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Health, Education and Human Services Division

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June 12, 1997

The Honorable John B. Breaux
Ranking Minority Member
Special Committee on Aging
United States Senate

Subject: Medicare HMOs: Setting Payment Rates Through Competitive Bidding

Dear Senator Breaux:

Managed care is an increasingly popular option among Medicare beneficiaries. Nearly 5 million beneficiaries are now enrolled in health maintenance organizations (HMO) that operate under a Medicare risk contract. The Congressional Budget Office estimates that Medicare will spend $24.2 billion on risk HMOs this fiscal year. This amount is expected to grow to over $71 billion in fiscal year 2002. Risk contract HMOs have the potential to be advantageous for two reasons. First, the payment of a capitated rate for all services needed by each enrollee gives these plans a financial incentive to hold down costs. In addition, risk contract HMOs often provide Medicare enrollees additional benefits at lower out-of-pocket costs than Medicare fee-for-service. Nevertheless, there is widespread concern that Medicare's current payment methodology prevents the program from actually realizing any cost savings from managed care.

In January of this year, the Health Care Financing Administration (HCFA) announced it would test competitive bidding as an alternative method for setting Medicare HMO payment rates in the Denver, Colorado, area. The announcement followed several years of HCFA-sponsored research on competitive bidding design and an earlier attempt to launch a similar demonstration in Baltimore, Maryland.[1] The test planned for the Denver area is

[1]HCFA's competitive bidding demonstration in Baltimore was originally scheduled to begin in 1997. Because of local opposition, HCFA officials decided not to implement the demonstration in Baltimore. (See enc. I for a time line of HCFA's research on HMO payment alternatives and implementation of the demonstration.)

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part of a 3-year demonstration that will also evaluate new HMO enrollment procedures, the use of third-party counselors, and the provision of better information to beneficiaries on health coverage options.

After soliciting input from local HMOs and modifying certain aspects of the demonstration's design in response to their comments, HCFA issued a formal call for bids on April 1, 1997. HMOs raised a number of objections to the demonstration, however. On May 12, 1997--3 days before the bids were due--the American Association of Health Plans (AAHP) as well as various HMOs and other groups sued to enjoin HCFA from carrying out the demonstration. A federal district court issued a temporary restraining order preventing HCFA from proceeding with the bidding process until the case is resolved on its merits. Consequently, the demonstration may not begin as scheduled.

This letter responds to your request that we (1) discuss the potential advantages of competitive bidding in the Medicare HMO program, (2) describe the main features of HCFA's planned demonstration in Denver, and (3) outline HMOs' key objections to it. To address these objectives, we reviewed literature on competitive bidding and drew on our prior work on that subject as well as on Medicare managed care. We also interviewed HCFA and AAHP officials.

SETTING SOME HMO PAYMENTS THROUGH COMPETITIVE BIDDING MIGHT PRODUCE SAVINGS FOR MEDICARE

Because of flaws in the current payment system, managed care is not producing savings for the Medicare program. In fact, the government spends more money to serve HMO enrollees than it would if those same individuals received care through Medicare's traditional fee-for-service system. Although HMOs do compete for market share, this form of competition tends primarily to benefit HMO enrollees, who receive additional benefits or pay lower premiums.

GAO has long recommended that Medicare consider alternative payment strategies so that the program can realize the promise of managed care savings. Competitive bidding is one such alternative that may be feasible in certain areas with well developed HMO markets.[2] In 1995, the Physician Payment Review Commission (PPRC) outlined a possible Medicare competitive bidding system. Competitive bidding systems have been successfully implemented

[2]Other alternatives include reforms of the current methodology used to calculate HMO rates.

elsewhere. For example, the Arizona Medicaid program uses competitive bidding to set HMO capitation rates.

Medicare Rate-Setting System Based on Fee-for-Service Spending Generates Excess HMO Payments

Medicare law ties HMO payment rates to local spending in the traditional fee-for-service program. Every year, HCFA estimates average per-beneficiary spending in each county's fee-for-service sector, an amount known as the adjusted average per capita cost (AAPCC).[3] Base HMO payment rates, or "county rates," are then set at 95 percent of the AAPCC.[4] To arrive at the capitation rate paid for each HMO enrollee, HCFA applies a risk-adjustment factor to the county rate that is intended to align the rate with how much an enrollees's expected costs differ from the average beneficiary's cost.[5]

Although Medicare's risk contract HMO program was designed to save the program 5 percent of the costs for beneficiaries who enrolled in HMOs, a decade of research has found that this program instead costs Medicare money. The research shows that Medicare's rate-setting method produces excess payments to HMOs. Recently, PPRC estimated that annual excess payments to HMOs nationwide could total $2 billion. On the basis of our analysis of 1995 payments to California HMOs, we reported that Medicare may have overpaid that state's HMOs by $1 billion during the year.[6]

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[3]In determining each county's AAPCC, HCFA also includes a projection of national program spending increases.

[4]There is substantial geographic variation in HMO monthly payment rates–from a low of $221 in Arthur County, Nebraska, to a high of $767 in Richmond County, New York–because differences in medical prices and in beneficiaries' use of services cause fee-for-service spending to vary widely among counties. Some of the variation in the use of services–both high and low–may reflect inappropriate levels of care.

[5]Our work has shown that, even after HCFA's risk adjustments, the capitation rate is only weakly related to a beneficiary's expected fee-for-service costs.

[6]Medicare HMOs: HCFA Can Promptly Eliminate Hundreds of Millions in Excess Payments (GAO/HEHS-97-16, Apr. 25, 1997).

Current Form of HMO Competition Benefits Enrollees, Not Taxpayers

In many urban areas, several HMOs compete against one another for shares of the Medicare managed care market. About 25 percent of all beneficiaries live in areas served by two to four Medicare HMOs and another 25 percent live in areas served by five or more HMOs. However, current Medicare rules encourage a form of competition that benefits HMO enrollees, but not taxpayers.

If competition forces HMOs to become more efficient and find ways to reduce costs, these "savings" typically are passed on to enrollees, not shared with the government. Medicare does not permit HMOs to earn profits on their risk contracts that are higher than those on their commercial business. Consequently, if HCFA estimates that–given the HMO's estimated costs– Medicare capitation payments would result in an HMO earning excess profits, the plan must reduce premiums (or other beneficiary out-of-pocket expenses), offer additional benefits, or return money to the program. Virtually all HMOs in this situation decide to reduce premiums or offer additional benefits.[7]

Competition and the quest for increased market share encourage many HMOs to charge a premium lower than the one approved by HCFA or offer additional benefits. For example, Health Options, Inc., operating in the competitive South Florida market, is permitted by HCFA to charge a monthly premium of $94 for the package of benefits it offers. However, Health Options has waived this premium, and beneficiaries pay no monthly fee to the plan.[8]

Competitive Bidding Previously Proposed for Medicare and Studied by HCFA

The idea of using competitive bidding to set Medicare HMO payment rates is not new. In 1994, we recommended that HCFA conduct preliminary research

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[7]Medicare Managed Care: HMO Rates, Other Factors Create Uneven Availability of Benefits (GAO/T-HEHS-97-133, May 19, 1997).

[8]All HMO enrollees must continue to pay their monthly part B premium to Medicare.

on alternative HMO payment methods–including competitive bidding.[9] In 1995, PPRC recommended that payment rates for Medicare HMOS be set through competitive bidding in markets with a sufficient number of HMOs bidding to achieve price competition. PPRC has also endorsed the concept of Medicare competitive bidding.

In PPRC's 1995 Annual Report to Congress,[10] the Commission described how a competitive bidding system might be set up for Medicare. PPRC identified two elements that were essential to obtaining bids at or close to the costs of efficient HMOs:

- active price competition in bidding among multiple bidders and
- a financial penalty for bidders that bid higher than the price that ultimately is established.

A financial penalty for high bidders could take many forms. PPRC suggested that Medicare require high bidders to charge beneficiaries a monthly premium. The amount of the premium would be equal to the difference between the HMO's bid and the "winning" bid as determined by HCFA. By not excluding any HMO, this approach maximizes the options available to beneficiaries. However, HMOs would still have an incentive to submit low bids because low bidders–who do not have to charge a premium–would find it easier to attract enrollees and gain market share.

PPRC recommended that HCFA adopt a flexible approach to determining the "winning" bid–that is, the bid amount above which HMOs would have to charge beneficiaries a premium. According to PPRC, HCFA should, for example, consider any capacity constraints of low bidders. If the winning bid would result in many beneficiaries being shut out of no-premium plans, then HCFA should select a higher bid as the winning bid. A flexible approach could also help prevent HMOs from gaming the bidding system.[11]

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[9]Medicare: Changes to HMO Rate Setting Method Are Needed to Reduce Program Costs (GAO/HEHS-94-119, Sept. 2, 1994).

[10]Washington, D.C.: PPRC, 1995.

[11]For example, in some markets, one HMO enrolls a large portion of the Medicare beneficiaries. If, instead of using a flexible approach, HCFA used a rigid, mechanical rule–say, one that selected the average bid, weighted by enrollment, as the winning bid–the large HMO would have an advantage. The

For the past few years, HCFA has actively considered how best to design a Medicare managed care bidding demonstration. (See the time line in enc. I.) The agency funded a demonstration design report written by nationally recognized experts in competitive bidding. HCFA awarded a grant to an external contractor responsible for beneficiary enrollment issues and the preparation of beneficiary educational materials. HCFA also assembled technical expert panels of nationally recognized experts in Medicare managed care, health economics, beneficiary education, and other relevant areas that provided input on the demonstration's design. (Enc. II lists the HCFA contractors and consultants working on bidding design.)

Arizona Contains Medicaid Costs Through Competitive Bidding

For over a decade, Arizona has used a competitive bidding process to award managed care contracts in the state's Medicaid program, known as the Arizona Health Care Cost Containment System (AHCCCS).[12] In 1995, we reported that AHCCCS (pronounced "access") likely saved the federal government $37 million and the state $15 million in acute-care costs during fiscal year 1991 (at the time, the latest year for which data were available for analysis).[13]

Each health plan that wishes to serve AHCCCS beneficiaries must submit a bid (one for each geographic area the plan wants to serve) containing the capitation rate the HMO is willing to accept and other information, such as the extent of the HMO's provider network. AHCCCS officials then assign a score to each bid. A limited number of contracts are awarded in each county on the basis of the scores. Although plan officials know the factors AHCCCS considers, they have only a general sense of the weights assigned and do not know exactly how the scores are derived.

Plans are not assured of winning an AHCCCS contract; consequently, they have a strong incentive to submit the lowest bid for which they can provide the

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large HMO would know–before submitting its bid–that its bid would have a disproportional influence in the determination of the winning bid and could bid accordingly.

[12]Since its inception in 1982, Arizona has operated its Medicaid program under a Section 1115 demonstration waiver.

[13]Arizona Medicaid: Competition Among Managed Care Plans Lowers Program Costs (GAO/HEHS-96-2, Oct. 4, 1995).

required beneficiary services and still earn a profit. AHCCCS had a 3-year bidding cycle until recently, when it switched to a 5-year cycle. Therefore, HMOs not awarded contracts will continue to be shut out of Arizona's Medicaid program for several years.

HCFA'S PLANNED DEMONSTRATION WOULD TEST POTENTIAL OF COMPETITIVE BIDDING TO PRODUCE SAVINGS

In January 1997, HCFA announced plans to conduct a 3-year competitive pricing demonstration in the Denver, Colorado, area.[14] Through this demonstration, HCFA plans to test the payment implications of competitive pricing for HMOs and the effects of improving the ability of beneficiaries to make informed choices about their Medicare options. The demonstration, planned to start in January 1998, has three main components: competitive bidding by HMOs; a coordinated enrollment period and third-party insurance counselors; and comparative information on beneficiaries' health insurance options.

The following briefly describes the key features of each of the three main components.

Competitive Bidding Process

- Any health plan electing to participate in Medicare must submit a bid and offer the standard benefit package as defined by HCFA. This package will include "extra benefits" (not covered under Medicare fee-for-service) currently received by many Denver beneficiaries in managed care plans, including prescription drugs. Health plans may also submit bids for more comprehensive packages they wish to market to Medicare beneficiaries.

- HCFA will array the bids and then determine a new government contribution toward the purchase of all plans. The new amount would replace the current formula-based AAPCC capitation rate. In calculating the government contribution, HCFA will consider the potential disruption of current managed care enrollees. For example, HCFA will try to avoid

[14]The geographic area of the demonstration includes five counties: Adams, Arapahoe, Denver, Douglas, and Jefferson.

setting the government contribution at a level that would require many beneficiaries to switch plans to avoid having to pay a monthly premium.

- Plans whose bids are below the new government contribution have the option of adding additional benefits equivalent in value to the difference, thereby making their product more attractive to beneficiaries. All plans with bids at or below the new government contribution will be paid the new government contribution.

- Plans that bid above the new government contribution can choose between or blend two options: (1) charge the difference between their bid and the government contribution as a beneficiary premium or (2) accept a reduced payment equal to the new government contribution minus the difference between the plan's bid and the new government contribution.

- Plans that submit bids may opt out of participating in the demonstration. However, these plans, and HMOs that choose not to bid, will be excluded from serving Medicare beneficiaries in the Denver-area for the duration of the demonstration.

Coordinated Open Enrollment and
Use of Third-Party Insurance Counselors

- The demonstration will include a guaranteed open enrollment season during which a HCFA contractor will conduct an intensified information campaign. As under current law, however, plans may enroll beneficiaries during other times of the year as well.

- All enrollments and disenrollments will be conducted by a HCFA third-party contractor. Plans will not be permitted to enroll beneficiaries, as allowed under current regulations, but they may continue all currently permitted marketing and sales activities.

- Beneficiaries will continue to be permitted monthly to disenroll from an HMO to fee-for-service or from one HMO to another if the desired plan is accepting new enrollees.

Beneficiary Information and Education

- HCFA will prepare and distribute a comprehensive set of brochures to all Medicare beneficiaries in the demonstration area explaining the features

of Medicare fee-for-service, Medigap, and managed care programs. The materials will include a chart comparing coverage under fee-for-service Medicare with the benefit packages and premiums for all managed care plan options available in the area.

- Beneficiaries may obtain additional information from HCFA-sponsored counselors.

- Information provided by HCFA and HCFA-sponsored counselors will help Medicare beneficiaries make informed choices from among all available health coverage options, but will not advocate either managed care or fee-for-service.

HMOs OBJECT TO PARTICULAR ASPECTS OF PLANNED DEMONSTRATION, NOT COMPETITIVE BIDDING CONCEPT

AAHP, Denver-area HMOs, and other groups have raised objections to HCFA's planned demonstration in a lawsuit seeking to enjoin the agency from implementing the demonstration project. We met with representatives of AAHP to obtain their views on the demonstration. At our meeting, the AAHP representatives stated that they are not opposed to the concept of competitive bidding. In fact, AAHP is now assembling a technical work group that will develop industry suggestions for implementing Medicare competitive bidding. However, they raised concerns about HCFA's authority and the process by which HCFA is implementing the Denver demonstration.

In their lawsuit and in discussions with us, AAHP officials objected to HCFA's intention to prohibit health plans that do not submit bids from serving Denver-area Medicare beneficiaries. Specifically, they believe that HCFA has not properly exercised statutory and regulatory authority by refusing to renew contracts of health plans in the demonstration area and excluding plans from the Medicare program for the duration of the demonstration if they choose not to participate. These officials make several arguments in support of their view. AAHP officials said that historically HCFA has entered into contracts with health plans that meet statutory and regulatory criteria and has routinely renewed those contracts. They believe that the addition of a requirement that plans must participate in a competitive bidding demonstration as a condition of receiving or renewing a Medicare contract amounts to a change in the current Medicare regulations governing HMO participation that is unlawful because it is being made outside the normal rule-making process.

AAHP officials said they do not question HCFA's authority to establish a competitive pricing demonstration. However, they believe that the existing demonstration authority does not relieve HCFA of its obligation to meet the requirements of the rule-making process if the agency wishes to condition the renewal or issuance of Medicare HMO contracts on participation in the demonstration.

In our 1995 report, Medicare Managed Care: Growing Enrollment Adds Urgency to Fixing HMO Payment Problem,[15] we recognized that HCFA's legislative authority to conduct demonstration projects does not address managed care options explicitly. In our report, we did not conclude that the agency, as a matter of law, lacked sufficient authority to conduct a demonstration like that planned for Denver. We did say, however, that in the interest of facilitating such demonstrations the Congress should consider enacting legislation to give HCFA explicit authority to mandate HMO participation.

According to AAHP officials, HCFA did not sufficiently consult with area plans before finalizing the design of the demonstration. HCFA did allow some time for HMOs to comment on the demonstration's design, and in response to their comments, modified certain aspects of the demonstration. Regarding HCFA's decision to use a third-party enrollment counselor, AAHP officials expressed concern that introducing competitive bidding and new enrollment arrangements simultaneously would result in problems with processing new enrollees. These officials also questioned whether HCFA would be able to isolate and assess the independent effects of competitive bidding and the use of third-party enrollment counselors. We have not, however, analyzed the merits of the HMOs' concerns, whether they had sufficient time to comment, or whether HCFA's resulting modifications were adequate.

AAHP officials also stated that area plans did not have adequate information on key aspects of the demonstration before the bidding deadline. Such information, they believe, includes demographic data upon which to base the bid price. AAHP officials said the plans also want to know which factors HCFA intends to consider in evaluating the bids and determining the government contribution. However, HCFA has informed plans that the agency will consider

[15]GAO/HEHS-96-21, Nov. 8, 1995.

several factors, such as the capacity constraints of low bidders, in determining the government contribution.[16]

Finally, AAHP officials said that in the private sector, market forces have operated to promote cost-effective coverage and quality care when employers have offered all coverage options--managed care and fee-for-service--under the same rules. AAHP officials suggested that the mechanisms for promoting competition between private health plan options and the Medicare fee-for-service program be considered in any competitive pricing demonstration. Inclusion of the Medicare fee-for-service program would be impractical under Medicare's current structure, because no single entity exists that could represent all the fee-for-service providers. However, a description of covered services and cost-sharing for the fee-for-service option is included in the comparative information that HCFA will distribute in the demonstration area.

CONCLUSIONS

Medicare's current system for setting HMO payment rates, which is based on local fee-for-service spending, generates excess payments to some health plans. These excess payments are substantial (perhaps $2 billion annually) and are likely to grow as the managed care program grows. Alternative payment mechanisms could reduce excess HMO payments and help Medicare--and taxpayers--realize the savings potential of managed care. Competitive bidding is one such alternative mechanism that might be successfully employed in certain markets.

To succeed, a competitive bidding system must provide health plans an incentive to submit bids that reflect no more than the plans' expected costs and a reasonable profit. Allowing plans to choose to remain outside of the competitive bidding process and collect the AAPCC-based rate, while other area plans submit competitive bids, would unravel the fundamental incentives of competitive bidding. Similarly, plans that bid, but bid high relative to their

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[16]HCFA's bid solicitation package informed plans that the level of government contribution would "depend on many factors, including the . . . distribution of bids, the capacity of low and high bidders, and other factors." HCFA also told plans that the government contribution would be set above the lowest bid, but below the 1998 AAPCC. HCFA's stated goal was to set a level of government contribution "that yields some savings to the government, while maintaining the ability of efficient health plans to offer the [demonstration's] standard benefit package at a low or zero premium."

competitors, must face some consequence. The mechanism proposed by HCFA for the Denver demonstration (and recommended by PPRC) is to require high bidders to charge beneficiaries a premium--making it harder for high bidders to gain market share. This is a much weaker consequence than excluding high bidders from the marketplace--as is done in the Arizona Medicaid program. However, HCFA's mechanism has the advantage of preserving the widest possible choice of plans for Medicare beneficiaries.

We recognize that HCFA's legislative authority does not explicitly address the type of competitive bidding demonstration planned for Denver. HCFA may already possess the necessary authority; however, in the interest of facilitating demonstrations that test new methods of paying HMOs, including competitive bidding, we continue to believe--as we stated in our 1995 report--that the Congress should consider enacting legislation to give HCFA explicit authority to mandate HMO participation in demonstration projects.

AGENCY COMMENTS

We made draft copies of this correspondence available for review by officials at HCFA and AAHP. These officials suggested some changes, and we modified the text accordingly. AAHP officials stated that, with their changes incorporated, the draft accurately reflected their concerns about the demonstration.

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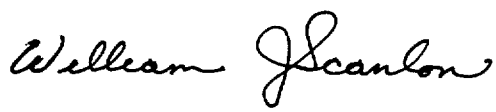
As agreed with your office, we will make copies of this letter available to other interested parties.

Please call either James C. Cosgrove, Assistant Director, at (202) 512-7029 or me at (202) 512-7114 if you or your staff have any questions concerning this letter. Charles A. Walter and Stefanie G. Weldon also contributed to this letter.

Sincerely yours,



William J. Scanlon
Director, Health Financing and
Systems Issues

SELECTED PLANNING AND DESIGN EVENTS FOR HCFA'S COMPETITIVE PRICING DEMONSTRATION

Time frame	Event
1989	HCFA funds research at University of Minnesota on options for HMO payment.
1990	HCFA contractor provides research report, "Issues Regarding Health Plan Payments Under Medicare and Recommendations for Reform."
1993	HCFA contractor provides research report, "Development of the Competitive Pricing Proposal for Medicare."
1995	
May	HCFA's request for proposal (RFP) solicits contractor design assistance for pricing demonstration. Second RFP issued for consumer information and enrollment component of demonstration.
September	HCFA contracts with Abt Associates and University of Minnesota to help develop and implement Medicare Competitive Pricing Demonstration. HCFA also contracts with Benova, Inc., for information design and enrollment strategy.
December	HCFA contractor provides research report, "Alternative Models of Competitive Pricing for Medicare."
1996	
January	University of Minnesota contractor provides research report, "Selection of Sites for a Medicare Competitive Pricing Demonstration," proposing 16 candidate sites.
February	Contractor's (Abt Associates) Technical Expert Panel and HCFA consultants meet to review draft competitive pricing demonstration design report.
	HCFA's contractor, Benova, Inc., convenes panels representing beneficiaries and health plans for input on information and enrollment design.
March/April	HCFA narrows possible sites and asks for suggestions from AAHP.
May	HCFA announces Baltimore as first site for a 1997 pricing demonstration.

June	HMOs and state and federal legislators raise concerns about Baltimore demonstration.
August	Abt Associates issues final design report, "Medicare Competitive Design Demonstration Design Report."
	Benova, Inc., provides beneficiary-tested information prototypes and proposed enrollment process design.
September	HCFA announces it will not pursue competitive pricing in Baltimore at this time.
October	HCFA begins internal consideration of alternative demonstration site.
1997	
January	HCFA announces Denver site and meets with Denver plans representatives.
February	HCFA solicits design comments and meets with Denver plans and beneficiary representatives.
March	Plans and AAHP raise additional comments and concerns.
	HCFA issues draft bid document for plans' comment.
April	HCFA formally issues bid package and notice of intent not to renew current contracts. Bids are due in mid-May.
	Colorado congressional representatives, governor, and Department of Insurance; HMOs; and industry associations send letters to HCFA expressing concerns about demonstration.
	HCFA holds bidders conference to address questions about demonstration.
	HCFA issues clarifications and answers to questions raised at bidders conference.
May	U.S. District Court (Colorado) grants HMOs temporary restraining order, halting bid process.
June	Court hearing scheduled on request to stop demonstration.

HCFA CONTRACTORS AND CONSULTANTS ON COMPETITIVE PRICING

The contractors and consultants listed in this enclosure assisted HCFA in its research on competitive pricing design. Their positions and organizational affiliations were current at the time they were enlisted to advise.

CONTRACTORS

Abt Associates - Prime Contractor
Robert Coulam - Project Director

University of Minnesota - Subcontractor to Abt Associates
Roger Feldman, Professor - Project Codirector
Bryan Dowd, Professor - Project Codirector

CONSULTANTS

Provided input to design reports and commented on all documents given to HCFA.

John Klein - Consultant, Health Strategies Group, Inc.

Sheila Leatherman - Vice President, United HealthCare Corporation

Barbara Lapwing - Vice President, Covantage Managed Benefit Solutions

Doug Wholey - Associate Professor, Carnegie-Mellon University

Harry Sutton - Consulting Actuary

TECHNICAL EXPERT PANEL

Reviewed the bidding design report and attended design meeting held February 29, 1996, with HCFA.

Jon Gabel - Director of Research, Group Health Association of America (now American Association of Health Plans)

Bruce Davidson - Senior Researcher, Value Health Sciences

Joyce Dubow - Senior Analyst, American Association of Retired Persons

Larry Levitt - Senior Analyst, Lewin-VHI

Tom Elkin* - Assistant Executive Officer, Health Benefit Services, California Public Employees' Retirement System

Alain Enthoven* - Professor, Stanford University

Mark Pauly* - Professor, University of Pennsylvania

* Did not attend Technical Expert Panel meeting, but provided written comments.

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