United States General Accounting Office

GAO

Report to the Chairman, Subcommittee on Health, Committee on Ways and Means, House of Representatives

November 1987

MEDICARE

Uncertainties Surround Proposal to Expand Prepaid Health Plan Contracting

GAO/HRD-88-14

GAO

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

Human Resources Division

B-199414

November 2, 1987

The Honorable Fortney H. (Pete) Stark
Chairman, Subcommittee on Health
Committee on Ways and Means
House of Representatives

Dear Mr. Chairman:

In a March 12, 1987, letter, you asked for our views on potential problems with a Department of Health and Human Services (HHS) proposal to seek legislative authority to contract on a prepaid or "capitation" basis with employer-based health plans to provide Medicare benefits to the employers' retirees. Under such contracts, an employer-based health plan would agree to provide Medicare-covered services to its Medicare-eligible retirees for a fixed monthly payment or capitation rate. The employer-based plan's loss or surplus would depend on whether its costs to provide the services are more or less than the payment.

You stated two concerns about the HHS proposal. First, it would authorize HHS to contract with non-health-care companies for the provision of health services for Medicare beneficiaries. This raises questions about the ability of such companies to provide access to quality care and the ability of HHS to monitor their performance. Second, employer-based plans might have an unfair competitive advantage over existing health maintenance organizations (HMOs) with Medicare capitation contracts.

Results in Brief

Our analysis of HHS's proposal shows many unresolved implementation issues. For example, the proposal would use an untried method to set capitation rates, and the mechanisms used under currently authorized capitation plans to assure reasonable Medicare costs and benefits for enrollees would not necessarily apply to employer-based plans. Because the concepts in the proposal have not been tested and HHS had problems implementing capitation initiatives in the past, we urge caution in proceeding with this proposal. Consequently, we believe legislative authorization for expanding the authority of HHS's Health Care Financing Administration (HCFA) to contract with non-health-care providers should be deferred until the concept has been tested and evaluated through demonstrations. HHS plans to begin such demonstration projects in this calendar year.

Background

Medicare is a federal program that assists most elderly and some disabled people in paying for their health care. The program, administered by HCFA, provides two basic forms of protection. Part A, Hospital Insurance, covers inpatient hospital services, posthospital care in skilled nursing facilities, hospice care, and care in patients' homes. In calendar year 1986, Medicare part A covered about 31 million beneficiaries, and benefits amounted to about $49.8 billion.

Part B, Supplementary Medical Insurance, covers physician services and various other health care services, such as laboratory and outpatient hospital services. In calendar year 1986, Medicare part B covered about 30.5 million beneficiaries, and benefits totaled about $26.2 billion.

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 HMOs and "competitive medical plans"[1] by Medicare beneficiaries. These HMOs operate at risk because they contract to provide Medicare enrollees' covered health care for a predetermined monthly capitation rate. At that time, HHS published regulations implementing the risk-contracting provisions of the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248). This legislation made a number of changes to the law regarding risk contracts that enhanced their attractiveness to HMOs. As a result, the numbers of HMOs with risk contracts and of Medicare beneficiaries enrolled in them have increased rapidly.

During 1985, Medicare enrollment in risk-based providers grew by about 54 percent, from about 304,400 to 467,400 beneficiaries, and in 1986 by 79 percent, to 836,700 beneficiaries. According to HCFA data, over this period, Medicare payments to risk-based HMOs more than tripled, growing from about $495 million in calendar year 1985 to $1.6 billion in calendar year 1986. HHS expects continued rapid growth by risk-based HMOs in the Medicare marketplace.

Capitation payments create strong financial incentives for providers to constrain their costs of providing services to Medicare beneficiaries enrolled in the plans. Capitation payments also increase HHS's control over budgeted outlays. Because of this, HHS developed a proposal to expand the program, seeking authority to enter into risk contracts with

[1]Competitive medical plans are providers that operate like HMOs in that they provide services and are reimbursed on the basis of a predetermined fixed capitation rate. They are subject to essentially the same Medicare regulatory requirements except they are permitted greater flexibility than HMOs in how they set their commercial premium 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.

employer-based plans. HHS submitted its legislative proposal to the Congress in July 1987, as part of a legislative package referred to as the "Medicare Expanded Choice Act."

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. For example, Medicare beneficiaries are currently responsible for the first $75 of approved part B charges (the deductible) plus 20 percent of the remaining approved charges (the coinsurance amount). Also, beneficiaries are responsible for a part A inpatient hospital deductible of $520. Supplemental policies generally cover these amounts. According to a Department of Labor study, in 1983, an estimated 6.9 million retirees and their dependents were covered by employer-sponsored health benefit plans.[2]

Under the proposed new program—called by HCFA the "Medicare insured group"—an employer-based plan assumes, for a fixed capitation payment, the financial risks of providing health care benefits to Medicare beneficiaries affiliated with an employer's retirement plan. According to HHS, the Medicare-insured group program would enable employer-based plans to combine Medicare and employer-sponsored supplemental benefits into one integrated health care plan. By managing all their retirees' health care benefits, employer-based plans could more effectively monitor and control the price and utilization of benefits.

To gain experience with the Medicare-insured group concept, HHS plans to fund several demonstration projects under its demonstration waiver authority. The Department used a similar approach before nationwide implementation of the existing HMO risk-based contract program. Between 1980 and 1984, HHS awarded contracts to 32 HMOs to test the provider-based, risk-sharing arrangements. Currently, HHS is developing the demonstration protocol and negotiating with employer-based plans that have expressed an interest in participating. Thus far, several major employers, including Chrysler Corp., General Motors Corp., and at least one union (the Teamsters) have expressed an interest in participating.

[2]Employer-Sponsored Retiree Health Insurance, U.S. Department of Labor, Pension and Welfare Benefits Administration, May 1986.

Objectives, Scope, and Methodology

As requested, our objectives were to evaluate (1) HHS's proposal to contract on a prepaid capitation basis with employer-based plans to provide Medicare benefits to their retirees and (2) the potential effects on competition with existing HMOs. We focused on the proposed mechanisms for establishing capitation rates and ensuring that beneficiaries have access to quality care.

We reviewed HHS documentation related to the legislative proposal and demonstration projects HHS planned to test and evaluate its concepts. To obtain information on specific elements expected to be incorporated in the proposal, we discussed it with officials in HCFA's Office of Prepaid Health, the organization responsible for developing it. Also, we interviewed officials in HCFA's Office of Research and Demonstrations to obtain information on demonstrations they are planning to test the Medicare-insured group concept.

In addition, we reviewed the Medicare statute as it relates to currently authorized capitation contracts with HMOs and reviewed our earlier work on HCFA capitation initiatives under the Medicare and Medicaid programs.

As requested, we did not obtain agency comments on this report. Except for that, our work was done in accordance with generally accepted government auditing standards.

Issues for Resolution Before Legislation Is Enacted

Under current law, HHS can contract for health services only with established health care providers. The Medicare-insured group concept would expand HHS's Medicare risk-contracting authority by authorizing HHS to contract with employer-based health plans. This would significantly increase the number of organizations that could sponsor prepaid Medicare health care plans and could substantially increase the number of Medicare beneficiaries enrolled in such plans. In analyzing HHS's Medicare-insured group proposal, we explored issues related to

- the adequacy of methods that HHS was considering for determining capitation payment rates and the reasonableness of allowing the employer-based plans to retain any savings without limitation on the amounts retained,
- competition between Medicare-insured groups and existing HMOs, and
- the adequacy of administrative safeguards designed to protect beneficiary interests and help ensure quality of care.

In the past, HHS has experienced certain problems with new initiatives that exhibited rapid growth, as the Medicare-insured group program potentially could. Furthermore, capitation of organizations that are neither providers of services nor commercial insurers is an untested concept. These issues should be addressed before legislation authorizing nationwide implementation is enacted.

Need to Demonstrate Effectiveness of Proposed Reimbursement Methods

The methods HHS is considering for reimbursing employer-based plans that participate in the Medicare-insured group program vary significantly from those HHS currently uses to reimburse risk-based HMOs. There should be reasonable assurance that the capitation payment rates under this new methodology do not exceed what Medicare otherwise would pay for serving this group of beneficiaries if they remained in the fee-for-service sector. Additionally, payment safeguards, similar to those which limit an HMO's profit or surplus to that earned on its commercial business, should be explored to help assure that both Medicare beneficiaries and those enrolled in employer-based plans receive a fair value in medical coverage for the payments made.

Proposed Rate-Setting Methodology

Retired Medicare beneficiaries associated with specific employer-based plans, according to HCFA, may have different health status and utilization of services and health care costs than Medicare beneficiaries in general. The reasons for such differences include the employer-based plan members' particular work environment and past availability to them of health care coverage. But Medicare's Adjusted Average Per Capita Cost (AAPCC) methodology for setting capitation rates for HMOs is based on overall average Medicare costs in specific geographic areas (i.e., counties). This methodology, therefore, may not result in payment rates that accurately reflect Medicare's costs of serving a specific retiree group.

Rather than using the AAPCC rates for geographic areas in which the employer-based plan retirees live, HCFA is considering an experience-based rate-setting methodology. It would use prior Medicare cost and utilization data for the specific group of retirees as the basis for developing the monthly capitation payment rate. The Medicare-insured group would be paid 95 percent (the same percentage of the AAPCC paid HMOs) of what HCFA estimates the Medicare-insured group enrollees otherwise would have been expected to cost had they continued to receive their Medicare-covered health services in the fee-for-service sector.

Initially, the Medicare-insured group payment methodology would be experience based for each group. But once the project began, HCFA would no longer be processing a Medicare-insured group's Medicare enrollees' claims and would, therefore, not have Medicare claims data on that group's health costs to make experience-based adjustments when the rates are renewed. Consequently, HCFA will have to develop another method for determining necessary rate adjustments to account for such factors as inflation and program changes.

The experience-based method proposed for the Medicare-insured group concept differs substantially from commonly accepted methods for renewing group health insurance in the private sector. Insurance firms consider prior-year claims experience for the covered group in setting renewal rates. HCFA also uses prior-year experience for its fee-for-service beneficiaries as the basis for annual updates of the AAPCC for HMO beneficiaries. Because of the absence of continuing claims data under the Medicare-insured group concept, HCFA plans to base renewal rates for the initial experience-based rates on some index of cost growth, such as overall Medicare cost changes. As time passes, it might become increasingly difficult to measure objectively whether underpayments or overpayments to Medicare-insured groups were occurring.

HCFA officials acknowledge that this and other problems must be overcome in developing a workable rate-setting methodology for the Medicare-insured group program. For example, the director of HCFA's Office of Prepaid Health, in an article published in December 1986, said:

"There are a host of questions and concerns surrounding the issue of experienced-based rating, not the least of which is the adequacy of the data needed to construct an experienced-based rating formula. Other questions include the details of the experience-based rating formula itself and the methods for the renewal rating, through prospective pricing, of such groups from one year to the next."[3]

Because of these problems, we believe the rate-setting methodology should be fully developed and tested before general legislative authority is granted for the Medicare-insured group concept. HCFA plans to develop and test proposed rate-setting methods through its demonstrations.

[3]Kevin E. Moley, "Overview of Employer Capitation Activities," Health Care Financing Review, 1986 Annual Supplement, pp. 31-34.

Need to Consider a Reimbursement Safeguard

Any prospective rate-setting process, whether for HMOs or Medicare-insured groups, is subject to error. Among the possible causes are: the lag (now 2 years) between the time of the historical cost data used to calculate the rates and the period for which the rates apply, the assumptions and approximations used in setting the rates, and the possible differences in health status between a provider's enrollees and the group Medicare used to calculate the rate. To help ensure that payment rates do not result in overcompensating HMOs for the services they offer, the Congress provided for the "adjusted community rate" process. The adjusted community rate puts a ceiling on the amount of Medicare payments that may be retained by the HMO for its own use. Computed annually by each HMO and approved by HCFA, the adjusted community rate helps assure that the HMO is providing a fairly priced package of Medicare services or, alternatively, that Medicare is paying a fair price for services provided.

The adjusted community rate is an HMO's estimate of what it would charge beneficiaries for the basic Medicare benefit package if the HMO's commercial rates applied (adjusted for the utilization characteristics of the plan's Medicare enrollees). It includes whatever profit margin the HMO makes on its commercial business. If an HMO's AAPCC payment rate exceeds what the HMO would charge commercially, it must use the difference (called "savings") to provide additional services or lower premiums to its Medicare enrollees and/or reduce Medicare's payment rates. Such savings can be substantial. We reviewed the 1986 adjusted community rate submissions for a randomly selected sample of 15 HMOs and found the estimated savings (i.e., the value of the no-additional-cost benefits provided to Medicare beneficiary enrollees) averaged about 12.9 percent of the Medicare payments. About one-third of the HMOs had savings above 20 percent.

Most HMOs elected to return these savings to the beneficiaries in the form of additional services, such as eliminating enrollee copayments and deductibles, and adding services not covered by Medicare, such as routine physicals.[4] These are the same kinds of services that typically would be covered by Medigap plans provided by potential Medicare-insured group sponsors (e.g., employers or unions) that are committed to offer health benefits to their Medicare-eligible retired employees or members.

[4]HMOs can also elect to return savings to Medicare by reducing their payment rates or alternatively asking HCFA to deposit the savings in the "benefit stabilization fund." This fund can be drawn on by the HMOs during a subsequent 2-year period if their costs for Medicare enrollees exceeded forecasted levels.

We believe a safeguard, similar to the adjusted community rate, is needed to ensure that employers or other Medicare-insured group sponsors (such as unions) do not use the savings resulting from capitation solely to subsidize what they had previously obligated themselves to provide. Such a mechanism would channel the savings either to the Medicare-insured group enrollees (who would receive services in addition to those already provided) or to the Medicare program (by lowering capitation payment rates). To employ such a mechanism, HCFA would need to modify the existing adjusted community rate process because of the absence of commercial enrollees (and thus commercially offered premiums) in employer-based plans. HCFA plans to collect cost data from Medicare-insured plans during its demonstrations, which will allow it to assess the need for a reimbursement safeguard.

Effect of Competition With Existing HMOs Not Yet Determined

You expressed concern about the possible effects of a Medicare-insured group on existing Medicare prepaid plans and whether such groups might have a competitive advantage. Because of the rapid growth in HMOs with Medicare contracts resulting from the Tax Equity and Fiscal Responsibility Act, about half of Medicare beneficiaries now live in locations with one or more such organizations with Medicare contracts, according to HCFA officials. Thus, Medicare-insured groups may share markets with existing prepaid plans serving Medicare beneficiaries. This could increase competition in the prepaid health care market, and might cause the existing plans to lose enrollment. On the other hand, Medicare-insured groups could contract with such plans to provide services to the insured groups' retirees and this might cause such plans to gain in enrollment.

HCFA has not studied the potential effect of this competition, but plans to in its demonstration projects. Such study is needed because, as the HMO program grows, the addition of Medicare-insured group-sponsored managed care systems can be expected to have an effect on competition. The potential problems can be seen in one Detroit HMO we reviewed for another study. At the time of our review in early 1987, this HMO had enrolled about 2,900 retired employees (including dependents) who had retiree supplemental health benefits through their former employers (mainly two automobile manufacturers). The employer paid the retirees' HMO premiums in lieu of paying for the supplemental health coverage (similar to a traditional Medigap policy) that it provided other Medicare retirees not electing to join the HMO. In this case, the existing HMO offered the employer and retirees many of the same benefits that the Medicare-insured group program was expressly designed to offer. That is,

- the retirees had coordinated benefits (i.e., they did not have to submit claims to both Medicare and a supplemental insurer) and a broader benefits package than regular Medicare and
- the employer had the opportunity to reduce its costs because Medicare indirectly helped pay for the broader benefits (i.e., as discussed on p. 7, on average about 12.9 percent of Medicare's HMO payments were used by the HMOs sampled to provide additional services at no additional cost to the beneficiaries).

If this employer established a Medicare-insured group, it is not certain that the employer would continue contracting with this HMO, and in fact, the employer could establish itself as a competitor.

The relative competitive positions between Medicare-insured groups and HMOs could be influenced because capitation payments from Medicare could be higher for one than the other. In the example discussed above, the Detroit HMO had enrollees retired from six separate employers. The HMO received payment for these retirees on the basis of a single set of rates computed and published annually by Medicare for each geographic area (i.e., county). Under the Medicare-insured group concept, each insured group would have its own rates, which might be lower or higher than the Medicare rates being paid to the HMO. It is unclear what effects such a multiple rate structure would have on existing HMOs.

Need to Demonstrate Effectiveness of Financial and Quality Assurance Safeguards

For the Medicare-insured group program, as with any program for delivering health care on a prepaid basis, program safeguards are necessary to help assure that the risk-bearing organizations have the administrative systems, financial capacity, and minimum enrollment necessary to assume risks and provide quality care. Existing key legislative safeguards for HMOs may not be effective for Medicare-insured groups because the safeguards

- are based on the presumption that the organization seeking a Medicare contract is a health care provider and already established in the business of providing capitated health care services to commercial clients—presumptions not valid for most employer-based plans—and
- apply only to the HMO itself, not to subcontractors. To the extent that a Medicare-insured group provides its services through risk-sharing subcontracts with health care providers, the safeguards would not affect these providers.

To help ensure that Medicare beneficiaries enrolled in HMOs receive care comparable in quality to that prevailing in the areas served by these organizations, the Public Health Service and Social Security Acts establish certain safeguards. These include requirements that HMOs, before receiving a Medicare contract, must (1) have a certain minimum number and composition of enrollment (i.e., generally enroll at least 5,000 members, no more than 50 percent of whom can be Medicare/Medicaid recipients), and (2) demonstrate reasonable financial success over time in operating capitated systems.

The existing safeguards are based on the presumption that an HMO applying for a Medicare contract is a health care provider already established in providing capitated health care services to commercial clients. Typically, employer-based plans would not meet these presumptions; thus, existing Medicare safeguards may not apply or have their intended effect.

For example, the Social Security Act's 50-50 requirement, which limits an HMO's enrollment of Medicare (and Medicaid) beneficiaries to no more than 50 percent of its total enrollment, may not be applicable to Medicare-insured groups. The purpose of the requirement is to help ensure quality of care (assuming that an HMO's ability to attract commercial members is itself a safeguard). In addition, the requirement serves to limit the rate at which an HMO can expand its Medicare business (once the 50-percent threshold is reached, the HMO can enroll new Medicare members only by attracting new commercial members on a one-for-one basis).

This requirement may not apply or have its intended effect, because a Medicare-insured group will have no commercial enrollment. In the two cases where Medicare waived the 50-50 requirement for HMOs, and the HMOs continued to expand their Medicare enrollments beyond the 50-percent threshold, the HMOs developed significant financial problems. International Medical Centers, a Florida-based HMO, was terminated from the Medicare program because of financial and quality-of-care problems, and the United Health Plan in Los Angeles, California, is now operating under Chapter 11 bankruptcy. In both cases the HMOs underwent rapid growth, unrestrained by the need to attract commercial enrollees to meet the 50-50 requirement.

Additionally, existing safeguards in the Public Health Service and Social Security Acts apply only to the HMO contracting with HCFA to serve Medicare beneficiaries. In a July 1986 report,[5] we found that the effectiveness of existing HMO safeguards can be limited in those HMOs, such as International Medical Centers, which pass on much of the risk of enrollee health care costs to subcontractors. These risk-bearing subcontractors, which function in many respects as independent HMOs with little federal or state oversight, are not required to comply with Public Health Service and Medicare requirements.

To the extent that Medicare-insured groups elect to provide their enrollees' services through risk-bearing subcontractors, a situation can arise where such subcontractors function as HMOs without having to meet any of the federal and state financial and quality-of-care requirements normally imposed on these entities.

Consequently, it appears that existing safeguards may have little applicability to Medicare-insured groups and new types of safeguards may need to be designed. We believe that designing safeguards could best be done and tested through the demonstration projects. HCFA plans on applying the existing safeguards to proposed demonstration projects, but the details of how they will be applied were not specifically spelled out at the time of our review.

Demonstration Phase Should Be Evaluated Before Legislative Authorization

The need for an adequate demonstration and evaluation of a new activity such as the Medicare-insured group program has been identified in connection with two demonstrations involving the Medicare and Medicaid programs. Each of these initiatives involved the award of risk-sharing contracts to private sector health provider organizations in attempts to contain program costs. In reviews of these demonstrations, we identified numerous difficulties, ranging from problems with financial viability of some of the participating organizations to difficulties involving such fundamental administrative systems as those controlling beneficiary enrollment.[6]

In our reviews of the early implementation of the Medicare HMO initiative, for example, we found HHS's oversight efforts were not sufficient to

[5]Medicare: Issues Raised by Florida Health Maintenance Organization Demonstrations (GAO/HRD-86-97, July 16, 1986).

[6]The report noted above and Medicaid: Lessons Learned From Arizona's Prepaid Program (GAO/HRD-87-14, Mar. 6, 1987).

assure that all Medicare requirements were being adhered to. Specifically, we found that HHS administrative procedures and monitoring and enforcement of requirements were not sufficient to preclude

- confusion in enrolling and disenrolling Medicare beneficiaries in HMOs, which leads to claims processing delays for beneficiaries and duplicate payments by the program and
- noncompliance by HMOs with HHS's approved marketing practices and beneficiary grievance procedures.

We also identified limitations in HHS enforcement of quality-of-care and financial solvency safeguards.

Conclusions

It is probable that difficulties will arise with the Medicare-insured group initiative, if only because of the need to develop and demonstrate the effectiveness of new capitation rate-setting methods and financial and quality-of-care safeguards. For this reason and because of lessons learned from earlier demonstrations in Medicare and Medicaid capitation initiatives, HHS should proceed cautiously with the initial phases of such a complex new program. Consequently, we believe legislative authorization for expanding HCFA's authority to contract with non-health-care providers should be deferred until the concept has been tested and evaluated through demonstrations. The demonstrations are needed to show that

- the payment methodology is sound and assures reasonable Medicare costs and benefits to enrollees, and
- requirements are in place to help assure Medicare-insured group contracting organizations' financial solvency and quality of care.

Matters for Consideration by the Subcommittee

If the Subcommittee considers HHS's Medicare-insured group proposal, it should consider deferring authorizing implementation until HHS demonstrates that the Medicare-insured group rate-setting methods and beneficiary and program safeguards are reasonable and adequate.

As arranged with your office, unless its contents are announced earlier, we plan no further distribution of this report until 5 days from its issue date. At that time, we will send copies to the Director, Office of Management and Budget; the Secretary of Health and Human Services; the

Administrator of the Health Care Financing Administration; and other interested parties.

Sincerely yours,

Richard L. Fogel
Assistant Comptroller General

Requests for copies of GAO publications 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 publication 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

Address Correction Requested

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