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Testimony

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MEDICARE

Better Information Can
Help Ensure That
Refinements to BBA
Reforms Lead to
Appropriate Payments

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Health Financing and Public Health Issues
Health, Education, and Human Services Division



GAO

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Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today as you discuss the effects of the Balanced Budget Act of 1997 (BBA) on the Medicare program. BBA set into motion significant program changes to both modernize Medicare and rein in spending. The act's constraints on providers' fees, increases in beneficiary payments, and structural reforms together were projected to lower Medicare spending by \$386 billion over the next 10 years. Although some BBA provisions are in effect, data relevant to their impact are generally limited to date; other provisions have not yet been fully phased in. As a result, the act's full effects on providers, beneficiaries, and taxpayers will remain unknown for some time.

BBA's Medicare provisions were enacted in response to rapid program spending growth that was neither sustainable nor readily linked to demonstrated changes in beneficiary needs. The act's payment reforms represented bold steps to control Medicare spending by changing the financial incentives inherent in payment methods that, prior to BBA, did not reward providers for delivering care efficiently. To date, the Congress has remained steadfast in the face of intense pressure to roll back certain BBA payment reforms while waiting for evidence that demonstrates the need for modifications. Calls for BBA changes come at a time when federal budget surpluses and lower-than-expected growth in Medicare outlays could make it easier to accommodate higher Medicare payments. However, as the Comptroller General cautioned last week, the surpluses are merely projections that could fall short of expectations, and the imperative remains to find the reforms that will make Medicare sustainable and affordable for the longer term.¹

My comments today focus on payment reforms affecting certain providers in Medicare's traditional fee-for-service program and providers in Medicare's managed care program. Specifically, I will discuss the effects on three providers of post-acute care services—home health agencies (HHA), skilled nursing facilities (SNF), and providers of outpatient

¹Medicare Reform: Ensuring Fiscal Sustainability While Modernizing the Program Will Be Challenging (GAO/T-HEHS/AIMD-99-294, Sept. 22, 1999).

rehabilitation therapy—and on the health plans participating in the Medicare+Choice program.

In brief, some providers of post-acute care and health plans in the Medicare+Choice program may have to rethink their business strategies as a result of BBA payment reforms, which seek to make Medicare a more efficient and prudent purchaser. Imperfections in the design of BBA-mandated payment systems require attention, and better information can help policymakers distinguish between desirable and undesirable consequences. Based on such knowledge, refinements can help ensure that payments are not only adequate in the aggregate but are also fairly targeted to protect individual beneficiaries and providers. Our issued and ongoing studies of various payment methods are instructive in this regard, and a summary of our results to date follows.

- Home health care: Our work indicates that (1) the reductions in the number of HHAs and changes in utilization were consistent with the objectives of the interim payment system to control the rapid growth that had preceded BBA and (2) appropriate access to Medicare's home health benefit has not been impaired. However, the prospective payment system (PPS) is a more appropriate tool for the long term than the interim payment system, because it is intended to adjust payments for differences in beneficiary needs. As we examine the challenges of designing a PPS, we are finding that that the PPS will likely require further adjustments after it is implemented as more information on home health costs, utilization, and users becomes available.
- SNF care: A PPS was implemented beginning in July 1998 with a 3-year transition to fully prospective rates, giving providers time to adjust to the new system. Our ongoing work suggests that factors in addition to the PPS have contributed to fiscal difficulties for some corporations operating SNFs. Nevertheless, certain modifications to the PPS may be appropriate to ensure that payments are targeted to patients who require more costly care. The potential access problems that may result if Medicare underpays for high-cost cases could lead to beneficiaries' staying in acute

care hospitals longer, rather than foregoing care altogether. HCFA is aware of this potential targeting problem and is working to develop a solution.

- Caps on coverage of outpatient rehabilitation therapy: In 1999, BBA established an annual \$1,500 per-beneficiary cap on payments for outpatient physical therapy and speech/language pathology services combined and a separate \$1,500 cap on outpatient occupational therapy. The caps reflect a legitimate need to constrain service use. For the vast majority of outpatient therapy users, the caps are unlikely to curtail access to services. Only a small share of beneficiaries receiving therapy services are high users. Further, most outpatient therapy users will likely have access to hospital outpatient departments, which are not subject to the \$1,500 caps. In addition, owing to HCFA's partial approach to enforcing the caps, noninstitutionalized beneficiaries can avoid having the caps curtail service coverage by switching providers. Whether the caps restrict coverage for a small share of nursing home residents is less straightforward. A need-based payment system could help better target payments toward beneficiaries who genuinely require more services than allowed under the current dollar limits.
- Payments to Medicare+Choice health plans: Several BBA provisions address the long-recognized problem of excess payments to Medicare+Choice plans. Some provisions have begun to be phased in, such as reducing the annual rate updates; others have not yet become effective, such as the use of a risk adjustment method based on beneficiary health status. The net effect of the implemented revisions has been modest and, on average, has likely removed only a portion of excess payments built into the base rates. Moreover, the recent and upcoming rounds of plan withdrawals from Medicare are not, as the industry has argued, fully attributable to Medicare's lowered payment rates. The evidence emerging from recent rounds of withdrawals suggests that market share, enrollment size, and competition from other health plans factor into a plan's decision to participate in Medicare. Critical to making Medicare+Choice payment modifications are the establishment of an appropriate base rate and of a risk adjustment method that pays more for serving

beneficiaries with serious health problems and less for serving relatively healthy individuals.

BACKGROUND

The Medicare program consists of two parts: “hospital insurance,” or part A, which covers inpatient hospital, skilled nursing facility, hospice, and certain home health care services; and “supplementary medical insurance,” or part B, which covers physician and outpatient hospital services, outpatient rehabilitation services, home health services under certain conditions, diagnostic tests, and ambulance and other health services and supplies.

Growth in Medicare Spending for Home Health Care

During much of the 1990s, home health care was one of Medicare’s fastest growing benefits; between 1990 and 1997, Medicare spending for home health care rose at an annual rate of 25.2 percent. Several factors accounted for this spending growth, most notably the relaxation of coverage guidelines. In response to a 1988 court case, a change in the coverage guidelines essentially transformed the benefit from one that focused on patients needing short-term care after hospitalization to one that also serves chronic, long-term-care patients.² The loosening of coverage and eligibility criteria contributed to an increase in the number of beneficiaries receiving services and the volume of services they received. Associated with this rise in utilization was an almost doubling in the number of Medicare-certified HHAs to 10,524 by 1997.

Also contributing to the historical rise in home health care spending were a payment system that provided few incentives to control how many visits beneficiaries received and lax Medicare oversight of claims. As we noted in a previous report, even when controlling for diagnoses, substantial geographic variation existed in the provision of home health care, with little evidence that the differences were warranted by patient care

² Duggan v. Bowen, 691 F. Supp. 1487 (D.D.C. 1988).

needs.³ Additional evidence indicates that at least some of the high use and the large variation in practice represented inappropriate billings and unnecessary care.⁴ Medicare oversight declined at the same time that spending mounted, contributing to the likelihood that inappropriate claims would be paid. To begin to control spending, BBA implemented an interim payment system for HHAs beginning October 1, 1997. A PPS is scheduled to be implemented for all HHAs on October 1, 2000.⁵

Growth in Medicare Spending

For SNF Care

As required by BBA, on July 1, 1998, SNFs began a 3-year transition to a PPS, under which providers are paid a prospective rate for each day of care. Previously, SNFs were paid the reasonable costs they incurred in providing Medicare-covered services. Although there were limits on the payments for the routine portion of care (that is, general nursing, room and board, and administrative overhead), payments for ancillary services, such as rehabilitative therapy, were virtually unlimited. Because higher ancillary service costs triggered higher payments, facilities had no incentive to provide these services efficiently or only when necessary. Thus, between 1992 and 1995, daily ancillary costs grew 18.5 percent a year, compared to 6.4 percent for routine service costs. Moreover, new providers were exempt from the caps on routine care payments for up to their first 4 years of operation, which encouraged greater participation in Medicare.

³Medicare: Home Health Utilization Expands While Program Controls Deteriorate (GAO/HEHS-96-16, Mar. 27, 1996).

⁴Medicare: Improper Activities by Mid-Delta Home Health (GAO/T-OSI-98-6) and Office of the Inspector General, Department of Health and Human Services, Variation Among Home Health Agencies in Medicare Payment for Home Health Services (July 1995). Our 1997 analysis of a small sample of high-dollar claims found that over 40 percent of these claims should not have been paid by the program. See Medicare: Need to Hold Home Health Agencies More Accountable for Inappropriate Billings (GAO/HEHS-97-108, June 13, 1997).

⁵BBA required the HHA PPS to be in place on October 1, 1999. Subsequent legislation delayed the implementation by 1 year, eliminating any transition period.

Growth in Medicare Spending for Outpatient

Rehabilitation Therapy Services

Rehabilitation therapy comprises a substantial portion of the post-acute-care services provided by SNFs and other providers, such as rehabilitation therapy agencies and comprehensive outpatient rehabilitation facilities. Between 1990 and 1996, payments for outpatient rehabilitation therapy alone rose at an average rate of 18 percent a year, compared to 9.7 percent average growth rate for the same period for overall Medicare spending. BBA reforms were designed to control both the price and volume of therapy services provided in outpatient settings—the former by a fee schedule and the latter by per-beneficiary coverage caps.⁶ Specifically, BBA limits coverage for outpatient therapy to \$1,500 per beneficiary for physical therapy and speech/language pathology services, with a separate \$1,500 per-beneficiary limit for occupational therapy. Hospital outpatient departments are exempt from these coverage limits.

Historical Overpayments to

Medicare Health Plans

BBA sought to moderate Medicare's payments to managed care plans because beneficiaries who joined Medicare managed care cost—not saved—the government money. That is, the government was paying more to cover beneficiaries in managed care—an estimated several billion dollars more—than it would have if these individuals had remained in the traditional fee-for-service program. Medicare payments to managed care plans have been estimated to be too high by as much as 16 percent.⁷ Beginning in 1998, BBA made several changes to the method used to set Medicare+Choice plan payments, not all of which will reduce excess payments. Among other things, BBA

⁶Payments for inpatient rehabilitation therapy services, such as those provided by SNFs, HHAs, and rehabilitation facilities, are not subject to the fee schedule and are paid under other rules. In addition, outpatient therapy provided by critical access hospitals is not subject to the fee schedule.

⁷In a 1996 study, HCFA estimated that payments were too high by 8 percent in 1994. [See Gerald Riley and others, "Health Status of Medicare Enrollees in HMOs and the Fee-for-Service Sector in 1994. *Health Care Financing Review*, vol. 17, no 4 (Summer 1996)]. In a 1997 study, we estimated that aggregate payments to California plans were too high by 16 percent. [See Medicare HMOs: [HCFA Can Promptly Eliminate Hundreds of Millions in Excess Payments](#) (GAO/HEHS-97-16, Apr. 25, 1997)].

required a new risk adjustment method—a mechanism for adjusting payment rates on the basis of a beneficiary’s expected annual health care costs. It will be implemented in two stages. Beginning in 2000, HCFA plans to phase in an interim method based on inpatient hospital data; in 2004 it plans to implement a more comprehensive method incorporating additional medical data from other settings. The interim risk adjustment, if fully phased in, would reduce payments by 7 percent. BBA also reduced updates to health plan payment rates for a 5-year period ending 2002, for a cumulative rate reduction of less than 3 percent. However, the effect of these reductions is substantially moderated because BBA used 1997 payment rates as the foundation for rates in 1998 and future years. According to HCFA actuaries, a forecast error caused the 1997 rates to be an estimated 4.2 percent too high and, consequently, aggregate plan payments in 1998 were \$1.3 billion too high. The excess payments resulting from this forecast error will increase over time with managed care enrollment because it is built into the base rate.⁸

LITTLE EVIDENCE TO DATE OF IMPAIRED ACCESS
TO HOME HEALTH SERVICES, BUT FUTURE
PAYMENT SYSTEM WILL REQUIRE REFINEMENTS

BBA’s new payment policies addressing rapid spending growth for home health care included the establishment of an interim payment system, which is currently in effect, and a requirement to replace that system with a PPS by October 2000. Our published and ongoing studies discuss the effects of these BBA payment reforms and concerns about their design and implementation.

Concerns have been raised about the effect of the interim system, but, as we reported in May 1999, there was little evidence that appropriate access to Medicare’s home health benefit has been impaired.⁹ The pre-BBA payment system had controls for payments per visit but left volume unchecked. Since enactment of BBA, home health agencies have been paid under the interim payment system, which attempts to control the costs and total

⁸BBA did not allow HCFA to adjust the 1997 rates for forecast errors, although such adjustments had been a critical component of the pre-BBA rate-setting process. BBA permits HCFA to correct forecasts in future years but did not include a provision to allow a correction of its 1997 forecast.

volume of services. Indeed, our work indicates that overall home health utilization in the first 3 months of 1998 was below that in 1996 when Medicare spending for home health services nearly peaked. Moreover, the sizeable variation in utilization across counties has narrowed, a change consistent with the incentives of the interim payment system. Although these changes occurred at the time that about 14 percent of HHAs closed their doors to Medicare business, we found little evidence that beneficiary access to services was inappropriately curtailed.

Nevertheless, a home health PPS is a more appropriate payment tool because it can align payments with patient needs. Under PPS, payments will reflect the needs of the agencies' current beneficiaries rather than historical spending patterns. However, our ongoing work on this subject shows that a number of design issues remain, and the payment system will likely require continued adjustments even after implementation next year. It appears that HCFA intends to pay HHAs a per-episode rate for each 60-day period during which a patient receives services. Such per-episode payments are designed to balance competing goals of controlling service provision while giving HHAs flexibility to vary the intensity or mix of services delivered during the episode. Evidence indicates that HHAs do lower their costs in response to prospective payments for an episode of care. Whether they will inappropriately cut care remains to be seen. Under this prospective payment approach, HHAs also have incentives to increase the number of episodes of care provided, which could escalate, rather than constrain, Medicare spending. HCFA will need to adequately monitor service provision to ensure that beneficiaries receive the care they need and the number of episodes are not inappropriately increased.

The design of the case-mix adjustment mechanism is critical to adequately pay for patients with high service needs, yet not overpay for others with lower needs. Designing this mechanism requires detailed information about services and beneficiary characteristics, and such information is currently available only for a sample of users.

⁹Medicare Home Health Agencies: Closures Continue With Little Evidence Beneficiary Access Is Impaired (GAO/HEHS-99-120, May 26, 1999).

Furthermore, the wide geographic and agency-level variation in service use indicates that standards of care are not well-defined, nor are the criteria for who should use the benefit. As a result, the factors that will be used under PPS for grouping patients with similar resource needs may not adequately distinguish among types of home health patients, and the PPS payment adjuster that will be associated with each patient group may not reflect appropriate cost differences. Systematic errors could result in overpayments for some beneficiaries and underpayments for others. Underpayments could lead to impaired access.

Large variations in historic spending patterns mean that a PPS, which will be based on average payment amounts, will undoubtedly cause payment levels to rise for certain HHAs and fall for others. Although the PPS may incorporate an outlier policy—that is, extra payments for extremely costly cases—additional mechanisms to moderate payment changes may be appropriate. For example, an “inlier” policy to reduce the payment for a patient who receives few services may be warranted, particularly given the fact that multiple episode payments may be made for a single beneficiary. Policies addressing both extremes of service use could protect the access of beneficiaries with high needs and protect Medicare from overpaying for low-cost cases. A risk-sharing method, to account for cost differences across agencies, could provide further protection against underpayments or overpayments. Given the heterogeneous use of this benefit and the unresolved PPS design issues, moderating payments through risk-sharing might be warranted, even though such a mechanism would weaken HHAs’ incentives to provide care more efficiently.

**AGGREGATE PAYMENTS TO SNFs ARE ADEQUATE,
BUT REFINEMENTS NEEDED TO HELP MATCH
PAYMENTS TO PATIENTS’ SERVICE NEEDS**

Despite industry charges to the contrary, SNF payment rates under BBA are likely to provide sufficient, or even generous, compensation for providers. Nevertheless, the distribution of these payments may be out of balance, because the current case-mix adjustment method may not adequately ensure that providers serving high-cost

beneficiaries are paid enough and that those serving low-cost beneficiaries are not paid too much.

Under the new PPS, SNFs receive a payment for each day of covered care provided to a Medicare-eligible beneficiary. By establishing fixed payments and including all services provided to beneficiaries under the per diem amount, the PPS attempts to provide incentives for SNFs to deliver care more efficiently. Under the PPS, SNFs that previously boosted their Medicare ancillary payments—either through higher use rates or higher costs—will need to modify their practices more than others. Scaling back the use of these services, however, may not necessarily affect the quality of care. There is little evidence to indicate that the rapid growth in Medicare spending was due to a commensurate increase in Medicare beneficiaries' need for services.

Recent industry reports have questioned the ability of some organizations that operate SNF chains to adapt to the new PPS. Indeed, Medicare payment changes have been blamed for one corporation's filing for protection under bankruptcy law and the potential for another to similarly file. However, our ongoing work suggests that the PPS should not have an untoward impact on most SNFs and is only one of many factors contributing to the poor financial performance of these corporations. For most SNFs Medicare patients constitute a relatively small share of their business. In addition, the PPS rates are being phased in, to allow time for facilities to adapt to the new payment system, and most of the payments are still tied to each facility's historical costs. However, heavy investments in the nursing home and ancillary service businesses in the years immediately before the enactment of BBA, both to expand their acquisitions and upgrade facilities to provide higher-intensity services, has created difficulties for some corporations. Now under tighter payment constraints for both their SNF and ancillary service operations, these debt-laden enterprises will not be able to rely on overly generous Medicare payments. Thus, while PPS does represent a constraint on Medicare revenue and SNFs will have to adapt, the performance of some large post-acute providers is a reflection of many Medicare payment policy changes and strategic decisions made during a period when Medicare was exercising too little control over its payments. We

are gathering additional information and will report soon on the effect of the PPS on SNF solvency and beneficiary access to care.

We believe that overall payments to SNFs are adequate. In fact, we and the Department of Health and Human Services Inspector General (HHS IG) are concerned that the PPS rates Medicare pays may be too generous. Most of the data used to establish these rates—from 1995 cost reports—have not been audited and are likely to include excessive ancillary costs due to the previous system’s incentives and the lack of appropriate program oversight.¹⁰

We are also concerned that payments for individual beneficiaries could be inappropriately too high or low because of certain PPS design problems. The first of these involves the patient classification system. The classification system was based on a small sample of patients and, because of the age of the data, may not reflect current treatment patterns. As a result, it may aggregate patients with widely differing needs into too few payment groups that do not distinguish adequately among patients’ resource needs. In addition, the variation in non-therapy ancillary services costs does not appear to have been adequately accounted for in the payment rates, which may inappropriately compress the range in payments. Accordingly, access problems or inadequate care could result for some high-cost beneficiaries. Hospitals have reported an increase in placement problems due to the reluctance of some facilities to admit certain beneficiaries with high expected treatment costs, which will increase hospital lengths of stay for these patients. HCFA is aware of the limitations of the patient classification system and is working to refine the system to more accurately reflect patient differences.

Another concern is that the current patient classification system preserves the opportunity for SNFs to increase their compensation by supplying unnecessary services. A SNF can benefit by manipulating the services provided to beneficiaries, rather than increasing efficiency. For example, by providing certain patients an extra minute of therapy over a

defined threshold, a facility could substantially increase its Medicare payments without a commensurate increase in its costs.

WIDESPREAD EFFECT OF OUTPATIENT THERAPY
CAPS DOUBTFUL, BUT NEED-ADJUSTED
PAYMENT LIMITS WOULD BE BETTER

Questions have been raised about a BBA coverage restriction for a third group of post-acute-care services—outpatient rehabilitation therapy. Together with a fee schedule that replaces reasonable cost reimbursement for these services, BBA established an annual \$1,500 per-beneficiary cap on payments for outpatient physical therapy and speech/language pathology services combined and a separate \$1,500 per-beneficiary cap on outpatient occupational therapy.¹¹ Services provided by hospital outpatient departments are exempt from the per-beneficiary caps.

Rehabilitation therapy providers have raised concerns that the \$1,500 limits will arbitrarily curtail necessary treatments for Medicare beneficiaries, particularly victims of stroke, hip injuries, or multiple medical incidents within a single year. These concerns have led to several legislative proposals to include various exceptions to the caps or eliminate them altogether.

Our ongoing work on this topic suggests that eliminating the caps without substituting other controls could undermine BBA's comprehensive strategy for restricting payments for outpatient therapy services. Controlling the price for each unit of service—as is done with the new requirement that outpatient therapy providers be paid using Medicare's physician fee schedule—may not necessarily control Medicare expenditures if utilization

¹⁰The HHS IG recently reported on the inappropriateness of the base year costs. See Physical And Occupational Therapy in Nursing Homes: Cost of Improper Billings to Medicare (HHS IG, OEI-09-97-00122, Aug. 1999).

¹¹Physical therapy includes treatments—such as whirlpool baths, ultrasound, and therapeutic exercises—to relieve pain, improve mobility, maintain cardiopulmonary functioning, and limit the disability from an injury or disease. Speech/language pathology services include the diagnosis and treatment of communication, swallowing, oral motor and related cognitive functions and their disorders. Occupational therapy helps patients learn the skills necessary to perform daily tasks, diminish or correct pathology, and promote health.

rises. This is particularly likely, given the price and utilization controls established through PPSs on other providers of rehabilitation therapy. Thus, the per-beneficiary caps serve to limit the volume of services provided.

For the vast majority of beneficiaries, the coverage caps are unlikely to curtail access to needed services. An analysis by the Medicare Payment Advisory Commission shows that, in 1996, most users (86 percent) did not exceed \$1,500 in payments for physical therapy and speech/language pathology services or for occupational therapy.¹² Moreover, as the fee schedule likely reduces payments for many providers, the proportion of beneficiaries that are unaffected by the caps could be even higher in 1999 because beneficiaries could receive more services before reaching the per-beneficiary caps than under the former cost-based system.

Even for beneficiaries exceeding \$1,500 in payments under the fee schedule, mitigating factors exist. First, under the BBA exemption, Medicare beneficiaries have no limits on coverage for rehabilitation therapy provided by hospital outpatient departments, which are widely available nationwide. In addition, the caps will initially not be applied as specified in BBA. Implementing the caps involves many programming changes to Medicare's automated information systems that HCFA is unable to undertake concurrent with its year 2000 preparation efforts. As a result, HCFA's claims processing contractors will be unable to track therapy payments on a per-beneficiary basis. Instead, effective January 1, 1999, HCFA employed a transitional approach to implementing the caps. Under this approach, each provider of therapy services is responsible for tracking its billings for each Medicare patient and stopping them at the \$1,500 threshold. The consequence of this partial implementation is that noninstitutionalized beneficiaries may switch to a new provider when they have reached the \$1,500 limit under their current provider.

¹²A July 1998 report sponsored by the National Association for the Support of Long-Term Care and NovaCare, a rehabilitation services company, projects that 87 percent of beneficiaries will not exceed the per-beneficiary cap.

The effect of the per-beneficiary caps on nursing home residents is less clear. HCFA's policy explicitly states that the hospital outpatient department exemption does not apply to those therapy services furnished to nursing facility residents. Moreover, the ability of beneficiaries to switch outpatient providers under HCFA's partial implementation approach is, practically speaking, not available to nursing facility residents. Under new billing requirements, the nursing facility in which the beneficiary resides is required to bill for outpatient therapy provided to the resident, regardless of the entity that actually delivered the service. Therefore, unlike their noninstitutionalized counterparts, nursing facility residents cannot switch providers to restart the \$1,500 coverage allowance. Under these circumstances, some nursing home residents—like those needing extensive rehabilitation therapy resulting from such conditions as stroke or hip fractures—could be vulnerable to out-of-pocket costs for therapy.

Even the risk for these more vulnerable beneficiaries may be moderated, however, because nursing home residents seeking therapy for such conditions would likely receive a complement of rehabilitation services as a SNF inpatient—before the outpatient therapy coverage limit begins to apply. For example, individuals suffering a stroke or undergoing hip replacement would likely spend at least 3 days in an acute care hospital, which, combined with the need for daily skilled nursing care or therapy, would make them eligible for a Medicare-covered SNF stay of up to 100 days, during which they would likely receive therapy services. After their Medicare coverage period ends, nursing facility residents can continue to receive outpatient therapy services under Medicare part B, subject to the coverage limits. BBA mandates that HCFA develop a classification system based on diagnosis to determine differences in patients' therapy needs and propose possible alternatives to the caps in a report due January 1, 2001. This report will be significant in that a need-based system could help ensure adequate coverage for those beneficiaries requiring an extraordinary level of services and prevent overprovision to those requiring only limited amounts.

MEDICARE+CHOICE REMAINS RELATIVELY INEXPENSIVE
FOR BENEFICIARIES, BUT IMPROVED RISK ADJUSTMENT
NEEDED TO TARGET PAYMENTS APPROPRIATELY

Developing appropriate refinements to BBA reforms affecting Medicare+Choice requires consideration of several aspects of Medicare's managed care program. At the moment, plan withdrawals from Medicare+Choice in 1999, and recent announcements that additional plans will withdraw in 2000, have prompted debate about whether BBA reforms have resulted in inadequate payment rates. At the same time, our published and ongoing work indicates that Medicare managed care payments to health plans likely continue to exceed the cost of providing Medicare-covered benefits

Our analysis of the 1999 withdrawals showed that payment rates alone could not explain plans' participation decisions. Withdrawals were not limited to low payment rate counties. The data suggested that local market conditions affected plans' participation in a county. A plan was more likely to withdraw from counties it had recently entered, where its enrollment was low, or where its market share was small relative to other plans serving the same county. Although our final analysis will not be available for a few weeks, our preliminary assessment suggests that similar factors help explain the pattern of the 2000 withdrawals.

Plan withdrawals may well reflect a normal market correction spurred by a changing business environment. Prior to BBA, health plans could expand into new areas with relatively little risk because overgenerous Medicare rates provided protection from the ill consequences of small enrollment or large competitors. Between 1993 and 1998, the number of plans and enrollees tripled. However, as BBA slowed payment growth, health plans may have reevaluated their expansion decisions, making such factors as potential enrollment, market share, and competition a key part of plans' decisions to withdraw from certain geographic areas.

A local example illustrates the importance of nonpayment factors in plans' participation decisions. In 1996, Blue Cross' Free State health plan in Maryland—which until that time had served only some of the state's large urban counties—extended service statewide. Free State recently announced, however, that beginning in 2000 it would substantially reduce its geographic service area. The plan is withdrawing from 17 rural and small urban counties even though BBA will increase the average base rate in those counties by nearly 6 percent next year. In contrast, the large urban counties will receive only a 2.4 percent average rate increase, but Free State will continue its Medicare participation in these counties.

According to industry representatives, it is difficult for health plans to serve counties with few providers and enrollees because providers have little incentive to discount their fees and plans cannot spread risk over a large enrollment base. Although we cannot know with certainty, these factors may have influenced Free State's decision to discontinue service in Caroline County and 16 other rural and small urban Maryland counties. For example, in Caroline County Free State faced no competitors, had enrolled 19 percent of the beneficiaries, and would have received a 7.5 percent Medicare rate increase in 2000. However, less than 4,700 beneficiaries live in the county and Free State's 19 percent market share represented an enrollment of less than 900 beneficiaries. In contrast, the plan will continue to serve seven counties where the number of beneficiaries ranges from about 15,200 to 116,600.

In addition to our work on plan withdrawals, our assessment of BBA payment changes indicates that, relative to the cost of providing the package of traditional Medicare benefits, payments to health plans remain excessive. For one thing, plans annually receive a billion-plus-dollar overpayment in aggregate as a consequence of BBA's terms for setting the base payment rate. This problem, owing to an uncorrected forecast error, will be built into future base rates because BBA has not provided explicit authority for HCFA to correct the forecast error. In our June 1999 report, we suggested that the Congress consider certain modifications to Medicare's base payment rates to health plans

to eliminate, among other things, the excess payments resulting from the 1997 uncorrected forecast error.

Moreover, payments continue to exceed plans' costs of providing Medicare-covered services. In 1999, the average plan was required to provide \$54 in extra benefits per member per month so that projected Medicare payments would not exceed the plan's projected costs and normal profits. In addition, the average plan voluntarily provided another \$54 in benefits per member per month. The additional benefits can be reflected not only in coverage for services, but also in reduced beneficiary cost sharing. For example, in 1999 most plans did not charge a monthly premium and charged only a small copayment for outpatient services.

In 2000, enrollment in a Medicare+Choice plan will remain a relatively inexpensive way for a beneficiary to obtain prescription drug coverage in many areas. On average, plans will charge beneficiaries \$16 per month in premiums and most will offer prescription drug coverage. Beneficiaries will be charged a copay for prescription drugs that will average about \$17 for brand name drugs and \$7 for generic drugs. In contrast, the average monthly premium for private supplemental insurance policies (Medigap) offering, among other things, prescription drug coverage ranges from \$136 to \$194 per month in 1999. Moreover, those Medigap policies require a \$250 deductible with a 50-percent copayment.

Given that Medicare has spent more for the generally healthier beneficiaries enrolled in Medicare+Choice plans than for the generally sicker beneficiaries in traditional Medicare, the need to have payments better reflect beneficiaries' expected health care costs is critical. HCFA's new risk adjustment method, based on certain health status measures, is scheduled for phased implementation in 2000 and represents a major improvement over the current method. For the first time, Medicare managed care plans can expect to be paid more for serving beneficiaries with serious health problems and less for serving relatively healthy ones. The method scheduled for implementation in 2004 will be an improvement over the method used in 2000 because it is intended to include

better health status measures derived from more comprehensive data not currently available.

HCFA's plan to phase in the 2000 risk adjustment method slowly is designed to balance the needs of taxpayers and beneficiaries. In 2000, only 10 percent of health plans' payments will be adjusted using the new method. This proportion will be increased each year until 2003, when 80 percent of plans' payments will be adjusted using the interim system. Although a gradual phase-in of the interim risk adjuster delays the full realization of Medicare savings, it also minimizes potential disruptions for both health plans and beneficiaries. In 2004, HCFA intends to implement a more finely tuned risk adjuster that uses medical data from physician offices, outpatient departments, and other health care settings and providers—in addition to the inpatient hospital data on which the interim adjuster is based. This more comprehensive risk adjustment system cannot be implemented currently because many plans say they do not have the capability to report such comprehensive information.

CONCLUSION

In conclusion, BBA payment reforms seek to curb unnecessary Medicare spending. As the reforms begin to have their intended effects, pressure is building to return to more generous payment policies. Evidence to date shows that BBA is moving Medicare in the right direction but that adjustments will be needed along the way. These adjustments should be based on thorough, quantitative assessments so that misdiagnosed problems do not lead to misguided solutions. With the health care of seniors and the tax dollars of all Americans at stake, it will be prudent to uphold new payment policies that exact efficiencies but make adaptations when substantiated evidence supports the need to do so.

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Mr. Chairman, this concludes my prepared statement. I will be happy to answer any questions you or other Members of the Subcommittee might have.

GAO CONTACTS AND ACKNOWLEDGMENTS

For future contacts regarding this testimony, please contact William J. Scanlon at (202) 512-7114. Individuals making key contributions to this testimony included James C. Cosgrove, Hannah F. Fein, and Deborah Spielberg.

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