GAO

United States
General Accounting Office
Washington, D.C. 20548

Health, Education and Human Services Division

B-261060

May 1, 1996

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The Honorable Daniel P. Moynihan
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Committee on Finance
United States Senate

The Honorable Thomas Bliley, Jr.
Chairman
The Honorable John D. Dingell
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Committee on Commerce
House of Representatives

The Honorable Bill Archer
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The Honorable Sam M. Gibbons
Ranking Minority Member
Committee on Ways and Means
House of Representatives

Under legislation the Congress passed in 1987, a demonstration project was authorized to study whether permitting employers or labor organizations to combine Medicare benefits with supplemental benefits might reduce costs for both by managing the combined benefits better than could be done separately.[1] The parameters of this demonstration allowed a maximum of three employment-related groups to agree to pay for Medicare beneficiaries' covered health care services in exchange for a fixed per capita payment from Medicare. Participating employment-related groups are referred to as Medicare Insured Groups (MIG).

OBRA-87 also required that we monitor MIG demonstrations and report periodically on each project's status. For

[1]The Omnibus Budget Reconciliation Act of 1987 (OBRA-87) (P.L. 100-203, sec. 4015(a), Dec. 22, 1987).

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this, our fourth status report,[2] we (1) assessed the status of the demonstration program, (2) determined the status of individual MIG projects that were funded by the Health Care Financing Administration (HCFA), and (3) reviewed efforts to establish a reliable payment update methodology.

To develop this information, we reviewed HCFA and Department of Health and Human Services (HHS) documentation related to each MIG demonstration project. We also discussed the projects with officials from HCFA's Office of Research and Demonstrations and Office of the Actuary. Our work was conducted from March 1995 through February 1996 in accordance with generally accepted government auditing standards.

RESULTS IN BRIEF

Since OBRA-87 was passed, five groups entered into agreements with HCFA to explore the feasibility of operating MIGs. HCFA expenditures related to these agreements are $1.1 million over the last 8 years. As of February 1996, each of these five group agreements had been terminated--three because of concerns, at least in part, that the projects might not be financially successful. None progressed to the point where beneficiaries were enrolled.

HCFA officials terminated the Amalgamated Life Insurance Corporation's MIG project after prolonged delays and problems occurred during Amalgamated's efforts to obtain a health care delivery contract. Amalgamated also was skeptical of the project's financial viability. Both the Chrysler Motors Corporation and the Southern California Edison Company terminated projects after the feasibility stage because of concern that their MIGs would lose money. The Medical Center of Beaver, Pennsylvania, encountered delays in obtaining employer commitments and data needed for rate-setting analysis. It terminated the MIG project after the resignation of a top executive considered essential to the project.

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[2]See Medicare: Status Report on Medicare Insured Group Demonstration Projects (GAO/HRD-89-64, June 27, 1989), Medicare: Second Status Report on Medicare Insured Group Demonstration Projects (GAO/HRD-90-117, June 6, 1990), and Medicare: Third Status Report on Medicare Insured Group Demonstration Projects (GAO/HRD-92-53, Jan. 29, 1992).

The most recent group to terminate its MIG project, John Deere & Company, had developed an operating plan and had proposed a payment rate-setting method. However, Deere encountered several lengthy delays and problems, especially in developing a payment update methodology. The payment methodology proposed by Deere would have established a base rate using 1986 through 1990 claims data and updated this rate using changes to the United States Per Capita Cost (USPCC).[3] However, HCFA and the Office of Management and Budget (OMB) proposed using more recent claims data in determining this rate. This raised the possibility that new data might affect the financial feasibility for Deere's MIG as well as the prospect that additional time and expense would be incurred in reconstructing the rate-setting data. At the time our report was prepared, Deere had not provided its official rationale for deciding not to proceed.

BACKGROUND

Medicare is a federal insurance program that covers most elderly and some disabled people for a broad range of health services. HCFA, an agency within HHS, administers Medicare. Program beneficiaries are responsible for paying deductibles and coinsurance for most covered services. Some employers, labor unions, and other groups supplement Medicare benefits for affiliated retirees by paying these deductibles and coinsurance liabilities, and sometimes by paying for services not covered by Medicare.[4] In these cases, Medicare is billed first for services and pays its share. Then the bill is sent to the supplemental plan so that it can pay its share.

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[3]USPCC is a national estimate of the average incurred benefit cost of a Medicare enrollee. The USPCC rate is determined using estimation techniques.

[4]We estimated that employers spent about $13.7 billion for retiree health benefits in 1993; see Early Retiree Health: Health Security Act Would Shift Billions in Costs to Federal Government (GAO/HEHS-94-203FS, July 21, 1994). Although Medicare-eligible retirees, those 65 years old or older, made up 61 percent of the retirees covered by company health plans, we previously reported that these retirees receive only about one-third of the benefits because Medicare pays most of their health care costs.

In July 1987, HHS submitted a legislative proposal to the Congress to authorize fixed-price per-capita contracts with employment-related health plans that would pay for all Medicare-covered services. Rather than authorizing such contracting at HHS' discretion, the Congress passed a law that permitted HHS to undertake not more than three MIG demonstration contracts in any fiscal year to test the concept. The law also stipulated that expenditures for all the demonstration projects may not exceed $600 million in a fiscal year. Further, it required that the plans be paid a per capita rate equal to no more than 95 percent of Medicare's expected costs during the plans' first 3 years, for beneficiaries eligible to join the MIG.[5] The law also included provisions that protect enrollee rights, help assure that quality care is provided, and require that MIGs have the financial ability to meet health care liabilities.

As formulated by HCFA, a MIG project generally has three phases:

-- Feasibility assessment. Based on the historical cost of providing health care to its retirees and future cost projections, a group assesses the financial viability of operating a MIG.

-- Operating plan development. The group prepares a detailed plan covering the processes and activities necessary to operate a MIG. The plan should include a health care delivery network and a rate-setting methodology.

-- Implementation. The MIG begins enrolling beneficiaries, receives payments from Medicare, and assumes responsibility for Medicare-covered and supplemental health care services.

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[5]This procedure allows Medicare payments to be based on the claims experience of a plan's beneficiaries. In most HCFA managed care arrangements, payments are based on the plan's actual cost or 95 percent of the adjusted average per capita cost (AAPCC) in a county. OBRA-87 stipulates that MIG payments cannot exceed 115 percent of the county-based AAPCC in years 4 and 5 of the demonstration. After the demonstration period, MIG payments are limited to 95 percent of the AAPCC.

Enrollment of Medicare beneficiaries in a MIG must be voluntary. For these enrollees, Medicare makes a fixed capitation payment and the MIG accepts the financial risk of providing the full range of Medicare-covered services. This permits the employment-related group to combine Medicare and Medicare supplemental benefits into a comprehensive health care plan that might produce administrative efficiencies and have better control over prices and utilization of medical services and supplies. Under this theory, Medicare would save money because it would pay lower than expected fee-for-service costs and the employment-based group's costs would be reduced. In addition, MIG enrollees could benefit from having only one party for claims processing.

MIG DEMONSTRATION PROJECT STATUS

Since OBRA-87, HCFA has awarded $1.1 million to explore the MIG initiatives of five employment-related groups (see table 1). None of these groups enrolled individuals in a MIG, and of the five, only Deere developed a MIG operating plan. Two groups (Chrysler Motors Corporation and Southern California Edison Company) terminated their efforts after completing feasibility assessments, and a third (Medical Center of Beaver) terminated during the feasibility assessment phase. HCFA terminated the Amalgamated Life Insurance Company's agreement on June 30, 1995, after a lengthy operating plan development period during which the group failed to submit required reports and made little progress. This group had signed a MIG cooperative agreement with HCFA in October 1987. A detailed discussion of these terminated MIG projects is in the enclosure. The recently terminated John Deere MIG project was the most advanced of the five projects, having progressed to developing an operating plan. A discussion of Deere's project follows table 1.

Table 1: MIG Project Status, February 1996

Group	Agreement date	Current status	HCFA funding
Amalgamated Life Insurance Company	Oct. 1987	Terminated (6/95) after lengthy delays. Problems encountered developing a health care delivery system and demonstrating financial viability.	$279,498
Chrysler Motors Corporation	Mar. 1988	Terminated (8/89) due to concern with financial viability.	225,835
Southern California Edison Company	Jan. 1989	Terminated (7/91) citing costs and regulatory restrictions.	195,825
John Deere & Company	May 1990	Terminated (2/96). Deere has not provided written rationale for its decision.	395,959
Medical Center of Beaver	Dec. 1990	Terminated (4/94) after delays and management change.	31,908

Overview of John Deere & Company MIG

Deere completed a MIG feasibility assessment in August 1991 and submitted an operating plan in September 1994. HCFA approved this plan and, in December 1994, asked OMB to review waivers from Medicare regulations that Deere believed were necessary for the operation to succeed. In December 1995, OMB advised HCFA that it would concur with the waiver request but suggested that the claims data (1986-90) used by Deere to establish a base payment rate

should be updated.[6] HCFA and OMB agreed that payments to Deere could be based on these data for the first year of the MIG operations, but decided that future payments should be based on updates to a HCFA-determined base rate that used more recent claims information.

As of January 1996, HCFA funding for this project was about $396,000. Additional funds would have been required during the implementation phase for project evaluation. As a general rule, HCFA expects companies to absorb one-half their project costs, but HCFA does not have data on such costs incurred by Deere. On March 8, 1996, Deere notified HCFA that it decided to terminate its MIG demonstration project. Deere's final report on the project is due July 1, 1996.

Health Care Delivery at Deere

Deere workers are employed primarily in Illinois and Iowa. They produce farm, construction, and forestry equipment. Deere planned to operate its MIG through a wholly owned subsidiary, John Deere Health Care, Inc., which in turn operates a health delivery system for Deere employees and retirees and for other employers in Illinois and Iowa. Within this system, Heritage National Healthplan, Inc., administers a health maintenance organization that offers access to selected hospitals and physicians with whom it contracts. The system also operates the John Deere Family Healthplan, Inc., a staff model health maintenance organization with its own physicians, nurses, laboratory technicians, and support staff. MIG enrollees would have been given a choice of these delivery options or of a traditional fee-for-service plan that allows enrollees to select any Medicare-certified provider.

About 5,900 Medicare-eligible Deere retirees and spouses are enrolled in a health care prepayment plan operated under a Medicare cost contract. Another 11,100 Medicare-eligible retirees are in Deere's fee-for-service plan. These retirees, or the providers who serve them, can submit claims directly to the plan for payment rather than to Medicare's regular claims processing contractors. The plan pays the retiree, provider, or both and then submits

[6]At the time Deere's payment rate analysis was initiated, these data were the latest available from HCFA.

a claim to Medicare.[7] In 1989, Deere spent about $9 million for supplemental benefits for about 16,000 Medicare-eligible retirees.

PROBLEM DETERMINING HOW TO UPDATE RATES

When HCFA initially proposed contracting with employers to provide Medicare benefits to employers' retirees, HCFA planned to update initial experience-based payment rates using some index of cost growth, such as overall Medicare cost changes. HCFA could not directly update payment rates because MIGs would not be providing claims to HCFA, and thus HCFA would not have ongoing cost data for MIG enrollees. We pointed out that, as time passed, it might become increasingly difficult to measure objectively whether under- or overpayments to MIGs were occurring.[8] We concluded that the MIG rate-setting methodology should be thoroughly tested before the Congress passed general legislation authorizing MIG agreements on a nondemonstration basis.

The methodology proposed by Deere for updating Medicare's experience-based payments would have based HCFA payments on the average per capita cost of Medicare beneficiaries enrolled in Deere's MIG. A base rate would be determined by adjusting 1986 through 1990 claims payment data from Deere retirees (using changes to USPCC) to 1991. During the demonstration period, payments would be made by adjusting the 1991 per capita payment using the annual change in USPCC. Medicare would pay 95 percent of these amounts, which would also be adjusted for demographic characteristics (sex and age of Deere's enrollees) and to localize Deere's claims experience to the MIG service

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[7]As an incentive to encourage beneficiaries to join the managed care components of the MIG, Deere beneficiaries who select the fee-for-service plan will be responsible for handling paperwork involved with reimbursing physician charges not covered by Medicare.

[8]See Medicare: Uncertainties Surround Proposal to Expand Prepaid Health Plan Contracting (GAO/HRD-88-14, Nov. 2, 1987) and Medicare: Third Status Report on Medicare Insured Group Demonstration Projects (GAO/HRD-92-53, Jan. 29, 1992).

area. As mentioned earlier, OMB and HCFA suggested that the base rate be determined by using more recent claims data. However, before payment methodology questions were completely resolved, Deere decided to terminate its project. At the time our work was completed, Deere was initiating work on a final report describing the rationale for this decision.

Under the MIG demonstration project, HCFA planned to collect demographic, enrollee satisfaction, and health service cost and utilization data. Cost and use-of-services data are especially critical in determining whether a proposed updating method is acceptable.

AGENCY COMMENTS AND OUR EVALUATION

The Department of Health and Human Services, following its review of this letter, provided technical comments that we incorporated where appropriate.

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We are sending copies of this report to other congressional committees; the Director, Office of Management and Budget; the Secretary of Health and Human Services; and other interested parties.

Please call me at (202) 512-7119 if you or your staff have any questions. Major contributors to this letter are Thomas G. Dowdal, Assistant Director, and Peter J. Oswald, Evaluator-in-Charge.

Sarah F. Jaggar
Director, Health Financing
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Enclosure

TERMINATED MIG PROJECTS

Each of the five groups that entered into MIG demonstration agreements with HCFA have terminated their projects. The primary contributor to project terminations was concern over the financial viability of MIG operations; however, such factors as problems developing a health care delivery system and regulatory restrictions also entered into these decisions. A description of four of these terminated projects follows.

AMALGAMATED LIFE INSURANCE COMPANY

In October 1987, the Amalgamated Life Insurance Company and HCFA signed a cooperative agreement to study a possible MIG operation. Amalgamated completed a feasibility assessment and began developing a MIG operating plan in September 1988; however, numerous delays occurred and the plan was never completed. HCFA officials terminated the Amalgamated agreement on June 30, 1995, and received Amalgamated's final report on December 21, 1995.

Amalgamated is the administrator for the Amalgamated Clothing and Textile Workers Union health insurance benefit plan, which covered approximately 130,000 retirees and spouses in 1995. Beginning in 1988, the union plan supplemented retirees' Medicare benefits by covering the inpatient hospital deductible and hospital coinsurance. The union provides direct care at subsidized rates to its retirees and active workers through its network of health centers, one of which is in Philadelphia. Medicare-eligible retirees are responsible for part B deductible and coinsurance for services received at these health centers and receive nothing from Amalgamated when other providers are used. The union has 8,000 to 12,000 Medicare-eligible retirees and spouses in the Philadelphia area, which Amalgamated had proposed as the initial site for its MIG demonstration project.

HCFA extended the operating plan development phase under this agreement five times. The reason most often cited for delays in completing the development phase was Amalgamated's difficulties in negotiating a contract for health care delivery. In its final report, Amalgamated also expressed concern with the project's financial viability and cited difficulties in resolving payment rate issues. For example, Amalgamated cited the increased risk

associated with setting rates in relatively small population segments--such as employer groups.

CHRYSLER MOTORS CORPORATION

Chrysler terminated its MIG project efforts after completing a feasibility analysis in 1989. Chrysler made the following conclusions:

-- The MIG could not operate at a profit. Chrysler estimated savings of 3.8 percent--less than the 5-percent reduction from fee-for-service costs that Medicare required.

-- A Chrysler MIG would be unlikely to get provider payment levels as low as Medicare's because the MIG would lack Medicare's market power.

-- A Chrysler MIG could only achieve operating cost levels as low as Medicare's after many years of operation and substantial administrative investments.

SOUTHERN CALIFORNIA EDISON COMPANY

In July 1991, the Southern California Edison Company decided not to proceed past the feasibility analysis phase because of concern about controlling enrollee health costs and regulatory restrictions. For example, the company cited the need to include enrollment change restrictions in a MIG that were at odds with the MIG project's authorizing legislation. Southern California Edison decided that instead of a MIG, it would develop a managed care program for all retirees. If this program was successful, Southern California Edison advised HCFA that it would reconsider instituting a MIG in 1995 or thereafter. As of January 1996, however, the company had not expressed such interest to HCFA officials. Southern California Edison is a self-insured employer offering health benefits to its employees and retirees. The company operates eight primary care clinics and a large corporate pharmacy.

MEDICAL CENTER OF BEAVER, PENNSYLVANIA

A fourth MIG sponsor, the Medical Center of Beaver, terminated its project in April 1994. HCFA had signed a cooperative agreement with the medical center in December 1990 to explore establishing a MIG. The proposal was an

attempt by a health care provider to pool a group of employers to offer their retirees health benefits under the MIG concept. This would give small-to-medium-sized employers an opportunity to participate in a MIG. Because HCFA was concerned about employer commitment to this MIG, HCFA required that before funding the feasibility phase, the medical center obtain letters of commitment from employers willing to join the MIG and obtain information on at least 4,000 total Medicare retirees to assure a credible experience-based analysis. After commitments were obtained from five employers, it became clear to administrators from the Medical Center of Beaver that merging information from these employers would be considerably more difficult than anticipated and would cost far in excess of the proposed budget.

HCFA authorized and disbursed $102,256 for this project. The project was terminated before these moneys were expended and Beaver returned about $70,000. HCFA officials stated that Beaver's termination was related to a change in management at the medical center.

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