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UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, D.C. 20548

HUMAN RESOURCES
DIVISION

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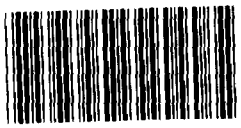
Item on agenda #115

Mr. Jay B. Constantine
Chief, Health Professional Staff
Subcommittee on Health
Committee on Finance
United States Senate

SEP 01105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Dear Mr. Constantine:

Subject: HEW's Contract With Group Health Cooperative of Puget Sound Covering Medical Care Provided to Medicare Beneficiaries--Noncompliance With Open Enrollment Requirements and Other Selected Issues (HRD-80-3)

Pursuant to your August 3, 1979, inquiry, we have examined aspects of the administration of a contract between the Department of Health, Education, and Welfare (HEW) and the Group Health Cooperative of Puget Sound, a health maintenance organization. Under this contract, HEW pays the Cooperative for providing medical care to Medicare beneficiaries enrolled with the Cooperative.

The contract between HEW and the Cooperative is a risk contract. If the actual cost of providing care to the Cooperative's Medicare enrollees is lower than HEW's actuarial estimate of what it would have cost to provide medical care to those enrollees on a fee-for-service basis, HEW makes an incentive payment to the Cooperative to share the savings. If the actual cost of providing care to the Cooperative's Medicare enrollees is higher than HEW's actuarial estimate of what it would have cost to provide medical care to those enrollees on a fee-for-service basis, the difference--referred to as "losses"--must be absorbed by the Cooperative and offset from savings realized in later years.

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For the 15-month contract period from October 1, 1976, through December 31, 1977, the Cooperative received an incentive payment of about $1.3 million because its cost of providing Medicare covered services to its enrollees was about 22 percent lower than HEW's actuarial estimate of what it would have cost to provide Medicare covered services on a fee-for-service basis.

The data in this report relating to the Cooperative's costs and payments are based on HEW's interim settlement with the Cooperative in October 1978. Final settlement had not been made as of September 13, 1979.

OPEN ENROLLMENT REQUIREMENTS

The contract requires that the Cooperative shall, in accordance with section 1876 of the Social Security Act, as amended, and HEW's regulations and general instructions, have an open enrollment period of at least 30 consecutive days for individuals who are Medicare beneficiaries. Open enrollment periods must be held at least once every year and the Cooperative must accept Medicare beneficiaries up to the limits of its capacity on a first-come, first-served basis, without restrictions, except as may be authorized by regulations and general instructions. HEW regulations also require the health maintenance organization to notify the general public of its open enrollment periods in an appropriate manner in appropriate media throughout its enrollment area.

HEW's open enrollment regulations were not fully complied with by Group Health Cooperative during open enrollments held in 1976, 1977, and 1978, and HEW did not effectively enforce these regulations. The Cooperative observed a continuous open enrollment period from October 15, 1976, through all of 1977; however, Medicare beneficiaries residing within the Seattle, Washington, city limits and an adjacent northern area called the Shoreline District were excluded from an open enrollment opportunity until November 1977. The Cooperative notified HEW of this exclusion in a letter dated October 12, 1976--3 days before the beginning of the open enrollment period. We could not find a specific response to the Cooperative's October 12, 1976, letter in HEW's files, but an HEW letter to the

Cooperative dated July 26, 1977, refers to oral discussions between HEW and Cooperative officials and states, in part:

> "During your Medicare enrollment period, you focused your activities on the suburban areas of Seattle and did not accept applicants for Medicare enrollment within the Seattle city limits. While this approach was taken because of the limited capacity of your facilities within the city, you did not place similar restrictions on enrollments for non-Medicare co-op [individual] membership or enrollments under your other group contracts.
>
> "Technically, this violated Article IV.G. of your Medicare contract. While the law and regulations do provide for an HMO [health maintenance organization] to limit Medicare enrollment under certain conditions, any limitation may not discriminate against the Medicare population and any limitation must be approved in advance."

The Cooperative said its medical facilities serving the excluded area were operating at or near capacity, and that the Cooperative would not have the capacity to provide adequate services in the excluded area until 1977, when a new medical facility was expected to come into service.

Although the Cooperative did not concentrate its advertisements in newspapers serving the excluded areas, advertisements were published during October 1976 in 11 newspapers with a total circulation of about 530,000 serving the open enrollment area. The advertisements for seven newspapers ranged from about 7 to 62 square inches. The Cooperative was unable to provide copies of the remaining four newspaper advertisements.

According to a Cooperative official, about 525 Medicare beneficiaries residing in the area excluded from open enrollment opportunity until November 1977 had expressed interest in enrolling with the Cooperative. The Cooperative kept a list of these persons, and when the Cooperative decided to open the excluded area to Medicare enrollees,

these persons were mailed an announcement inviting them to apply for membership. However, a Cooperative official stated that advertisements were not published in the public media in November 1977 notifying the general public of the open enrollment.

In October 1978 the Cooperative observed an open enrollment period; however, no advertisements were placed in the public media such as newspapers and radio. A Cooperative official stated that some "low key" advertising is used to publicize the Cooperative. For example, posters are placed in hospitals and clinics. Also, in 1978 open season announcements and descriptive brochures were mailed to Medicare beneficiaries who had previously expressed an interest in enrolling with the Cooperative. The Cooperative also included referral cards in this mailing for the recipients to give to friends and acquaintances so that they might apply for membership. However, HEW's regulations require the Cooperative to notify the general public through public media throughout its enrollment area of its open enrollment periods. In this connection, the Director of the Health Care Financing Administration's Office of Demonstrations and Evaluations, in an internal memorandum dated May 8, 1979, stated, in part:

> "Open Enrollment: We know that [the Cooperative] conducted a minimum effort for open enrollment in 1976, 1977, and 1978. There is a question of the extent to which [the Cooperative] actually violated Medicare requirements since the regulations are vague."

A Cooperative official stated that the Cooperative preferred to not advertise in the public media because, in the past, a local medical society objected to the Cooperative advertising on the basis that it was unethical. He also said they believed their "low key" advertisements were effective in recruiting new enrollees.

HEW and Cooperative officials agreed that HEW's open enrollment regulations were vague on some issues. For example, the regulations require a health maintenance organization to notify the general public of its open enrollment periods in an appropriate manner in appropriate media throughout its enrollment area, but the regulations

do not specify any criteria for determining appropriate manner and media, nor do they specify any criteria for determining the required frequency of advertisements.

Notwithstanding this problem with the regulations, we believe that the Cooperative did not comply with and HEW did not enforce existing regulations in that (1) during the 1976 open enrollment period the Cooperative did not enroll Medicare beneficiaries residing in certain geographic areas and (2) during 1977 and 1978 the Cooperative did not notify the general public in appropriate media throughout its enrollment area.

HEW officials have recognized that the Cooperative has not fully met its responsibility for providing open enrollment periods, and HEW is attempting to persuade the Cooperative to meet its responsibility. In an August 14, 1979, letter to the Cooperative, HEW's Director of Group Health Plan Operations stated, in part, that

> "We are pleased that Group Health Cooperative of Puget Sound is planning a Medicare open enrollment period with the intent of publicizing the plan throughout your enrollment area, and we will take steps to send our notification to all Medicare beneficiaries in your area. Our concern that the [Cooperative] enrollment periods have not, to date, met the full requirements of regulations have been conveyed to [the Cooperative] on a number of occasions.
>
> "I would like to emphasize the fact that continual failure to hold an open enrollment period meeting the regulatory requirements could jeopardize the continuance of the risk contract now held by Group Health Cooperative of Puget Sound."

The following table shows the number of Medicare beneficiaries enrolling with the Cooperative between October 1, 1976, and July 31, 1979, through open enrollment opportunities. The data in the table exclude Medicare beneficiaries enrolling as a result of being a spouse or dependent of a

member, and also exclude beneficiaries enrolling as a result of the Cooperative's enrollment of groups of people (such as a group employed by a single employer).

	Medicare beneficiaries enrolled through open enrollment opportunities			
	1976	1977	1978	1979
January	-	19	25	9
February	-	30	23	8
March	-	15	8	2
April	-	17	2	1
May	-	21	2	1
June	-	13	1	0
July	-	16	0	0
August	-	21	1	-
September	-	13	0	-
October	0	27	1	-
November	0	46	126	-
December	16	60	65	-
Total	16	298	254	21

Other factors also influence the total number and proportion of the Cooperative's enrollees who are Medicare beneficiaries. For example, some enrollees die or disenroll from the Cooperative, and new Medicare and non-Medicare beneficiaries may enroll with the Cooperative as a result of an employee group becoming associated with the Cooperative. The following data show the total Cooperative enrollment and the number and percent of Medicare enrollees on selected dates:

	Total enrollees	Medicare enrollees	
		Number	Percent
October 1976	214,883	11,760	5.5
December 1977	236,007	15,497	6.6
July 1979	268,559	18,728	7.0

As the above data indicate, there has been a gradual increase in the proportion of the Cooperative's enrollment that are Medicare beneficiaries. However, the proportion of the Cooperative's enrollees that are Medicare beneficiaries is considerably lower than the proportion of Medicare

beneficiaries to the total population in the Cooperative's three-county service area. As of July 1, 1977, there were about 168,900 Medicare beneficiaries in those three counties--this represented 11 percent of the total population of about 1,533,800.

You asked whether there was any basis for recovering all or part of the $1.3 million incentive payment because of the Cooperative's failure to fully comply with HEW's open enrollment requirements. HEW's contract with the Cooperative covering the 15-month period ending December 1977 does not specifically relate the incentive payment to the open enrollment requirement, nor does the contract specify any penalty for failure to meet the open enrollment requirement. Under these conditions, we believe HEW's basic alternatives were to terminate the contract or to attempt to persuade the Cooperative to fully comply with the open enrollment requirement. We do not believe there is any basis under the contract for retrospectively recovering all or part of the incentive payment based on the Cooperative's failure to fully comply with the open enrollment requirement.

DIFFERENCE IN MEDICARE COST BASED ON BENEFICIARIES' RACE

In your August 3, 1979, inquiry, you pointed out that HEW reimbursement to the Cooperative is based on its actuarial estimate of what it would have cost to provide medical care to Medicare beneficiaries on a fee-for-service basis. Section 1876(a)(3)(A)(iv) of the Social Security Act requires that this actuarial estimate be made

> "* * * with appropriate adjustment to assure actuarial equivalence, including adjustments relating to age distribution, sex, race, institutional status, disability status, and any other relevant factors * * *."

HEW's actuarial estimate included adjustments for age distribution, sex, institutional status, and disability status, 1/ but did not include an adjustment for race. You

1/This adjustment distinguished between persons qualifying for Medicare on the basis of disability as opposed to those qualifying on the basis of age.

indicated that on the average nonwhites stayed in the hospital longer than whites and expressed concern that the Cooperative may have been overpaid for Medicare enrollees if it did not enroll a proportionate share of nonwhite Medicare beneficiaries.

HEW data confirm that, nationwide, when nonwhite Medicare beneficiaries are hospitalized, the Medicare reimbursement is, on the average, higher than that for whites. In 1976 the average reimbursement for inpatient hospital services for each hospitalized beneficiary was $2,431 for nonwhites and $2,106 for whites. However, whites are hospitalized more frequently than nonwhites. In 1976, 23.1 percent of white beneficiaries were hospitalized, whereas 19.4 percent of nonwhite beneficiaries were hospitalized. A composite of these two variables shows that the average inpatient hospital cost per enrollee is greater for white than for nonwhite beneficiaries. In 1976, the average reimbursement per Medicare beneficiary for inpatient hospital care was about $487 for whites and about $471 for nonwhites.

A representative of HEW's Office of Financial and Actuarial Analysis explained that race was not considered when determining what Medicare costs would have been under the fee-for-service basis because:

--Even though medical costs often vary according to beneficiaries' race, it is believed that these variances result from other social and economic factors which are otherwise taken into account in determining fee-for-service costs. For example, life expectancy varies by race--whites live longer than nonwhites on the average--and beneficiaries' ages are taken into account when determining the fee-for-service costs.

--In the private insurance business, distinctions normally are not based on race; e.g., rates for life or hospital insurance normally do not vary by race.

COOPERATIVE HOSPITAL COSTS AND UTILIZATION ARE LOWER THAN THOSE UNDER THE FEE-FOR-SERVICE BASIS

During its first contract period (October 1976 through December 1977) as a health maintenance organization under

section 1876 of the Social Security Act, as amended, the cooperative received $1.3 million as an incentive payment. The incentive payment represents a sharing of the difference between the actual costs of providing care to Medicare enrollees and HEW's actuarial estimate of what it would have cost to provide medical care to those enrollees on a fee-for-service basis.

The following shows the Cooperative's Medicare parts A and B reported costs per member-month and HEW's estimate of what those costs would have been under the fee-for-service basis.

	HEW estimate of fee-for-service	Reported	Difference Amount	Difference Percent
	(Costs per member month)			
Medicare part A	$41.81	$29.50	$12.31	91
Medicare part B	21.00	19.76	1.24	9
Total	$62.81	$49.26	$13.55	100

As the above data indicate, 91 percent of the difference in Medicare costs relate to part A services, which are predominately inpatient hospital care.

Our analysis indicates that the Cooperative's savings from inpatient hospital care was attributable to its lower daily cost of providing inpatient hospital care and the lower rate of utilization of inpatient hospital care by the Cooperative's Medicare enrollees. During calendar year 1977 the average daily hospital cost for hospitalized Medicare Cooperative enrollees was about $163 a day, compared with about $218 a day for other hospitalized Medicare beneficiaries in the State of Washington. 1/ Also during 1977, Medicare

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1/HEW did not have data readily available showing the hospital cost and utilization data for the Cooperative's three-county service area.

enrollees with the Cooperative utilized inpatient hospital care at the rate of 1,584 inpatient days per 1,000 enrollees, whereas other Medicare beneficiaries in the State of Washington used inpatient hospital care at the rate of 2,503 inpatient days per 1,000 beneficiaries.

Based on these data, the cost to provide inpatient hospital care to 1,000 Medicare Cooperative enrollees would be about $258,000 ($163 x 1,584), and the cost to provide such care to 1,000 other Medicare beneficiaries in the State of Washington would be about $546,000 ($218 x 2,503). The resulting difference in the cost of providing inpatient hospital care is about $288,000 ($546,000 - $258,000). We estimate that the Cooperative's lower daily cost of inpatient hospital care accounts for about 41 percent, and the Cooperative's lower rate of inpatient hospital utilization accounts for about 59 percent of the Cooperative's overall lower cost of providing care to hospitalized Medicare patients.

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As you requested, we did not obtain written comments from HEW or the Cooperative, but we allowed an HEW representative to review a draft of this report, and he agreed that it accurately and fairly presented the issues discussed.

We trust that this information will help the Senate Finance Committee's deliberations.

Sincerely yours,

Gregory J. Ahart
Director