United States General Accounting Office

GAO

Report to Congressional Committees

June 1990

MEDICARE

Second Status Report on Medicare Insured Group Demonstration Projects

GAO/HRD-90-117

GAO

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

Human Resources Division

B-239495

June 6, 1990

The Honorable Lloyd Bentsen
Chairman, Committee on Finance
United States Senate

The Honorable John D. Dingell
Chairman, Committee on Energy and Commerce
House of Representatives

The Honorable Dan Rostenkowski
Chairman, Committee on Ways and Means
House of Representatives

Section 4015(a) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) authorizes the Secretary of Health and Human Services (HHS) to conduct demonstrations of contracting on a prepaid capitation basis with Medicare Insured Groups (MIGs) to provide Medicare benefits to retirees.[1] The law also requires us to monitor contracts with these MIGs and report on the status of the projects. This is our second status report.

In our first status report,[2] we noted that HHS's Health Care Financing Administration (HCFA) had entered into cooperative agreements with three companies to establish MIGs. We also questioned HCFA's interpretation of section 4015(a) because MIG contracts awarded under its interpretation could lead to increased Medicare costs. We recommended that HCFA apply section 4015(a) payment limitation and surplus retention restrictions to all MIG projects. In HHS's comments on the report, it agreed to implement our recommendations.

[1]Section 4015(a) pertains explicitly to "Medicare Insured Group Demonstration Projects." Such groups may include Medicare qualified health maintenance organizations and other entities that meet the specified restrictions and requirements. Reference is made to employers in section 4015(a)(7). The legislative history suggests that employment-related groups, such as employers and unions, were the entities most likely to participate.

[2]Medicare: Status Report on Medicare Insured Group Demonstration Projects (GAO/HRD-89-64, June 27, 1989).

Current Status of Three Cooperative Agreements

The Southern California Edison Company (SCEC) and Amalgamated Life Insurance Company MIGs were still in the feasibility analysis stage of their cooperative agreements with HCFA in April 1990.[3] SCEC was continuing to develop its proposed method for determining Medicare payment rates to it, and Amalgamated was still in the process of developing its health care delivery system. As of April 1990, neither MIG had enrolled any Medicare beneficiaries, and HCFA was not sure when either project would become operational. Chrysler Motors Corporation terminated its MIG demonstration project after a feasibility study found it would not operate at a profit. Because section 4015(a) authorized three projects, HCFA is continuing to negotiate with other prospective sponsors.

Background

Medicare is a federal program that assists most elderly and some disabled people in paying for their health care, generally on a fee-for-service basis. The program, administered by HCFA, provides two basic forms of protection. Part A, Hospital Insurance, covers inpatient hospital, skilled nursing facility, hospice, and home health services. Part B, Supplementary Medical Insurance, covers physician services and various other health care services, such as laboratory and outpatient hospital services. In 1989, Medicare covered about 33.7 million beneficiaries and spent about $58.2 billion for part A and $38.2 billion for part B.

In February 1985, as part of an effort to contain the growth of Medicare costs, HHS initiated a nationwide program to expand the use of risk-based health maintenance organizations (HMOs) by Medicare beneficiaries.[4] These HMOs operate at risk because they contract to provide enrollees' covered health care for a predetermined monthly capitation rate equal to 95 percent of the Adjusted Average Per Capita Cost (AAPCC). AAPCC rates are actuarial estimates of the costs Medicare will incur, on average, for serving beneficiaries on a fee-for-service basis. AAPCC rates are developed for each county in the nation.

Because Medicare law requires that HMO capitation rates be based on 95 percent of Medicare's average costs in the areas covered by the HMOs,

[3]These cooperative agreements require completion of a feasibility analysis phase and an operational development phase before a company can proceed to the implementation phase of its demonstration project, the point at which it can begin to enroll Medicare beneficiaries.

[4]HCFA also has risk contracts with competitive medical plans which operate like HMOs in that they are paid a predetermined fixed capitation rate, are subject to essentially the same Medicare regulatory requirements, but are permitted greater flexibility in how they set their commercial rates and the services they offer commercial members. For the remainder of this report, when we use the term HMO, it also refers to competitive medical plans.

the program is designed to reduce Medicare outlays for HMO enrollees by 5 percent. In July 1987, HHS submitted a legislative proposal to the Congress to further expand the program, seeking authority to enter into risk-based contracts with employer-related plans.

We reported on unresolved issues in HHS's proposal to contract with employer-related groups on a capitation basis.[5] Because the MIG concept had not been tested and HHS had problems implementing previous capitation initiatives, we urged caution in proceeding with the proposal, thereby recommending that the Congress consider deferring authorization to implement the program until HHS demonstrated that MIG rate-setting methods and beneficiary and program safeguards are reasonable and adequate. Section 4015(a) authorizes such demonstrations and contains important safeguards for both Medicare and its beneficiaries.

The MIG Concept

Many employers and unions provide their Medicare-eligible retirees with supplemental policies that pay for part of the retirees' medical expenses not covered by Medicare. An HHS study concluded that in 1987, an estimated 10.7 million retirees and their dependents were covered by employer-sponsored health benefit plans.[6] We estimated that employers' annual benefit payments for retirees' medical care were about $9 billion in 1988.[7] Although retirees over age 65 (Medicare eligible) made up two-thirds of all retirees covered by company health plans, they received only about one-third of the benefits because Medicare pays a large portion of their health care costs.

Under the MIG demonstration program, Medicare beneficiaries decide whether to enroll in a MIG. For beneficiaries who enroll, the MIG assumes, for a fixed capitation payment from Medicare, the financial risk of providing the full range of Medicare-covered services. The MIG program enables employer-related groups to combine Medicare and employer-sponsored Medicare supplemental benefits into one integrated health care plan. HHS postulated that, by managing all their retirees' health care benefits, employer-related groups could effectively monitor and control the price and utilization of benefits, thereby holding down overall costs.

[5]Medicare: Uncertainties Surround Proposal to Expand Prepaid Health Plan Contracting (GAO/HRD-88-14, Nov. 2, 1987).

[6]Health Insurance Coverage of Retired Persons, National Medical Expenditure Survey, U.S. Department of Health and Human Services, Public Health Service, September 1989.

[7]Employee Benefits: Companies' Retiree Health Liabilities Large, Advance Funding Costly (GAO/HRD-89-51, June 14, 1989).

Under this theory, Medicare costs would be reduced. Likewise, the employer-based group would have lower costs for Medicare supplemental benefits than it otherwise would. In addition, MIG enrollees should benefit from having to deal with only one party for claims processing and from receiving the additional benefits the MIGs may offer as incentives to enroll.

Objectives, Scope, and Methodology

As specified in section 4015(a), our objectives were to (1) monitor the status of HCFA's implementation of the MIG demonstrations and the status of any projects awarded and (2) review the potential effects of section 4015(a) requirements on these projects.

We reviewed HCFA and HHS documentation related to the MIG demonstration to determine the projects' status. To obtain information on current developments, we discussed the demonstration program with officials in HCFA's Office of Research and Demonstrations, which is responsible for implementing the demonstration and awarding the cooperative agreements. We also reviewed OBRA requirements for projects and reviewed prior GAO work on HCFA's capitation initiatives under the Medicare and Medicaid programs.

We did not obtain written comments from HHS on this report; however, HCFA officials' comments have been incorporated where appropriate.

Our work was conducted between February 1989 and April 1990 in accordance with generally accepted government auditing standards.

Chrysler Decides to Discontinue Its MIG Project

In November 1989, Chrysler Motors Corporation decided to discontinue its MIG demonstration project during the feasibility analysis phase. Chrysler concluded that a MIG was not feasible. The overall operating costs of a MIG would not be at least 5 percent lower than Medicare fee-for-service costs and, therefore, the MIG would operate at a loss.

A major objective for Chrysler when it began analyzing its MIG project was to explore a method to help control the rising health expenditures for approximately 62,000 retired employees under its Medicare supplemental benefits program.[8] The MIG was a joint project between Chrysler

[8]According to Chrysler's 1987 annual report, it incurred $202.9 million in expenses during 1987 for health and life insurance for its retirees. In 1987 Chrysler had about 82,000 retired employees covered by its pension plan, of which 20,000 were not eligible for Medicare benefits.

and the International Union (United Automobile, Aerospace and Agricultural Implement Workers). Chrysler's 1988 health benefits program covered up to 365 days of inpatient hospital care, up to 730 days of skilled nursing care, prescription drugs, and Medicare deductibles and coinsurance.

The first phase of Chrysler's project was to analyze the feasibility of a MIG. Chrysler hired a consultant to (1) analyze available information about current health care costs and utilization, (2) estimate savings from available managed care initiatives, (3) develop a proposal for a Medicare rate-setting methodology, and (4) investigate administrative issues. Chrysler's consultant concluded that a MIG was not feasible because it would not be able to operate at a profit for the following reasons:

- HCFA's recent success in cost containment, such as controlling the price of care through prospective payment programs, had reduced the potential for savings through further initiatives. Based on 1986 data, a Chrysler MIG could only achieve a net savings equivalent to 3.8 percent of Medicare and company-furnished health payments by implementing a number of managed care initiatives, including case management, exclusive provider organizations, and retrospective utilization review. This falls short of the 5-percent reduction necessary for a MIG to be profitable under section 4015(a).
- A MIG could achieve administrative cost levels as low as Medicare's only after many years and substantial investment. A Chrysler MIG's administrative costs would be 5 percent of claims costs. This compares to an estimate of 2.3 percent in administrative costs for Medicare and company-furnished benefits combined.
- A MIG would probably not be able to negotiate provider payment rates as low as Medicare's payment levels because the MIG would lack Medicare's market power and government status.

Status of SCEC MIG Project

In January 1989, HCFA entered into a cooperative agreement with the Southern California Edison Company to explore establishing a MIG, and the project is still in the feasibility analysis phase. HCFA budgeted about $198,000 for its share of that phase, which was scheduled to be completed in January 1990. HCFA, however, granted an extension through April 1990 and is planning to grant another extension through March 31, 1991, allowing SCEC additional time to develop a proposal for a method of setting the capitation rate HCFA would pay during the demonstration period. At the completion of the feasibility analysis phase, SCEC will decide whether to continue with the MIG demonstration project.

SCEC, an investor-owned utility company, is interested in a MIG project as a possible means to moderate rising retiree health care costs without reducing benefits. About 10,000 retirees and their dependents receive health services through SCEC's benefit plan, about 4,800 of whom are Medicare eligible. The combined cost of health care and life insurance benefits for all of SCEC's retirees and their dependents was about $23 million in 1988.

Retirees can choose to obtain their health care services from an HMO or from SCEC's provider organization, PrimeCare. Nearly all SCEC retirees have selected PrimeCare, which pays in full for covered services at participating providers, including clinics operated by SCEC. If the retirees go to a nonparticipating provider, PrimeCare pays 80 percent of reasonable charges. PrimeCare covers inpatient, outpatient, substance abuse, mental health, and chiropractic services; and it pays the part B premiums for Medicare-eligible retirees. Additionally, PrimeCare has an annual out-of-pocket expense limit of $1,500 per person. PrimeCare has opened one geriatric health care center and is in the process of opening two others.

SCEC proposes to use PrimeCare for its MIG project with the possibility of adding benefits for long-term care and hearing aids. SCEC proposes to open its MIG to all Medicare-eligible retirees, except dialysis and transplant patients and beneficiaries who are eligible because of a disability.

SCEC proposed a Medicare payment-rate methodology. HCFA, however, questioned the methodology because portions of it were not based on the cost experience of SCEC's Medicare-eligible retirees. As of April 30, 1990, a final rate-setting methodology had not been approved by HCFA, nor had an operational date for the MIG been finalized.

Status of the Amalgamated MIG Project

Amalgamated Life Insurance Company remains in the feasibility analysis phase of its cooperative agreement with HCFA. Amalgamated is the administrator for the Amalgamated Clothing and Textile Workers Union health insurance benefit plan, which covers about 500,000 workers and their families, including approximately 130,000 retirees and spouses. Most of the retirees are low-income Medicare beneficiaries who received only limited health insurance coverage during their working years. In 1988, Amalgamated supplemented union 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 about 12,000 Medicare-eligible retirees and spouses in the Philadelphia area, and Amalgamated has proposed this area as the initial site for its MIG demonstration project.

In September 1988, HCFA and Amalgamated signed a cooperative agreement to establish a MIG demonstration project. HCFA extended for the second time the feasibility analysis phase through December 31, 1990, due to Amalgamated's difficulties in negotiating a contract for inpatient care with a Philadelphia health care facility. HCFA informed Amalgamated that the remaining $129,500 budgeted for this phase will not be made available until an inpatient-care contract is signed.

How Rates Will Be Updated Has Not Been Determined

At the time of our November 1987 report, HCFA planned to update MIGs' initial experience-based payment rates using some index of cost growth, such as overall Medicare cost changes. HCFA would no longer be obtaining cost data for MIG enrollees because it would not receive claims from them and, thus, would not be able to directly update payment rates. We pointed out that, as time passed, it might become increasingly difficult to measure objectively whether underpayments or overpayments to MIGs were occurring. We concluded that the MIG rate-setting methodology should be thoroughly tested before general legislation authorizing agreements was granted.

As of April 1990, HCFA had not decided how to update experience-based payment rates. HCFA officials said they are waiting for a prospective MIG to present a payment updating method for the agency to evaluate. Under the demonstration, HCFA plans to collect demographic, enrollee satisfaction, and health service cost and utilization data. The specifics about the exact data to be collected and the uses of them had not been finalized. Cost and use of service data will be critical to determining whether a suitable method for updating rates can be found. We will continue to monitor developments in the rate-updating and data collection areas.

HHS Agrees With Our Prior Recommendations

In our June 1989 report, we questioned HCFA's interpretation of the requirements placed on MIG demonstrations. In line with our interpretation, we recommended that the Secretary of HHS require HCFA to

- apply the 95 percent of the experience-based rate payment limitation and the surplus retention restrictions of OBRA to all MIG projects,
- define surplus as the excess of Medicare payments over the costs of providing Medicare-covered services, and
- require that all surplus over that amount either be used for additional benefits not previously funded by the employer or be returned to the Medicare program.

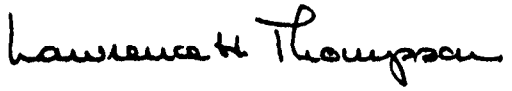
In November 7, 1989, comments on these recommendations, HHS stated that after consultation with its Office of the General Counsel, it intends to implement all three.

Conclusions

HCFA has been working for about 2 years to implement MIG demonstration projects. Currently, none of the projects have progressed further than the feasibility analysis phase. At the end of its feasibility analysis, Chrysler decided not to proceed with the demonstration, concluding that it would not be able to operate a MIG profitably. Little progress has been made in the last year by Amalgamated or Southern California Edison. Neither company has developed a method of setting capitation rates that HCFA has approved. Both companies have received extensions of the feasibility analysis phase of their cooperative agreements.

Based on Chrysler's decision to drop out of the MIG demonstration and the slow progress being made by Amalgamated and SCEC, it is not known when any MIG project will become operational.

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. This report was prepared under the direction of Janet L. Shikles, Director, Health Financing and Policy Issues, who may be reached on (202) 275-5451 if you or your staff have any questions. Other major contributors are listed in appendix I.



Lawrence H. Thompson
Assistant Comptroller General

Major Contributors to This Report

Human Resources Division, Washington, D.C.	Jane L. Ross, Senior Assistant Director, (202) 275-6195 Thomas G. Dowdal, Assistant Director G. Jeff Chaney, Assignment Manager
Philadelphia Regional Office	Michael J. Stepek, Evaluator-in-Charge Linda P. Schmeer, Evaluator

Requests for copies of GAO reports should be sent to:

U.S. General Accounting Office
Post Office Box 6015
Gaithersburg, Maryland 20877

Telephone 202-275-6241

The first five copies of each report are free. Additional copies are $2.00 each.

There is a 25% discount on orders for 100 or more copies mailed to a single address.

Orders must be prepaid by cash or by check or money order made out to the Superintendent of Documents.

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

Official Business
Penalty for Private Use $300

First-Class Mail
Postage & Fees Paid
GAO
Permit No. G100