriateness. Thus,

it is unclear whether and how Concordia might see fit to update its fees in the future.

Along with agreeing with the contractor on what constitutes prevailing charges for fee-setting purposes, there are several ways in which DOD could consider establishing its fee requirements. One would be to require that fee allowances be reviewed on some periodic basis over the remainder of the contract, updating as necessary to ensure that the fees are as close as possible to expected charges. The Medicare program offers another way to determine fees: It uses a 12-month experience period ending 6 months before the application period (thus, a lag of 12 months from the midpoint of the prevailing charge base period and the start of the fee application period). Alternatively, in the absence of actual claims experience, an overall trend reflecting historic charge data could be used to periodically update fees, similar to the way that Concordia fixed its premium increases between 1996 and 2001 (such as the recent trend of 5- to 6-percent annual increases).

Concordia's Dental Network Meets the 35-Mile Requirement

When Concordia took over the contract in February 1996, concerns were raised that its initial network of about 31,000 dentists would be inadequate compared with DDP*Delta's reported network of 109,000 dentists. In the areas we reviewed, however, Concordia's network of participating dentists easily meets DOD's requirement for access to a general dentist within 35 miles of a beneficiary's home. But in two remote military base areas in Idaho and Nevada, the number of available dentists is insufficient for Concordia to develop an adequate network. In a third area, Jacksonville, North Carolina, nearly all dentists have declined to participate in Concordia's network. Data were not available in time for us to test Concordia's compliance with DOD's second network requirement—that participating general dentists give beneficiaries an appointment within 21 days.

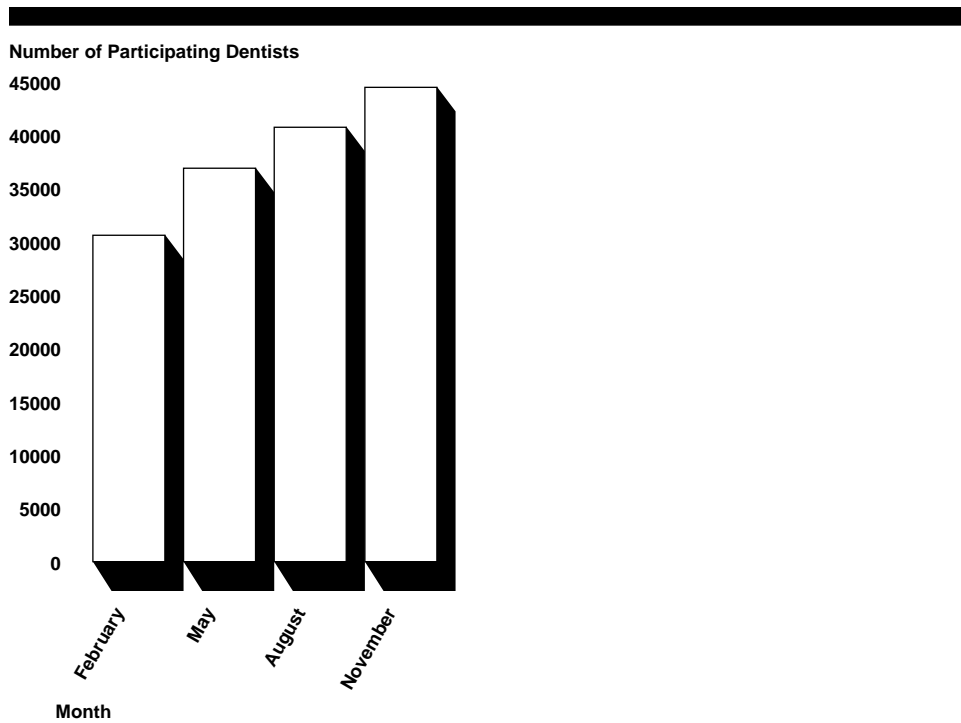
Concordia Continues to Expand Its Network of Participating Dentists

Concordia is required to establish a network of participating general dentists so that beneficiaries can obtain a routine dental appointment within 35 miles of their residence and within 21 days.⁹ Beneficiaries' access to participating dentists is important because their out-of-pocket

⁹Where these requirements are not met, Concordia must pay claims for all dental services based on the dentist's actual billed charge, less any applicable copayment. Concordia's fee schedules for participating and nonparticipating dentists do not apply. This situation applies to Fallon Naval Air Station, Nev.; Mountain Home Air Force Base, Ind.; and Camp Lejeune Marine Base and Cherry Point Marine Air Station, N.C.

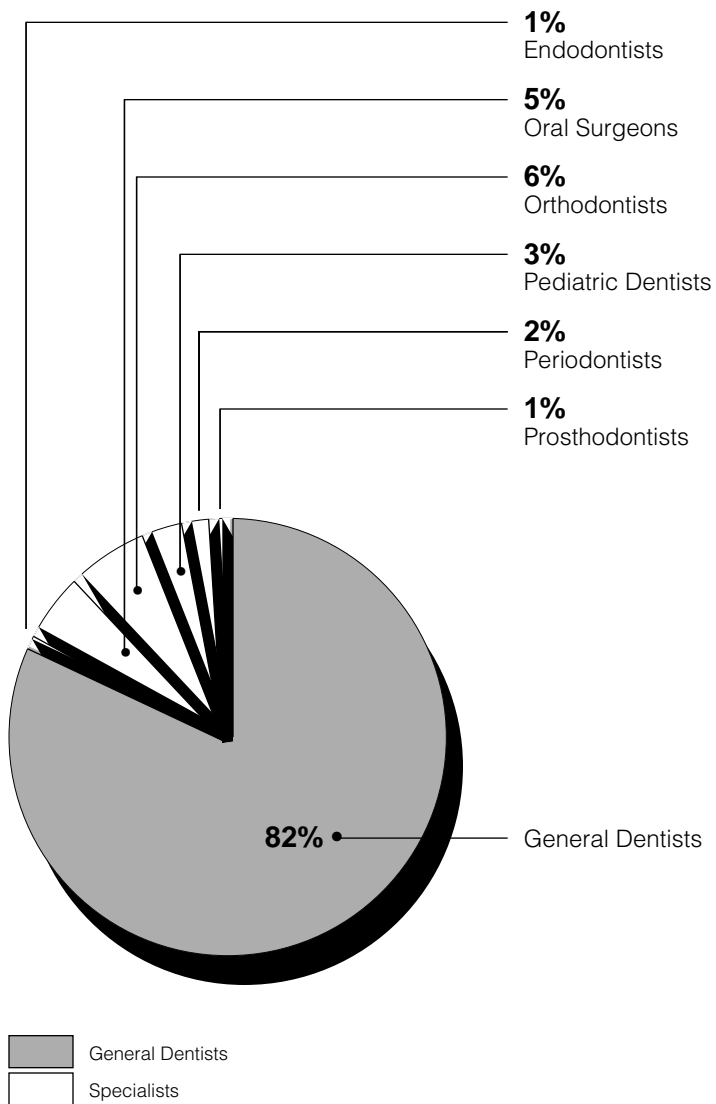
costs are lower when their care is obtained from a participating dentist. Concordia has continued to recruit dentists for its network, and between February and November 1996, increased the number of participating dentists from about 31,000 to nearly 45,000, as shown in figure 1.

Figure 1: Expansion of Concordia's Participating Dentist Network, February-November 1996



By November 1996, Concordia had successfully recruited about 8,100 dental specialists—about 18 percent of its total network (see fig. 2). Moreover, according to Concordia, participating dentists delivered about 82 percent of the dental services provided to beneficiaries (see table 1 for the numbers of participating and nonparticipating dentists as of November 1996).

Figure 2: Composition of Concordia's Network of Participating General and Specialty Dentists as of November 1996



Note: Periodontists specialize in treating gum disease; endodontists specialize in diseases of tooth pulp and perform root canals; prosthodontists replace missing teeth with dentures or bridges; and orthodontists correct misaligned teeth.

Table 1: Concordia's Participating and Nonparticipating Dentists, November 1996

Category of dentist	Number of participating dentists	Number of nonparticipating dentists ^a
General	36,379	21,686
Endodontist	605	345
Oral surgeon	2,306	582
Orthodontist	2,773	1,900
Pediatric	1,177	462
Periodontist	1,023	409
Prosthodontist	205	68
Total	44,468	25,452

^aThe number of nonparticipating dentists is based on analysis of the number who provided services and submitted claims to Concordia through November 1996.

Taking into account the distribution of beneficiaries and dentists, we reviewed the adequacy of Concordia's network of dentists within 35 miles of each beneficiary zip code at 21 military base areas (see table I.2 for a list of the 21 areas we examined).¹⁰ At all 21 installations, we found overall that Concordia's network meets the 35-mile network requirement for participating general dentists.¹¹ Also, a more general analysis showed that Concordia would only need a total network of about 7,300 dentists, if optimally distributed, to meet the expected need for dental services by the 1.8 million beneficiaries.

Finally, in an effort to enhance beneficiary convenience, DOD is considering alternatives to the current or future FMDP contract in the 35-mile network requirement for FMDP participating dentists. These alternatives include reducing the distance in nonrural areas from 35 miles; identifying maximum beneficiary drive time to reach the dentist; and using proximity to dentists within residential zip codes. Along with enhanced beneficiary access, we believe that DOD needs to consider ability to measure contractor compliance with any new network standard. We noted, moreover, that the distance between a beneficiary's residence and a dentist's office is currently being measured by Concordia and would not

¹⁰Our estimates of needed dentists are based on conservative actuarial assumptions that participating dentists would spend no more than 10 percent of their time treating all FMDP beneficiaries. Thus, in the likely event that some of the participating dentists in these locations treat more FMDP beneficiaries and that some beneficiaries would elect to use nonparticipating dentists, fewer participating dentists would actually be needed.

¹¹We found a shortage of four pediatric dentists at two zip code locations (Fort Stewart, Hinesville, Ga.; and Fort Hood, Killeen, Tex.) serving 22,000 beneficiaries. This is not a contract violation, because the 35-mile requirement does not apply to specialists. In addition, a general dentist can provide the same services to children as a pediatric dentist.

require any change in Concordia's information system. But compliance with a beneficiary travel time standard would be more difficult to determine and may require beneficiary surveys.

Compliance With 21-Day Appointment Requirement

Data were not available for us to reliably measure whether Concordia's network complied with the 21-day appointment requirement. Concordia officials told us that, to satisfy this requirement, they rely in part on a customer service phone number for beneficiary complaints about scheduling dental appointments.¹² Because both Concordia and DOD plan beneficiary satisfaction surveys in 1997, more information should be available about the beneficiaries' ability to get appointments with participating dentists within the 21-day standard.

Three Areas Still Have Inadequate Provider Networks

Concordia has been unsuccessful in establishing adequate networks at three military base areas. Two of the areas, Mountain Home Air Force Base, Mountain Home, Idaho; and Fallon Naval Air Station, Fallon, Nevada, are in remote locations where access would remain inadequate even if all available dentists participated. Also, despite continued recruitment efforts, Concordia has not succeeded in establishing the required network of participating dentists at the third area, Camp Lejeune Marine Corps Base in Jacksonville, North Carolina, and nearby at Cherry Point Marine Air Station in Havelock, North Carolina. Without an adequate dental network, beneficiaries cannot realize cost savings from accessing a participating dentist.

The Jacksonville and Havelock areas are unique in that about 57,000 beneficiaries and 70 dentists are located in these communities, but only one Jacksonville dental office has signed on with Concordia and the others have declined to participate. During August 1996 discussions with us, many of the local dentists complained about Concordia's general management of the program, citing conflicts with Concordia's representatives and problems with its claims processing. Concordia officials told us they had hoped to gain network participation in Jacksonville and Havelock after they raised fees in August 1996, but to date the situation has not changed.

In October 1996, the Assistant Secretary of Defense, Health Affairs, directed his staff, in consultation with Concordia, to work on resolving the

¹²Concordia's FMDP benefits booklet informs beneficiaries of the 21-day and 35-mile requirements for accessing a participating general dentist and provides a toll-free customer service number to call if a beneficiary has trouble scheduling an appointment.

Jacksonville and Havelock impasse. As of January 1997, Health Affairs was considering several remedial interventions but had not yet decided on a course of action.

Claims Processing and Marketing Activities Meet Contract Requirements

During the contract's early months, Concordia was not meeting the claims processing time limit but is now doing so for all dentists. Likewise, Concordia's data on processing claims to authorize coverage for proposed dental services (known as predeterminations) show that it did not meet the established time limit in the early months of the contract. In addition, Concordia's policy to pay only for certain alternative less expensive treatments is permitted under the contract and regulations. Finally, Concordia's marketing activities meet contract requirements.

Concordia Claims Processing Is Now Timely

In evaluating contract bids, DOD ranked FMDP claims processing as the most important factor. Concordia's contract requires that it operate a single processing, adjustment, development, and control system enabling it to process claims through payment or denial. Ninety percent of claims must be processed to completion within 21 days of receipt.¹³ Also, when requested by a dentist or beneficiary, Concordia is required to provide a predetermination—a written estimate of what it will pay and what the beneficiary will be responsible for paying—for a proposed dental treatment. Seventy-five percent of predeterminations must be processed to completion within 21 days of receipt. In March 1996, as required, Concordia began to self-report monthly statistics to TSO that the Contracting Officer's representative used to track compliance with the claims processing requirements.

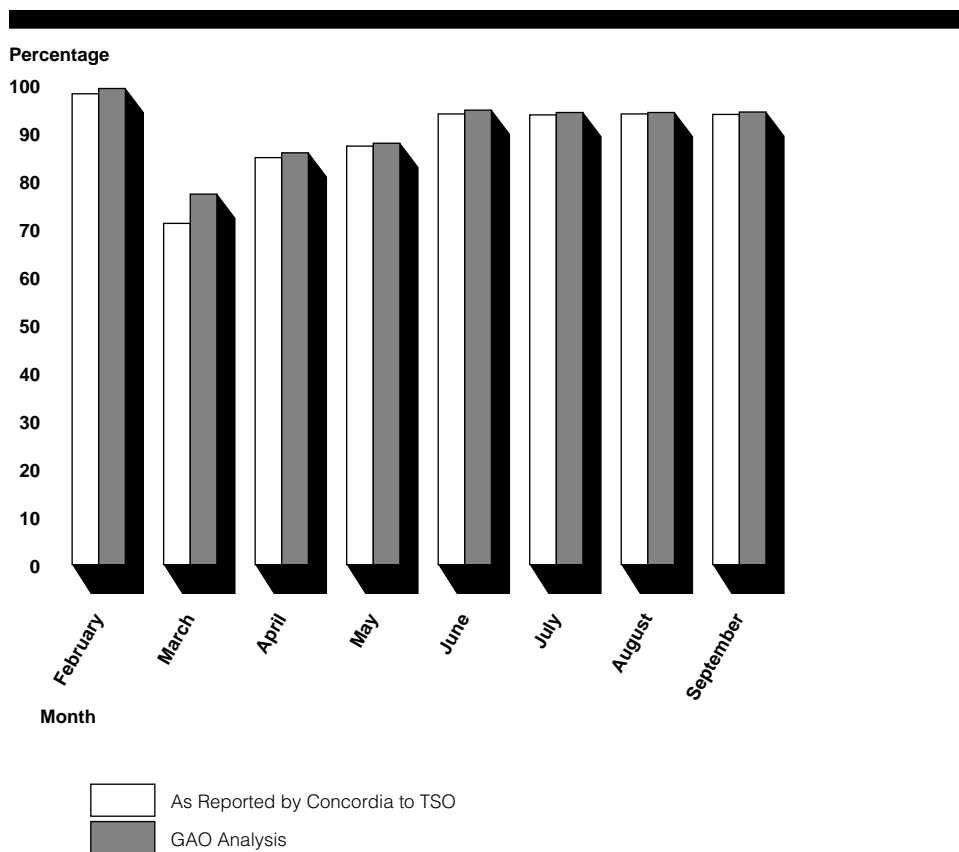
In response to concerns about the timeliness of Concordia's claims processing, we analyzed the claims records for all payments and predeterminations from February through September 1996 and compared our results with Concordia's reported statistics.

Payment Claims

Our review of February through September 1996 claims records showed that Concordia has consistently processed claims from all participating and nonparticipating dentists within the 90-percent, 21-day established time limit since June 1996 (see fig. 3).

¹³Claims are processed to completion when all services and supplies on the claim have been settled; payment has been determined on the basis of covered services; allowable charges have been applied to maximums and/or denied; and checks and written explanation of benefits have been prepared for mailing to providers and beneficiaries.

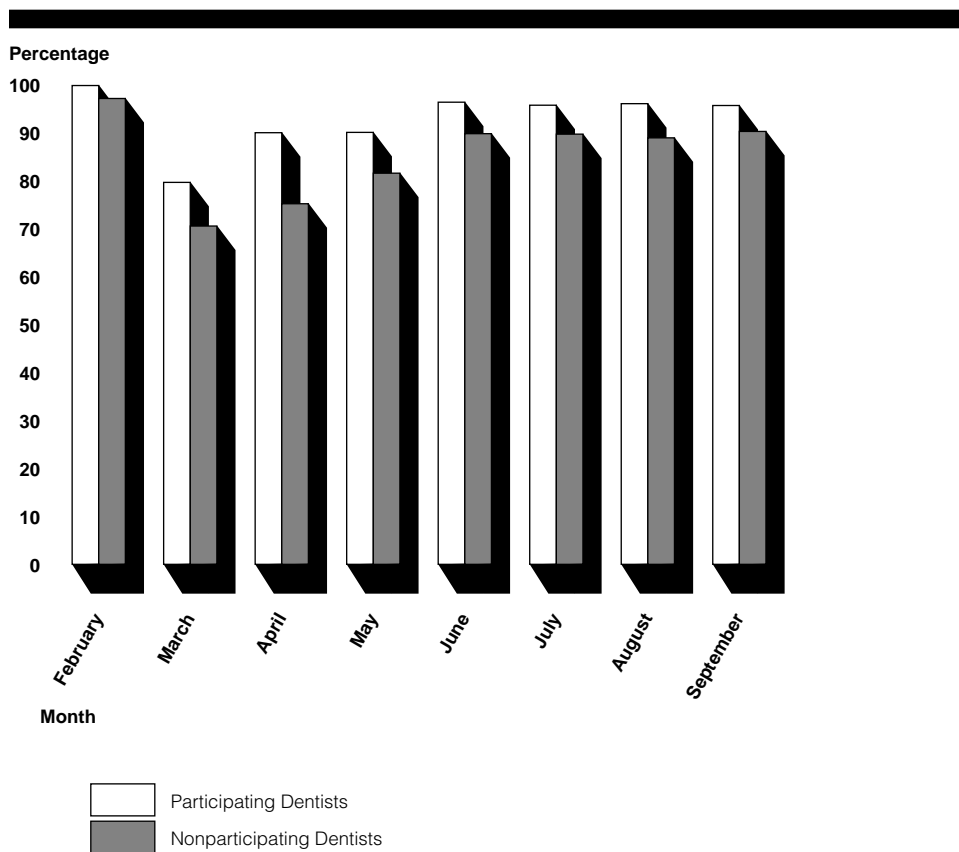
Figure 3: Percentage of Claims Processed Within the 90-Percent, 21-Day Requirement, 1996



Some nonparticipating dentists complained that Concordia was tardy in processing and paying their claims. The contract’s timeliness requirements for processing participating and nonparticipating dentists’ claims are the same. Concordia met the timeliness requirement for processing participating dentists’ claims in 5 of the 8 months analyzed, but processed nonparticipating dentists’ claims on time in only 2 of the 8 months (see fig. 4). In January 1997, Concordia officials explained to us that these differences, especially in the contract’s early months, were due in part to the additional time it took to document that nonparticipating dentists were authorized to provide dental care (that is, were licensed or certified). Concordia is required to authorize all dentists and to not pay for any service furnished by a dentist who is not authorized. In addition, they explained that nearly all nonparticipating dentists submit paper claims

rather than file them electronically, and paper claims typically take longer to process.

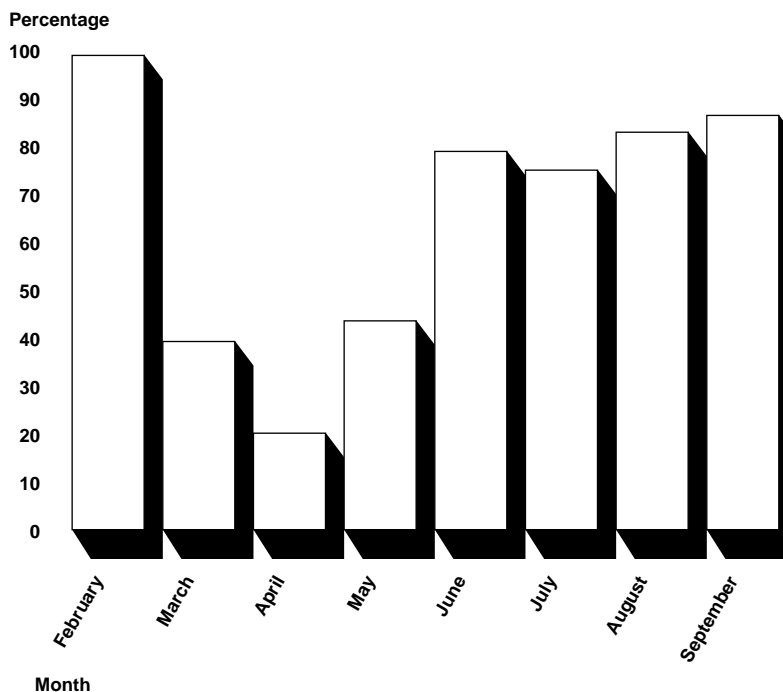
Figure 4: Comparison of Claims Processed Within the 90-Percent, 21-Day Requirement for Participating and Nonparticipating Dentists, 1996



Predetermination Claims

In the contract’s early months, Concordia encountered major difficulties in its automated system for tracking predeterminations. As a result, Concordia did not comply until July 1996 with the contract requirement that it report predetermination timeliness statistics to TSO. DOD’s Contracting Officer’s representative told us he was aware the company was working on the problem, and thus held off formally citing Concordia for the reporting deficiency. Our analysis showed that Concordia met the required processing time limit in 4 of the 8 months (see fig. 5). The representative, moreover, was unaware that Concordia had not met the requirements during March, April, and May.

Figure 5: Percentage of Predeterminations Processed Within the 75-Percent, 21-Day Requirement, 1996



Concordia's Policy to Pay for Less Costly Treatments Is Consistent With Requirements

Both DOD's regulations and the contract authorize Concordia to limit benefit payments to less expensive courses of treatment that meet acceptable dental standards. In addition, Concordia defined this policy in its benefits brochure distributed to all beneficiaries and dentists.¹⁴ Between April and September 1996, Concordia denied over 4,000 fixed bridges and crowns, instead only allowing payment for less costly treatments. Concordia's application of this policy caused dissatisfaction on the part of some dentists and was also the subject of criticism by the previous contractor, DDP*Delta. All complained that more costly treatments should be allowed as long as the treatments are appropriate and necessary. These sources also cited Concordia's statements published shortly after taking over for DDP*Delta that there would be no change in dental benefit coverage and that Concordia's coverage would be the same as DDP*Delta's. The DDP*Delta executive in charge of the FMDP contract through January 1996 told us that his company paid for all necessary

¹⁴Concordia's policy, known as "optional or alternative treatment," applies to prosthodontia services (bridges and dentures) and other restorative services (crowns and cast restorations, onlays, and so on). The policy allows payment for a less costly adequate treatment instead of a more costly treatment (removable denture instead of a fixed bridge, or amalgam filling instead of a crown).

services and, in his opinion, DOD and Concordia are inappropriately reducing FMDP benefits.

Our review of the regulations and contract requirements does not support a conclusion that Concordia is inappropriately reducing FMDP benefits. According to the requirements, the authority to make benefit determinations and authorize FMDP payments rests primarily with the insurer, Concordia. In exercising this authority, Concordia may establish, in accordance with generally acceptable dental benefit practices, an alternative course of treatment policy that allows less costly treatment than the treatment selected by the dentist and beneficiary. TSO officials also agreed that Concordia's practice to pay on the basis of less costly treatments is consistent with DOD's long-standing position that health care delivery contractors implement such cost controls as utilization management and limitations and exclusions in determining covered benefits. Furthermore, TSO officials told us that Concordia's alternative treatment policy is not a reduction in FMDP benefits, since the basic benefit structure is unchanged and, within each benefit category (for example, restorative or prosthodontia services), a range of treatments can correct a condition. Nonetheless, in response to the criticisms, Concordia officials told us they obtained TSO agreement to modify the policy. Thus, since October 1996, Concordia has been paying for fixed bridges in some instances where previously it paid for removable dentures.

Concordia's Marketing Activities Comply With Contract Requirements

Concordia is required to have a marketing program involving specific activities to facilitate beneficiary and dental provider understanding of program benefits, limitations and exclusions, and Concordia's administrative procedures. We found that Concordia has carried out these required activities, which include

- developing and distributing an 88-page benefit brochure to beneficiaries, dentists, and uniformed services' health benefits advisors (HBA);
- publishing and distributing quarterly news bulletins to dentists, congressional offices, and HBAs;
- establishing a network of professional dental relations representatives who provide educational services to dentists by making personal visits and giving annual half-day seminars,
- establishing a network of 10 dental benefit advisors who provide representation at military installation briefings and workshops, and educate HBAs about the dental program; and

-
- developing, maintaining, and distributing quarterly update lists of participating dentists to HBAS to assist beneficiaries in selecting a dentist.

Although not required to do so, Concordia also distributed to dentists a reference guide giving detailed instructions and information on such topics as claims submission, covered services, and the appeals process. Concordia also produced a video for use at military installations to educate beneficiaries about the program. Currently, to further encourage enrollment, Concordia is targeting marketing efforts on active duty sponsors and eligible family members returning from overseas assignments where FMDP is unavailable.

DOD's Oversight Is Not Sufficient to Ensure Compliance

Within DOD, there is shared organizational responsibility for overseeing all health benefits programs, including FMDP. TSO has the authority for day-to-day contract oversight, while the Office of the Assistant Secretary of Defense, Health Affairs, provides policy guidance, management control, and coordination. TSO appoints a contracting officer's representative, who has specific duties and functions. In addition, the contract requires that TSO conduct periodic contract performance evaluations, but does not specify how or when these evaluations are to be done.

To date, DOD's level of effort to oversee Concordia's contract performance can be characterized as "hands off." For the most part, the information DOD uses to monitor contract performance (for example, monthly claims processing reports statistics) is self-reported by Concordia and not independently verified by the Contracting Officer's representative. Also, the representative spends much of his time on such other FMDP matters as obtaining and incorporating the service branches' comments on Concordia's draft FMDP publications and responding to external inquiries and complaints about the program. Since April 1996, the Contracting Officer's representative has twice visited Concordia's facility for 2-day meetings and to observe claims and customer service operations.

DOD has also conducted two "in-progress reviews" with the contractor, organized by Health Affairs. At these meetings, Concordia representatives briefed DOD participants on the program's status and the company's progress and performance in meeting the contract requirements. Also, the Contracting Officer's representative and DOD dental project officers have met with Concordia to focus on internal administrative action items and seek general information updates from the contractor. Health Affairs staff

provided satisfactory appraisals of Concordia's then-current performance based on the meetings.

In our view, this is a "hands off" approach to oversight and does not provide assurance that the contractor is performing as required in critical task areas. In discussions with us, DOD officials pointed out that the contract has a fixed price, such that the contractor bears most of the cost risk associated with poor or nonperformance. Nonetheless, DOD officials agreed with us that the contract's human services nature requires that they act to ensure satisfactory performance and compliance with key contract requirements. Thus, they said they plan to conduct an evaluation of Concordia's performance in the summer of 1997 and will set about defining what critical task areas to include and how the evaluation is to be carried out.

Finally, as part of its ongoing effort to integrate military dental care into its regional health care system, DOD is looking at expanding FMDP oversight authority to local dental commanders and regional dental advisors. Among other proposals, the Deputy Assistant Secretary, Clinical Services, wants to require that all appeals of Concordia's dental benefit decisions filed with TSO be forwarded to TRICARE regional dental advisors for review and recommendations.¹⁵ As described, however, the proposals do not address oversight of Concordia's performance in critical task areas, such as fee appropriateness, network adequacy, and claims processing timeliness.

Conclusions

The 5-year FMDP contract between DOD and Concordia will cost about \$1.9 billion and deliver comprehensive dental health care to over 1.8 million military family members. The changeover in FMDP contract administrator from DDP*Delta to Concordia was accomplished with considerable difficulty. Negative publicity brought concerns about whether Concordia was providing satisfactory dental care to DOD beneficiaries and whether DOD was acting to ensure that Concordia performed in accordance with contract requirements.

While Concordia now pays dentists fees based on more up-to-date charge data than the fees it paid during the contract's first 6 months, neither the regulatory nor contract requirements to pay dentists at certain maximum levels (or less if billed charges are lower) are specific enough for DOD to

¹⁵If beneficiaries or participating dentists disagree with Concordia's benefit decision, they may appeal the decision through three levels in the appeals system: reconsideration by Concordia; formal review by TSO of Concordia's reconsideration decision on cases over \$50; and a hearing by TSO on the result of the formal review on cases over \$300.

determine the appropriateness of Concordia's fees. Also, Concordia's network of participating dentists appears adequate now, but, without reasonable fees and targeted DOD surveillance, installations could gradually lose dentists and imperceptibly fail to meet local populations' needs. Concordia's claims processing and marketing functions are also within contract requirements, but DOD needs, on an ongoing basis, to assure itself that Concordia continues to satisfactorily administer these critical tasks. Remaining to be seen is whether DOD's planned evaluation of Concordia or extension of oversight authority to regional and local dental commanders will address the key contract areas discussed in this report.

Recommendations to the Secretary of Defense

To position DOD to ensure contractor compliance with the FMDP's requirements, we recommend that the Secretary of Defense direct the Assistant Secretary of Defense, Health Affairs, to require that

- discussions be held with the contractor and, as appropriate, the contract modified to clearly state how prevailing charges are to be established for fee-setting purposes, including the method and frequency for reviewing and, as appropriate, revising the fee schedules;
- future FMDP requests for proposals require that the contractor's start-up fees it pays to dentists reflect prevailing charges established in the same manner as above or, if needed, be adjusted with a trend factor to approximate such charges; and
- a contract oversight strategy be developed that efficiently targets the (1) appropriateness of Concordia's fee schedules; (2) adequacy of its networks; (3) timeliness of its claims and predeterminations processing; and (4) efficacy of its marketing activities.

Comments From United Concordia Companies, Inc., and DOD and Our Evaluation

We obtained written comments from Concordia and DOD on a draft of this report.

Comments From Concordia

Concordia stated that it was pleased with our findings about the company's performance in the task areas reviewed. But Concordia objected to, among other matters, any suggestion that its initial fees resulted in some underpayment. Our report merely illustrates what the

effect may have been had Concordia's initial fees been as up to date as its August 1996 fees, but clearly acknowledges that the company was under no regulatory nor contractual requirement to update them. While Concordia is required to cap its provider fees at certain percentiles based on prevailing rates within the region, neither the regulations nor the contract establish how prevailing rates should be set or whether or how often fees should be reviewed or revised.

Concordia commented further that if it had adjusted its initial fees as the report suggests, it would not have made the August 1996 adjustments. And it estimated that if the initial fees had remained in effect for the entire year, the difference in fee payments from what were actually made would have been negligible. But Concordia officials could not provide, when we contacted them, enough detail about the estimate's basis for us to judge its validity. Although adjusting the fees as Concordia suggests might have resulted in a more equitable fee spread throughout the year, further analysis is needed to arrive at such a conclusion. Moreover, because Concordia is not required to do so, it is unclear whether and how Concordia might see fit to update its fees during the contract's 4 remaining option years.

Concordia also commented that its initial claims processing timeliness problems resulted from the bid protest, which caused a 6-month delay in starting work under the contract. We did not attempt to assess whether the delayed contract start, in fact, led to such start-up problems, but the delay actually added 6 weeks to the normal 6-month transition period. Concordia also commented that the initial difference in processing times for nonparticipating and participating dentists' claims was not the result of any discriminatory practices on its part. We have no basis for, nor does the report draw, such a conclusion.

Concordia also referred in its comments to a beneficiary survey it did that identified high levels of satisfaction among beneficiaries with their ability to get appointments. We did not evaluate Concordia's survey approach nor its methodology. DOD's beneficiary survey results, moreover, should be available sometime this year and should provide independent information with which to judge Concordia's performance against the appointment time standard.

Concordia also separately suggested some technical changes to the report, which we incorporated as appropriate. Concordia's comments are presented in their entirety in appendix III.

Comments From DOD

In its overall comments, DOD stated that it concurs with the report's findings that Concordia currently meets contract requirements and that this outcome is largely due to DOD's proactive oversight of the contract. As discussed below, we disagree with DOD's view of its oversight role.

DOD did not concur with our first recommendation and partially concurred with the second recommendation—both of which are aimed at clarifying how Concordia and future contractors are to meet regulatory and contractual requirements bearing on establishing dentist fees. DOD stated that rather than imposing prescriptive, process-oriented requirements on the contractor, it selected the firm, fixed-price contract and used an outcomes-based approach to procure these services. DOD said that what we have recommended would undermine that strategy, increase program costs, and restrict the contractor's ability to take advantage of innovative financing methodologies.

An important outcome of the contract—like an adequate dentist network and timely claims processing—is the establishment of appropriate dentist fees. In fact, the contractor is required by regulation and the contract to cap its fees at certain percentiles based on prevailing rates in the region. But, while the contract provides standards for what constitutes an adequate network and timely claims processing, in effect the contractor is left to determine whether its fees are appropriate and how the fee requirements are to be met. Rather than adding more process requirements to the contract, our recommendations are aimed at clarifying the current fee requirements so that both DOD and the contractor can determine when fees comply with the requirements.

Moreover, we disagree that our recommendations would inappropriately increase program costs. Rather, we believe the program's integrity requires that participating and nonparticipating dentists receive reasonable fees commensurate with the winning bidder's fee-level proposals and applicable regulations. And, because Concordia's annual fixed premiums are based on projected dental charges and other factors affecting its costs through 2001, we believe it is reasonable to assume that such rates need not be affected and should provide sufficient revenue to cover the costs of fair and reasonable dentists' fees during the contract's option years. Contractor costs, and consequently beneficiary copayments, could be somewhat higher if dentists' fees are required to be more up to date, but this would depend almost entirely upon the mutually agreed-to basis for prevailing rates and the contractor's current practices. While DOD asserts that network adequacy is the true test for fee appropriateness, we

believe that such an interpretation fails to recognize the separate regulatory and contractual requirements that relate to dentists' fees. In addition, DOD's concerns that the contractor may not use innovative financing strategies if fee appropriateness is established appear baseless. Rather, as stated in the report, the contractor now can innovatively, though unfairly, enhance its profitability by holding dentist fee increases below historic trends while enjoying fixed premium increases that more closely track projected dental charge trends during the contract's option years. Thus, we believe that defining prevailing rates for fee-setting purposes would help to ensure fairer, more equitable dentists' payments and contractor costs that legitimately reflect going market conditions.

DOD also commented that it chose the firm, fixed-price contract vehicle for the FMDP contract to meet the tenets of the Federal Acquisitions Streamlining Act of 1994 (FASA) to seek less prescriptive contract requirements and readily available commercial services. But DOD's FMDP acquisition plan stated that the program had not been designated as subject to acquisition streamlining and, according to DOD, the FMDP request for proposals (RFP) was identical to the prior contract's RFP, which preceded FASA. Also, the FMDP RFP was more than 150 pages long, including a 42-page statement of work. In contrast, an apparently streamlined RFP for selected reserve personnel's dental services released in December 1996 was 17 pages, including a 13-page work statement.

In partially concurring with our second recommendation about fee setting in future FMDP RFPs, DOD said that future proposals would require that initial fee schedules be based on prevailing charge data. But DOD continues to assume a specification for establishing and reviewing prevailing charges when none now exists in the regulations or the proposed RFP. Concordia, for example, was also required to base its fees on prevailing charges, but by the time its initial fees were applied, they were based on 2-year-old data. Furthermore, DOD went on to temper its concurrence with our recommendation by stating that including the new requirement in future RFPs would cause bidders to build risk premiums into their bids. We question DOD's basis for this concern, however, and believe that the effects of competition on bidders' behavior remain to be seen. Thus, we continue to believe that DOD should take the actions called for in our recommendation.

While DOD said it concurred with our third recommendation to develop an effectively targeted oversight strategy, it went on to say that its proactive oversight strategy now assures it and the Congress that the contractor is

performing as required. DOD concluded that our finding that the contractor is performing within the contract's requirements points out the efficacy of its oversight.

We disagree with DOD's assertions about its oversight role. As we point out in the report, DOD has not independently verified contractor-reported data on claims processing timeliness, network adequacy, or ongoing fee appropriateness, and, without GAO's findings, DOD lacks a credible basis for concluding that the contractor is meeting contract requirements. DOD commented that, in addition to its oversight activities discussed in the report, it conducted a benchmark test of Concordia's ability to process claims before services were delivered. But this was a test of Concordia's potential, rather than actual, performance. Also, DOD commented that it made a site visit shortly after service delivery began to Jacksonville, North Carolina, to discuss concerns about the contract transition. But this visit was in reaction to local dentists' complaints that Concordia's fees were too low and about a host of other alleged contractor performance problems. Therefore, we continue to believe that the report accurately depicts DOD's contract oversight thus far, and that DOD needs to begin to proactively and independently monitor the appropriateness of Concordia's fee schedules, adequacy of its networks, timeliness of its claims processing, and efficacy of its marketing activities.

DOD's comments are presented in their entirety in appendix IV.

As arranged with your offices, we will distribute copies of this report to the Senate Armed Services Committee and Senate and House Appropriations committees; the Secretary of Defense; United Concordia Companies, Inc.; the Director, Office of Management and Budget; and other interested parties. Copies will also be made available to others upon request.

Please contact me on (202) 512-7111 if you or your staff have any questions concerning this report. Other GAO contacts and staff acknowledgments are listed in appendix V.



Stephen P. Backhus
Director, Veterans' Affairs and
Military Health Care Issues

Contents

Letter		1
Appendix I		28
Scope and	Concordia Fee Schedules	28
Methodology	Concordia Participating Dentists Network	31
	Concordia Claims Processing and Marketing	33
Appendix II		35
Information on FMDP		
Benefits and		
Premiums		
Appendix III		36
Comments From		
United Concordia		
Companies, Inc.		
Appendix IV		39
Comments From the		
Department of		
Defense		
Appendix V		44
GAO Contacts and		
Staff		
Acknowledgments		
Tables	Table 1: Concordia's Participating and Nonparticipating Dentists, November 1996	12
	Table I.1: Dental Procedure Fees Analyzed by GAO	29
	Table I.2: Military Base Areas Selected to Assess Concordia's Participating General Dentist Network's Compliance With 35-Mile Requirement	31
	Table II.1: Benefits Covered by FMDP Program	35

Table II.2: FMDP Annual Premium Paid by Active Duty Sponsor and Government, August 1995-July 2001	35
---	----

Figures

Figure 1: Expansion of Concordia's Participating Dentist Network, February-November 1996	10
Figure 2: Composition of Concordia's Network of Participating General and Specialty Dentists as of November 1996	11
Figure 3: Percentage of Claims Processed Within the 90-Percent, 21-Day Requirement, 1996	15
Figure 4: Comparison of Claims Processed Within the 90-Percent, 21-Day Requirement for Participating and Nonparticipating Dentists, 1996	16
Figure 5: Percentage of Predeterminations Processed Within the 75-Percent, 21-Day Requirement, 1996	17

Abbreviations

DOD	Department of Defense
FASA	Federal Acquisitions Streamlining Act of 1994
FMDP	Family Member Dental Plan
HBA	health benefits advisor
RFP	request for proposals
TSO	TRICARE Support Office

Scope and Methodology

In conducting our review, we examined FMDP program and contract documents obtained from DOD and Concordia. We reviewed applicable legislation, DOD regulations and policies, contract requirements, and information on the 1995 through 1996 bid protest and district court lawsuit by DDP*Delta. We interviewed Concordia, DOD, and military officials at various locations. We also interviewed a limited number of participating and nonparticipating dentists in North Carolina, Colorado, and Virginia and representatives of DDP*Delta and the American Dental Association. We conducted our work at the Office of the Assistant Secretary of Defense, Health Affairs, Washington, D.C.; TSO, Aurora, Colorado; Camp Lejeune Marine Corps Base, Jacksonville, North Carolina; Fort Bragg Army Base, Fayetteville, North Carolina; Norfolk Naval Station, Norfolk, Virginia; Langley Air Force Base, Hampton, Virginia; Fort Eustis Army Base, Newport News, Virginia; Peterson Air Force Base and Fort Carson Army Base, Colorado Springs, Colorado; and at Concordia's Camp Hill, Pennsylvania, office. We did our work from June 1996 through January 1997 in accordance with generally accepted government auditing standards.

Concordia Fee Schedules

To do our work on Concordia's fee allowances for dentists, we obtained actuarial assistance from the Hay Group. To evaluate the adequacy of both sets of fee allowances, we reviewed Concordia's actuarial methodologies; compared Concordia's February and August 1996 fees for selected procedures; and verified whether Concordia's revised fees are set at the required percentile levels for participating and nonparticipating dentists. We analyzed claims data from Concordia reporting actual charges by dentists for the period February 1 through June 30, 1996, for the 26 frequently incurred dental procedures listed in table I.1. We did not verify Concordia's data for accuracy or consistency. Claims that were reported after August 31 but before October 24, 1996, were included in the data set supplied by Concordia. Concordia provided the following data: (1) claim number, (2) dollar charge submitted by dentist, (3) dental procedure code, (4) date of service, (5) frequency of procedure, (6) dentist state and zip code, (7) Concordia fee schedule region, and (8) dental specialty.

**Appendix I
Scope and Methodology**

**Table I.1: Dental Procedure Fees
Analyzed by GAO**

Procedure code	Dental procedure
Diagnostic	
00110	Initial exam
00120	Periodic exam
00272	Two bitewing X rays
00274	Four bitewing X rays
00330	Panorex X ray
Preventive	
01110	Adult prophylaxis
01120	Child prophylaxis
01203	Child fluoride
01204	Adult fluoride
01351	Sealant, per tooth
Basic restorative	
02140	Amalgam restoration, one surface
02150	Amalgam restoration, two surfaces
02160	Amalgam restoration, three surfaces
Crowns	
02750	P/m crown, high noble metal
02751	P/m crown, base metal
02752	P/m crown, noble metal
Root canal	
03310	Root canal therapy, anterior tooth
03330	Root canal therapy, molar
Gum disease treatment	
04341	Periodontal scaling & root planing, quadrant
04210	Gingivectomy, quadrant
04260	Osseous surgery
Removable denture	
05110	Complete upper denture
05214	Lower partial denture, cast metal base
Fixed bridge	
06750	Abutment crown, porcelain fused to high noble metal
Oral surgery	
07110	Extraction, single tooth
07240	Extraction, complete bony impaction

To verify how Concordia set its August 1996 fee allowance percentiles for nonparticipating and participating dentists, we analyzed 2 million claims for the 26 procedures listed in table I.1. For each procedure, we arrayed the claims data from highest-dollar submitted charge to lowest-dollar submitted charge and then numbered from one (being the lowest submitted charge) up to the total number of claims (being the highest submitted charge). We determined the 50th percentile as follows: The total number of claims was multiplied by 0.5 to determine the position of the 50th percentile. That number is P(50). The actual charge amount at P(50) was identified as the 50th percentile. If P(50) was a fraction, then the 50th percentile is the average of the charges just below and above P(50).

We also estimated how much more Concordia would have paid to dentists between February and August 1996 if it had updated the initial fee schedules using more recent charge data in the same way that it updated fee schedules in August 1996, that is, using charge data from the 5-month period of February through June 1996. The estimate was derived by comparing Concordia's actual claims expenses under the initial fee schedules with the claims expenses that would have been paid under the revised August 1996 fee schedules. We determined the weighted average increase in fees for each of the 26 dental procedures shown in table I.1. Then, to determine which claims would have been reimbursed in full (that is, because the actual charge was at or below the trended maximum fee allowance), we determined the percentage of claims that were at, above, and below the February 1996 fee schedules for participating and nonparticipating dentists. This resulted in an average increase of \$1.71 per claim to reflect Concordia's actual claims expense if it had used the revised August 1996, rather than the initial February 1996, fee schedules, which yielded a total difference in payment of \$3.5 million. We then interpolated the \$3.5 million to estimate what the payment difference would have been if Concordia had used July 1995 through November 1995 charge data from the outset. This interpolation was done by calculating the lag between the midpoint of the claims experience period used for the initial February fee schedules (Mar. 1, 1994) and the revised August 1996 fee schedules (Apr. 15, 1996), which is 25.5 months. Next, we calculated the lag between the midpoint of the claims experience period used for the initial February 1996 fee schedule and the alternative July through November 1995 claims experience period (Sept. 15, 1995), which is 18.5 months. Multiplying \$3.5 million by 18.5/25.5 yields an estimate of \$2.5 million. This estimate approximates the results of applying a 5-percent trend.

Concordia Participating Dentists Network

To evaluate Concordia’s network, we obtained actuarial assistance from the Hay Group. DOD regulations specify two requirements in order for the insurer’s network to be in compliance with the FMDP contract: (1) a beneficiary must be able to obtain an appointment within 21 days with a participating general dentist and (2) the participating general dentist must be within 35 miles of the beneficiary’s home. No similar requirements exist regarding specialists. To determine whether Concordia’s network is adequate, we analyzed detailed data on 21 military base areas (see table I.2) and summary data on dentists and beneficiaries in the nationwide FMDP service area. The 21 sites serve 37 percent of the total FMDP beneficiary population and were judgmentally chosen in consultation with DOD to provide a mix of (1) large and small beneficiary populations, (2) adequate and potentially inadequate networks, and (3) rural and urban locations.

Table I.2: Military Base Areas Selected to Assess Concordia’s Participating General Dentist Network’s Compliance With 35-Mile Requirement

Military base area	State	Enrolled beneficiaries
San Diego Naval Station and Camp Pendleton Marine Corps Base	California	119,292
Fort Carson Army Base and U.S. Air Force Academy	Colorado	42,609
Fort Benning Army Base and Fort Stewart Army Base	Georgia	50,304
Scott Air Force Base	Illinois	13,345
Fort Campbell Army Base	Tennessee and Kentucky	35,463
Keesler Air Force Base	Mississippi	17,075
McGuire Air Force Base and Fort Dix Army Base	New Jersey	6,738
Fort Bragg Army Base and Seymour Johnson Air Force Base	North Carolina	75,682
Fort Sam Houston Army Base, Lackland Air Force Base, and Randolph Air Force Base	Texas	48,171
Fort Hood Army Base	Texas	53,565
Norfolk Naval Station, Langley Air Force Base, and Fort Eustis Army Base	Virginia	153,916
Fort Lewis Army Base	Washington	46,766

Our analyses were based on (1) the number of beneficiaries, (2) the number of dentists that have signed with the network, (3) the number of dentists who have not signed with the network but have submitted claims to Concordia, and (4) the frequency of services expected by the

beneficiaries. To perform our analyses, we obtained from Concordia the following information: (1) GeoNetworks¹⁶ reports consisting of dental providers and beneficiaries at the 21 military bases as of October 1996, (2) utilization reports on the frequency of visits per beneficiary as of August 1996, (3) the number of services performed per dentist for claims paid through August 1996, (4) nationwide data on the number of participating providers as of November 1996, and (5) the total number of beneficiaries enrolled nationwide in the FMDFP as of November 1996. We inflated the reported number of services provided to estimate the annual amount; we did not adjust the data to reflect incurred but not billed services. We did not verify Concordia's source data for accuracy.

To determine whether Concordia's network met DOD's 35-mile standard at 21 selected military base areas, we analyzed Concordia's GeoNetworks system reports, which provide the proximity of dentists to beneficiaries within specified distances. However, this analysis did not address frequency of utilization or whether beneficiaries could obtain appointments with participating general dentists within 21 days. Because data were not available in time to assess Concordia's compliance with the 21-day requirement, we adopted an alternative methodology to determine the adequacy of the network, including both general dentists and specialists, at the 5-digit zip code level for each of the 21 military base areas. For this methodology, we projected the number of dental procedures that beneficiaries could be expected to incur over a year and organized them by type of specialty. For each type of dental specialist, we estimated an individual dentist's productivity with regard to treating FMDFP beneficiaries. We used individual dentist productivity rates with regard to treating FMDFP beneficiaries. We obtained these productivity rates from the American Dental Association, and they represent the number of procedures that a dentist could perform in a year, based on the type of treatment specified.¹⁷

We then computed the number of dentists, by specialty, needed to supply the services demanded by FMDFP beneficiaries by dividing the annual demand, by specialty, by the number of services a single dentist could

¹⁶GeoNetworks is a software system developed by GeoAccess Corporation that provides capability to analyze the proximity and number of health care providers to beneficiaries. Concordia used this software to measure the distance in miles between beneficiaries and participating and nonparticipating dentists for the 21 military bases we selected for study.

¹⁷Bureau of Economic and Behavioral Research, *Distribution of Dentists in the United States by Region and State: 1991* (Chicago, Ill.: American Dental Association, 1993) as cited by Rosa G. Moy, Gordon R. Trapnell, John C. Wilkin, and C. William Wrightson, *Estimation of the Requirements for Dentists in the TRICARE Active Duty Family Member Dental Plan* (Annandale, Va.: Actuarial Research Corporation, 1995), p. 8.

complete in a year. We further modified this computation by assuming the dentist would devote only 10 percent of his or her time to treating FMDP patients. Although in some areas participating dentists may devote significantly more time to care of FMDP patients, we used 10 percent as a conservative assumption. That is, if Concordia's network is adequate under this conservative assumption, it likely would be adequate under nearly all demand scenarios.

Finally, to address the question of whether Concordia has established an adequate network of participating dentists nationwide, we used the Concordia data on the total number of services provided by both participating and nonparticipating dentists, and the estimated dental provider productivity estimates discussed earlier to estimate the number of network dentists needed to perform all the services (based on nationwide utilization). We then compared these estimated needs for dentists with the actual number of participating dentists in the nationwide network to determine whether that total number is sufficient to service the FMDP nationwide beneficiary population.

Concordia Claims Processing and Marketing

To evaluate Concordia's claims processing performance, we focused on its compliance with contract standards for timeliness. We did not evaluate the accuracy of Concordia's benefit determinations (that is, the amount paid by Concordia as well as the amount not covered and why). We reviewed Concordia's monthly reports to TSO on payment and predetermination claims processing timeliness from February through September 1996. In addition, we obtained Concordia's computerized records for 1.8 million claims processed from February through September 1996 in order to perform our own analysis of timeliness and verify the accuracy of Concordia's reported statistics to TSO. For payment claims, we calculated the length of time it took to process the claims from the date of receipt to the payment date. For predetermination claims, we used the date of receipt to the finalized or settlement date to calculate timeliness because these types of claims do not have a payment date. We also did analysis comparing the timeliness of payment claims between participating and nonparticipating dentists because some nonparticipating dentists complained about delays in receiving payment for their services.

Regarding Concordia's "optional or alternative treatment" policy, we reviewed that policy against legal requirements set by DOD regulations and contractual provisions, as well as Concordia's technical proposal and beneficiary and dental provider publications that describe the use of the

policy to limit benefit payments for certain dental services. We reviewed Concordia statistics on the number of claims on which the policy was applied between April and October 1996. In addition, we obtained the views of officials from DOD, Concordia, DDP*Delta, and several dentists about Concordia's policy and whether or not it represents a reduction in dental benefits.

To evaluate Concordia's marketing performance, we reviewed the contract requirements and collected publications and other communication documents from Concordia to assess compliance with the contract terms. Among the publications obtained and examined were the benefit booklet (Your Dental Benefit Booklet: TRICARE Active Duty Family Member Dental Plan); quarterly newsletters (FMDP Alliance and FMDP Dental Courier); miscellaneous fact sheets; a draft dentist reference guide on FMDP benefits, policies, and procedures; a 23-minute videotape (Active Duty Family Member Dental Plan), and quarterly reports on the activities of Concordia's regional professional relations staff and dental benefits advisors during their visits to dentist offices and military bases. In addition, we observed two of Concordia's 1/2-day professional relations seminars for dental office staff in Williamsburg, Virginia, and Denver, Colorado.

Information on FMDP Benefits and Premiums

Table II.1: Benefits Covered by FMDP Program

Dental treatment category	Percentage of treatment cost covered by insurer
Routine oral exams and X rays ^a	100
Cleaning and fluoridation ^a	100
Sealants ^b	80
Fillings and certain basic crowns	80
Root canal	60
Gum disease	60
Oral surgery	60
Other crowns, onlays, cast restorations	50
Removable dentures and fixed bridges	50
Braces	50

^aLimited to two routine exams or treatments every 12 months. Other restrictions apply to X rays.

^bOn permanent first molars through age 10 and on permanent second molars through age 15; one sealant per tooth in a 3-year period.

Table II.2: FMDP Annual Premium Paid by Active Duty Sponsor and Government, August 1995-July 2001

Benefit year ending	Single enrollment			Family enrollment		
	Sponsor	DOD	Total	Sponsor	DOD	Total
July 1996	\$81.24	\$121.80	\$203.04	\$203.04	\$304.56	\$507.60
July 1997	86.28	129.36	215.64	215.64	323.52	539.16
July 1998	91.68	137.40	229.08	229.08	343.68	572.76
July 1999	97.08	145.68	242.76	242.76	364.20	606.96
July 2000	102.36	153.60	255.96	255.96	384.00	639.96
July 2001	109.32	163.92	273.24	273.24	409.92	683.16

Comments From United Concordia Companies, Inc.



United Concordia
Companies, Inc.

TRICARE - Active Duty Family Member Dental Plan

February 20, 1997

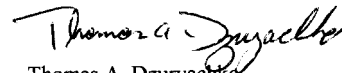
Mr. Stephen P. Backhus
United States General Accounting Office
One Massachusetts Avenue, N.W.
Suite 650
Washington, D.C. 20548

Dear Mr. Backhus:

Enclosed are United Concordia's comments on the U.S. General Accounting Office's Draft Report, "Defense Health Care: Dental Contractor Overcame Initial Obstacles, But More Proactive D.O.D. Oversight Needed." These comments reflect our thoughts on the Draft Report and are subject to reevaluation when the final version of this report is received. Additionally, because we understand that our comments will be included in their entirety in the Final Report, we would appreciate being notified if this will not be the case.

We appreciate the opportunity to review and comment on this report before its publication.

Sincerely,


Thomas A. Dzuryachko
Chief Operating Officer

TAD/tlw

Attachments

**Appendix III
Comments From United Concordia
Companies, Inc.**

Comments of United Concordia Companies, Inc. on the United States General Accounting Office (GAO) Draft Report "Defense Health Care: Dental Contractor Overcame Initial Obstacles, But More Proactive D.O.D. Oversight Needed." (GAO/HEHS-97-58).

United Concordia is pleased that, following an extensive review of the Family Member Dental Plan and its own analysis of United Concordia's claims data, the GAO concluded: 1) that the program's contract and performance guidelines are being met for claims processing; 2) that our network of participating dentists is five times larger than estimates deem necessary and ample to meet the program's access requirements in all 21 base areas evaluated; and 3) that United Concordia is meeting all of the contract requirements in the task areas reviewed.

Nonetheless, we take strong exception to the discussion in the Report regarding the methodology employed to establish the initial fee schedules and the impact of that methodology on the amounts paid to dentists. Although the GAO correctly notes in its Report that United Concordia complied with regulatory and contractual requirements in establishing fees, it suggests that United Concordia's method resulted in some underpayment. The fact is, the contract provides the flexibility to develop and change fee allowances to adjust for prevailing rates. United Concordia's fee schedules are in compliance with the prevailing charge requirements as specified in the RFP and contract. Thus, there is no underpayment.

Furthermore, had United Concordia adjusted its initial fee schedule using the GAO's suggested trend factor, those initial fee schedules would have remained in effect throughout the first year of the program and it would not have made revisions in August of 1996. In comparing the total fees which would have been paid using this approach to those which were actually paid during the year, our actuary has determined that the difference in payment would be negligible (less than one-tenth of one percent based on an analysis of the 26 procedures listed in Appendix I of the Report).

Although the report notes claims processing timeliness concerns during the initial transition of the program, those resulted largely from the Bid Protest, which caused a six-month delay in contract performance. From the outset of the contract, United Concordia has devoted significant resources to the program and, as recognized by the GAO, is currently in compliance. These efforts will result in substantial taxpayer savings compared to the previous contractor.

Moreover, with respect to the GAO's statement that claims from non-participating dentists had been processed "somewhat slower" than those from participating dentists, we note that, to the extent there was a difference, it was not a result of any discriminatory practices in our claims administration. As the GAO should be aware from its review, claims from participating and non-participating dentists are processed in precisely the same manner. Nonetheless, some additional time was required to process claims for non-

**Appendix III
Comments From United Concordia
Companies, Inc.**

participating dentists during the early months of the contract because of the additional efforts needed to document licensure or certification of those dentists before the claims were processed.

In that regard, we also note that there is no requirement in the contract to separately measure the processing of participating and non-participating dentists claims against the performance standards, as might be inferred from the Draft Report. Instead, the contract requires that all claims collectively be measured against the standard. We have consistently met or exceeded the contract's performance requirements for claims processed from June to the present.

In summary, the fact that United Concordia is meeting contract and performance requirements in the task areas reviewed by GAO reflects the company's dedication to providing superior dental benefit programs to all beneficiaries covered under FMDP. Part of this commitment also included a Beneficiary Satisfaction Survey which identified that 94% of the respondents indicated either excellent, very good, or good ability to get a regular appointment; 92% of the respondents indicated either excellent, very good, or good locations of dentists participating in the program.

Additionally, United Concordia is committed to further beneficiary surveys monitoring customer service and soliciting feedback from dentists as well as periodically revisiting and evaluating fee schedules to review their currency. These efforts ensure that not only are all contract requirements continually being met, but also that program beneficiaries are receiving superior benefits and service in keeping with United Concordia's mission of excellence in dental benefits programs.

Comments From the Department of Defense



HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

FEB 26 1997

Mr. Stephen P. Backhus
Director, Veterans' Affairs
and Military Health Care Issues
Health, Education, and Human
Services Division
U.S. General Accounting Office
Washington, DC 20548

Dear Mr. Backhus:

This is the Department of Defense (DoD) response to the General Accounting Office (GAO) draft report, 'DEFENSE HEALTH CARE: Dental Contractor Overcame Initial Obstacles, But More Proactive DoD Oversight Needed,' dated February 13, 1997 (GAO Code 101495/OSD Case 1295). The Department's specific responses to the draft recommendations are provided in Enclosure 1. In addition, detailed comments on specific aspects of the report are provided in Enclosure 2. We believe these responses and comments are supported by GAO's review, and represent current statutory and regulatory requirements.

The Department concurs with the conclusion made by GAO that United Concordia Companies, Inc. is performing in accordance with the terms of their contract with the government. We believe this is, in large measure, the result of close, consistent, and proactive oversight at all levels within the Office of the Assistant Secretary of Defense for Health Affairs, combined with outstanding interservice cooperation and communication. In light of this outstanding effort, the Department recommends that the title of the draft report be changed to read: DEFENSE HEALTH CARE: Dental Contractor Performing As Expected; Continued Proactive DoD Oversight Encouraged.

The Department appreciates the opportunity to comment on the draft report.

Edward D. Martin / for
Stephen C. Joseph, M.D., M.P.H.

Enclosures:
As stated

GAO DRAFT REPORT--DATED FEBRUARY 13, 1997
GAO CODE 101495/OSD CASE 1295
"DEFENSE HEALTH CARE: Dental Contractor Overcame Initial Obstacles, But More
Proactive DoD Oversight Needed"

DEPARTMENT OF DEFENSE RESPONSE TO THE RECOMMENDATIONS

Now on p. 21.

RECOMMENDATION 1: The GAO recommended that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs to require that discussions be held with the contractor, and as appropriate, the contract modified to clearly state how prevailing charges are to be established for fee setting purposes, including the method and frequency for reviewing and, as appropriate, revising the fee schedules. (p. 34/GAO Draft Report)

DoD RESPONSE TO THE DRAFT REPORT: Nonconcur. In its proposal, the contractor was required to commit to a five year firm, fixed price for the provision of dental care services to enrolled beneficiaries. This contractual vehicle was selected by the Department as part of a conscious strategy, in accordance with the Federal Acquisitions Streamlining Act (FASA), to seek best business practices from the commercial market where those services are readily available from commercial sources. A key component of FASA is to use a more outcomes-based approach to procurements, rather than a detailed, prescriptive, process-oriented approach. To require the contractor to commit to regular, periodic fee schedule adjustments would undermine this strategy, in that it would almost certainly increase the cost of the program, with a resulting increase in premiums - which must be shared with enrollees. Further, specifying the methodology that the contractor must follow to establish its reimbursement schedules would unnecessarily constrain the contractor's ability to take advantage of innovative financing methodologies (best business practices) which may further reduce costs to the government and enrollees. At present, the contractor is incentivized to establish prevailing fee schedules, for participating and nonparticipating providers, at a level which ensures that it can maintain a robust and contractually adequate network of participating providers. As was stated in the draft report, in those areas where the contractor fails to establish an adequate network, it must pay full charges, less any required enrollee cost share.

Now on p. 21.

RECOMMENDATION 2: The GAO recommended that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs to require that future Family Member Dental Plan Requests for Proposal require that the contractor's start-up fees it pays to dentists reflect prevailing charges established in the same manner as above, or if needed, be adjusted with a trend factor to approximate such charges. (p. 34/GAO Draft Report)

DoD RESPONSE TO THE DRAFT REPORT: Partially concur. Future Family Member Dental Plan Requests for Proposal will incorporate a requirement that start of health care delivery fee schedules be based upon currently available prevailing charge data. It may be expected, however that inclusion of this provision will result in increased costs to the government and beneficiaries as the result of risk premiums that offerors will incorporate in their bids. As stated previously, the Department continues to seek best business practices from the commercial market place and does not believe it prudent to unnecessarily constrain the contractor's ability to develop or take advantage of innovative financing methodologies (best business practices) which may

further reduce costs to the government and enrollees. For this reason, the Department does not believe it appropriate to require the contractor to commit to review, and potentially adjust fee schedules on a government-specified schedule. Likewise, the Department maintains that the true test of the “appropriateness” of provider of fee schedules (under a firm, fixed-price contract) is the ability of the contractor to build and maintain an adequate participating provider network.

RECOMMENDATION 3: The GAO recommended that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs to require a contract oversight strategy be developed that efficiently targets the (1) appropriateness of Concordia’s fee schedules; (2) adequacy of its networks; (3) timelines of its claims and predeterminations processing; and (4) efficacy of its marketing activities. (p. 35/GAO Draft Report)

DoD RESPONSE TO THE DRAFT REPORT: Concur with comment. In its draft report, GAO states that “Concordia’s network of participating dentists now amply meets DOD’s requirement for access to a general dentist within 35 miles of a beneficiary’s home.” GAO further states that “...between February and November 1996, [Concordia] increased the number of participating dentists from about 31,000 to nearly 45,000...” Of this nearly 15,000 participating dentist increase, nearly 10,000 dentists became participating dentists between February 1996 and August 1996 -- prior to Concordia’s implementation of their revised fee schedules. The Department believes this is *prima facie* evidence that Concordia’s fee schedules were, and remain, “appropriate.” The Department further notes that the investigators’ review of February through September 1996 claims records show that Concordia is now processing claims for participating and nonparticipating dentists within the 90 percent, 21 day established time limit” and that Concordia’s marketing activities meet contract requirements.” Prior to start of health care delivery, a team of government evaluators conducted a week-long, on-site test and evaluation of the contractor’s claims processing system known as a benchmark test. This benchmark test is designed to verify the contractor’s ability to accurately process the full range of claims they may be expected to receive. The contractor successfully passed this evaluation. In addition, the “in progress reviews” to which GAO refers on page 32 of their draft report were comprehensive briefings requested by, and presented to, the Deputy Assistant Secretary of Defense for Health Services Financing (DASD/HSF) and representatives of the military departments. Conducted on two separate occasions prior to the start of health care delivery, these briefings were presented by the senior Concordia executives responsible for contract performance. Briefing topics included provider network development, claims processing, and marketing. These briefings were also attended by the Contracting Officer’s Representative; DoD and Service Project Officers; and the Department’s dental consultant. Approximately one month after the start of health care delivery, the DASD/HSF also conducted a site visit to Jacksonville, North Carolina, accompanied by the Chief, Navy Dental Corps, and appropriate staff. During this visit, the DASD attended “Town Hall Meetings,” with beneficiaries, and called on the senior Marine Corps flag officers in the Jacksonville area to discuss their concerns with the contract transition and contractor performance. During this visit, Department representatives were observers at a meeting between the contractor and local dentists. The Department believes that, far from representing a “hands off” approach to contract oversight, this report, and the activities of a wide range of DoD officials, clearly leads to the conclusion that the Department’s proactive “contract oversight strategy” assures it and the Congress that the contractor is performing as required.

Now on p. 21.

Now on pp. 19-20.

GAO DRAFT REPORT--DATED FEBRUARY 13, 1997
GAO CODE 101495/OSD CASE 1295
"DEFENSE HEALTH CARE: Dental Contractor Overcame Initial Obstacles, But More Proactive
DoD Oversight Needed"

DEPARTMENT OF DEFENSE GENERAL COMMENTS

Health Affairs (HA) agrees that the contractor has overcome initial obstacles to its performance, however we do not concur with the assertion that the HA has taken a "hands off" approach to contract oversight. Further, we disagree with GAO's contention that we "thus far ha(ve) not acted to assure (the Department) and the Congress that the contractor is performing as required." In fact, administration of the Family Member Dental Plan (FMDP) by United Concordia Companies, Inc. has received regular and consistent oversight by a broad range of HA personnel, including those at the most senior levels within the Assistant Secretary's office. ASD/HA personnel have actively and regularly evaluated and overseen the contractor's performance since the earliest stages of the transition period. HA oversight has included the following activities:

- On two separate occasions prior to the start of health care delivery, the Deputy Assistant Secretary of Defense, Health Services Financing (DASD/HSF) requested, and was provided, comprehensive briefings on the status of the contractor's transition activities. These briefings were conducted by the senior contractor executives responsible for contract performance. Briefing topics included provider network development, claims processing, and marketing. These briefings were also attended by the Contracting Officer's Representative; Department and Service Project Officers; and ASD/HA's dental consultant. The DASD/HSF also conducted a site visit to Jacksonville, North Carolina, accompanied by the Chief, Navy Dental Corps, and appropriate staff. During this visit, the DASD participated in "Town Hall Meetings," with beneficiaries and called on the senior Marine Corps flag officers in the Jacksonville area to discuss their concerns with the contract transition and contractor performance. During this visit, ASD/HA's FMDP project officer and dental consultant were observers at a meeting between the contractor and local dentists.
- Prior to start of health care delivery, a team of government evaluators conducted a week-long, on-site test and evaluation of the contractor's claims processing system. This evaluation, known as a benchmark test, is designed to verify the contractor's ability to accurately process the full range of claims they may be expected to receive. It is a standard evaluation that has long been used to assess the readiness of CHAMPUS fiscal intermediaries. The contractor passed this evaluation.
- As noted in the draft report, "(s)ince April 1996, the Contracting Officer's Representative has twice visited Concordia's facility for two day meetings and to observe claims and customer service operations ... Also, the Contracting Officer's representative and DOD dental project officers have met with Concordia to focus on internal administrative action items and seek general information updates from the contractor." Assertions that the forgoing represent "a 'hands off' approach to oversight" are not supported by fact.

Appendix IV
Comments From the Department of Defense

HA concurs that the February 1996 fee schedule instituted by Concordia was based on less up-to-date charge data than were its revised August 1996 fees. Any potential contract compliance impact of this observation is speculative. We note that, according to Figure 1 of the draft report, the Concordia participating provider network grew nearly 30 percent between February 1996 and August, 1996. Figure 1 indicates that the network continued to grow through November 1996, the last month shown. We submit that, under a firm, fixed-price contract, the ability of the contractor to attract and retain participating providers in its network, is proof that provider reimbursement rates are "appropriate." GAO's comment that "without reasonable fees and targeted DOD surveillance, installations could gradually lose dentists and imperceptibly fail to meet local populations' needs" is further speculation which is contradicted by the network growth reported in Figure 1 of the draft report.

HA concurs with GAO's observation that the contractor is under no contractual requirement to review and update its fee schedules. We reiterate, however, that the contractor is contractually obligated to maintain an adequate network of participating providers and that the penalty for failing to maintain an adequate network is that the contractor must pay actual charges. This provision is consistent with the Department's acquisition strategy and the spirit and intent of the Federal Acquisition Streamlining Act, which emphasizes outcome-based performance requirements rather than highly prescriptive process requirements. HA further notes that the contractual provisions regarding appropriateness of fees under the current contract are identical to the previous contract. The GAO comment that "(h)ypothetically," a contractor could unfairly enhance its profitability" is speculation which does not bear on contract performance -- especially in a firm, fixed-price contract.

HA concurs with GAO's observation that the contractor has been unsuccessful in establishing adequate networks in two small, remote locations (Mountain Home, Idaho and Fallon, Nevada) as well as the Jacksonville/Havelock, North Carolina area. GAO notes in its draft report, however, that in all other areas they surveyed, Concordia's network amply meets the 35 mile access standard of the contract. GAO notes that data were not available to reliably measure whether Concordia's network complied with the 21 day appointment requirement. ASD/HA concurs with this observation.

HA concurs with GAO's observation that Concordia is processing claims and predetermination requests within contract standards. We likewise concur with the GAO observation that the contractor's marketing activities meet contract requirements. We again call attention to Concordia's successful completion of the benchmark test and note, for information, that all marketing materials developed by the contractor must be reviewed and approved by the government prior to release to the beneficiary community. This government review even extends to briefing slides used by Concordia's Dental Benefits Advisors in their presentations to service groups.

HA concurs with GAO's conclusion that United Concordia Companies, Inc. is performing in accordance with the terms of their contract with the government. We submit that GAO's observations clearly lead to the conclusion that this is the result of close, consistent, and proactive oversight at all levels within the Office of the Assistant Secretary of Defense for Health Affairs.

GAO Contacts and Staff Acknowledgments

GAO Contacts

Daniel M. Brier, Assistant Director, (202) 512-6803
Carolyn R. Kirby, Evaluator-in-Charge, (202) 512-9843

Staff Acknowledgments

In addition to those named above, the following individuals made important contributions to this report: Bonnie Anderson, who evaluated the adequacy of Concordia's fees and participating dentist network; Jean Chase and Darrell Rasmussen, who evaluated Concordia's claims processing and marketing performance and DOD's oversight; Vanessa Taylor and Robert DeRoy, who analyzed Concordia's claims processing timeliness; Dayna Shah, who provided legal analysis of Concordia's contract performance and DOD's oversight; and Pamela Tumler and Nancy Crothers, who provided writing assistance.

Ordering Information

The first copy of each GAO report and testimony is free. Additional copies are \$2 each. Orders should be sent to the following address, accompanied by a check or money order made out to the Superintendent of Documents, when necessary. VISA and MasterCard credit cards are accepted, also. Orders for 100 or more copies to be mailed to a single address are discounted 25 percent.

Orders by mail:

U.S. General Accounting Office
P.O. Box 6015
Gaithersburg, MD 20884-6015

or visit:

Room 1100
700 4th St. NW (corner of 4th and G Sts. NW)
U.S. General Accounting Office
Washington, DC

Orders may also be placed by calling (202) 512-6000
or by using fax number (301) 258-4066, or TDD (301) 413-0006.

Each day, GAO issues a list of newly available reports and testimony. To receive facsimile copies of the daily list or any list from the past 30 days, please call (202) 512-6000 using a touchtone phone. A recorded menu will provide information on how to obtain these lists.

For information on how to access GAO reports on the INTERNET, send an e-mail message with "info" in the body to:

info@www.gao.gov

or visit GAO's World Wide Web Home Page at:

<http://www.gao.gov>

**United States
General Accounting Office
Washington, D.C. 20548-0001**

**Bulk Rate
Postage & Fees Paid
GAO
Permit No. G100**

**Official Business
Penalty for Private Use \$300**

Address Correction Requested

