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

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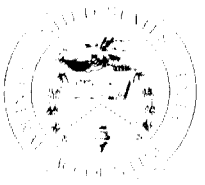
MEDICARE

Increase in HMO Reimbursement Would Eliminate Potential Savings



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Human Resources Division

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November 1, 1989

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

Dear Mr. Chairman:

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) modified Medicare's authority to enter into risk contracts with health maintenance organizations (HMOs) and revised the reimbursement provisions for such contracts. Under these TEFRA risk contracts, HMOs agree to provide all covered health care services to enrolled Medicare beneficiaries in return for a fixed payment amount per enrollee. The payment is set at 95 percent of Medicare's estimate of the average cost it would have incurred for HMO enrollees had they remained in the fee-for-service health care sector. This estimate is referred to as the adjusted average per capita cost (AAPCC). Within certain limits, the HMO can profit if its cost of providing services is less than the predetermined amount, but it risks a loss should its costs be higher. As of the end of fiscal year 1989, Medicare had TEFRA risk contracts with 131 HMOs enrolling 1.1 million beneficiaries.

On September 27, 1989, you advised us of a proposed change in the law that would raise reimbursement for HMOs with TEFRA risk contracts from 95 to 100 percent of the AAPCC. You asked us to review the legislative history of the 95-percent payment rate, and to evaluate the proposed increase in light of that history. This letter responds to that request.

Results in Brief

The history of Medicare reimbursement to HMOs with risk contracts shows that the Congress set the payment at 95 percent of the AAPCC to save Medicare program funds. That is, the fixed payment amount for Medicare HMO enrollees was intended to be 5 percent less than the expected Medicare cost if the enrollees had remained in the fee-for-service sector. Increasing the payment rate to 100 percent of the AAPCC would eliminate this potential Medicare savings from the HMO program.

Moreover, recent studies have found that even with the rate at 95 percent of the AAPCC, TEFRA risk contracts with HMOs may not have reduced Medicare outlays (see pp. 7-8). These studies show that Medicare beneficiaries enrolled in HMOs tend to be healthier and less likely to use health care services than non-HMO beneficiaries, and thus on average are less

costly to treat. They concluded that the methodology used to calculate the AAPCC does not accurately reflect these cost differences. Therefore, rather than paying less, Medicare may have paid HMOs more than if the same enrollees had remained in the fee-for-service sector. Increasing the HMO payment rate to 100 percent could exacerbate the problem.

Background

Medicare, authorized by title XVIII of the Social Security Act, is a broad health insurance program available to most persons 65 years old and above and to some disabled persons. Benefits are provided under two parts. Part A, hospital insurance, covers inpatient hospital, skilled nursing facility, home health, and hospice services. In fiscal year 1988, part A paid about $53 billion for about 32.4 million beneficiaries. Part B, supplementary medical insurance, covers physician services and a broad range of other services furnished on an outpatient basis, such as laboratory and X-ray services, and medical equipment used in the home. In fiscal year 1988, part B paid about $35 billion for an estimated 31.6 million beneficiaries. The Medicare program is administered by the Health Care Financing Administration (HCFA) under the Department of Health and Human Services (HHS).

Most Medicare beneficiaries receive their care in the fee-for-service sector of the health care system. In that sector most inpatient hospital and hospice care is paid on the basis of prospectively determined rates, and skilled nursing facilities and home health agencies are paid on the basis of cost. Part B services are paid on a reasonable charge basis or, as in the case of laboratory and anesthesiology services, on a fee schedule basis.

A proportion of Medicare beneficiaries is enrolled in HMOs, which are typically designed to provide care on a capitated payment basis. That is, the HMO receives a set monthly payment for each enrolled beneficiary and in return agrees to furnish necessary medical care, often with little or no cost sharing on the part of the enrollee. One advantage of capitated payment is that it gives the provider incentives to be cost-efficient and to avoid unnecessary care.

Under section 1876 of the Social Security Act, as amended by TEFRA (P.L. 97-248, Sept. 3, 1982), HMOs that enroll Medicare beneficiaries[1] may be paid in one of two ways for all part A and part B services. First, they

[1]TEFRA provisions also apply to competitive medical plans, which are eligible to contract with HCFA for Medicare payment but do not meet the definition of an HMO in the Public Health Service Act.

may be paid based on the actual cost of caring for the Medicare beneficiaries enrolled in the plan. The payment is estimated in advance based on the experience of the HMO, and adjusted retroactively to reflect actual allowable costs.

Alternatively, if the HMO meets certain conditions, it can elect to enter into a risk contract with the Medicare program. Under such a contract, it is paid a fixed monthly amount for each Medicare beneficiary enrolled and can profit, within limits, if its costs are less than the payment amount. This report focuses on the Medicare payment methodology for risk HMOs.

HMO Reimbursement Before TEFRA

Although the current method of reimbursing risk HMOs was established by TEFRA in 1982, the HMO payment provisions had their genesis in legislation initially reported by the House Committee on Ways and Means in May 1970, and again in May 1971. The original Medicare statute, enacted in 1965, did not explicitly provide for reimbursing HMOs. Until 1972, HMOs were paid under the legislative authority contained in section 1833 of the Social Security Act. This section provided for reimbursement of group practice prepayment plans for part B services to Medicare eligibles enrolled in such plans on a reasonable charge or reasonable cost basis.

The Congress was concerned, however, that by paying HMOs in this manner Medicare was not taking advantage of the savings that HMOs might offer if paid on a prospective per capita basis. Paying HMOs prospectively gives them strong incentives to institute utilization controls and efficient management practices because their profitability is influenced by their ability to provide services at less cost, on average, than the prospectively determined rates. Accordingly, the House Committee on Ways and Means in May 1970, and again in May 1971, recommended that the Medicare statute be amended to allow Medicare to pay HMOs on the basis of prospectively determined fixed per capita rates. This provision was passed by the House of Representatives in June 1971.

The provision passed by the House provided that HHS determine HMO rates annually at a rate actuarially equivalent to 95 percent of the estimated amount (adjusted for such factors as enrollees' age and morbidity differentials) that Medicare would pay on average for services to non-HMO enrollees. Through this mechanism, the Committee expected to save Medicare 5 percent compared to average payments made on behalf of beneficiaries not enrolled in HMOs.

To help guard against potentially excessive profits, the House version provided that HMOs' profits on their Medicare business be limited to no more than the profits on their non-Medicare business. HMOs would have had to refund profits above that rate to Medicare, use them to pay for additional benefits, or reduce premiums charged to Medicare beneficiaries.

But this legislation was not adopted. Instead, the Congress adopted a revised HMO coverage provision in the Social Security Act Amendments of 1972 (P.L. 92-603), which added section 1876 to the act. This section created two options for paying HMOs for all Medicare covered services—a cost reimbursement option and a capitation option. Under the capitation option, an HMO's cost per member was compared to the AAPCC for all Medicare beneficiaries in the HMO's service area. If the HMO's cost was higher than the AAPCC, it had to absorb the loss or carry it over to be offset by future "savings." If the HMO's cost was less than its AAPCC, it shared the savings with Medicare on a 50-50 basis with the HMO's profits limited to 10 percent of the AAPCC.

The Senate Committee on Finance was reluctant to adopt the prospective payment mechanism proposed by the House, apparently because of concern that this might result in excessive cost cutting by HMOs, thereby reducing quality of care to Medicare enrollees. In addition, the Committee was concerned that it might be impossible to calculate an actuarially equivalent payment rate that would assure that payments to HMOs were not excessive. The Committee report on the Social Security Amendments of 1972 expressed the latter concern as follows:

"... The second problem area involves the reimbursement of HMO's. If an HMO were to enroll relatively good risks (i.e., the younger and healthier medicare beneficiaries), payment to that organization in relation to average per capita non-HMO costs—without accurate actuarial adjustments—could result in large 'windfalls' for the HMO, as the current costs of caring for these beneficiaries might turn out to be much less than medicare's average per capita costs. Additionally, ceilings on windfalls might be evaded because an HMO conceivably could inflate charges to it by related organizations thereby maximizing profits through exaggerated benefit costs.

"It may not always be possible to detect and eliminate such windfalls through actuarial adjustment. Further, once a valid base reimbursement rate is determined, an issue remains as to the extent to which the HMO, and the Government should share in any savings achieved by an HMO."

The Congress was also concerned about potential quality-of-care problems. To minimize these concerns, and assure financial stability and an

adequate mix of enrollees, the 1972 amendments added several requirements that HMOs generally had to meet before entering into a Medicare contract. These included a minimum 25,000 enrollment, of which at least half were under 65 years of age, and an operating history of at least 2 years.[2]

HMOs did not regard this risk contract option favorably, apparently because of the limits placed on their profit potential and the fact that profits had to be shared with Medicare, while their losses had to be fully absorbed. In addition, the 25,000-member enrollment requirement made many of them ineligible to participate in the risk program. Consequently, between 1972 and the 1982 enactment of TEFRA, only one HMO elected to contract with Medicare on a continuing basis under the risk contract option.

Provisions Liberalized Under TEFRA

TEFRA encouraged more HMO risk contracts. Section 114 of TEFRA changed the Medicare law, amending section 1876 of the Social Security Act to (1) liberalize the beneficiary enrollment standards of the section and (2) adopt reimbursement provisions similar to those first proposed in 1971. The 25,000-enrollee standard was reduced to 5,000 enrollees, no more than 50 percent of whom could be Medicare and Medicaid enrollees. This allowed more HMOs to qualify for Medicare contracts than under the previous law.

TEFRA also created financial incentives for HMOs to participate in Medicare. Similar to the 1971 proposal, section 114 gave HMOs an opportunity to profit on Medicare as much as on their other lines of business. HMOs were paid on the basis of fixed per-enrollee rates of 95 percent of Medicare's estimate of the average cost it would have incurred for HMO enrollees had they remained in the fee-for-service sector (the AAPCC), thus providing a 5-percent savings for the Medicare program (assuming the AAPCC is accurately set). Instead of sharing any additional savings with Medicare, HMOs could retain all profits up to the level of profits earned on their non-Medicare enrollment. Also, similar to the 1971 proposals, HMOs had to use any savings above this amount to give Medicare enrollees additional health benefits or reduced liability for deductibles and copayments, or to reduce the Medicare payment rates.

[2]The Secretary could waive the 25,000-member requirement if the HMO operated in a sparsely populated area, and had at least 5,000 members and a 3-year history of successful operation.

In enacting TEFRA, the Congress continued to be concerned, as in 1972, that the AAPCC methodology for computing HMO payment rates was inadequate to accurately reflect the differing health care needs of Medicare beneficiaries who enroll in HMOs as compared to beneficiaries in the fee-for-service system. Without adequate adjustments to Medicare average costs, payment rates would either be too high or too low depending on whether HMOs attracted beneficiaries with lesser or greater health care needs. Therefore, the Congress established the effective date of the TEFRA HMO amendments as the later of (1) October 1, 1983, or (2) when the Secretary of HHS notified the cognizant congressional committees that HHS was "reasonably certain" that an appropriate methodology had been developed for computing the AAPCC to assure actuarial equivalence of HMO and non-HMO Medicare beneficiaries.

The Secretary made the required notification to the congressional committees on January 7, 1985, and section 114 of TEFRA became effective February 1 of that year.

Is the AAPCC Set Correctly?

The success of the TEFRA risk contract program—both from the government and the HMO perspective—depends on how accurately the AAPCC estimates what Medicare would have paid for HMO enrollees had they remained in the fee-for-service sector. HCFA estimates this amount based on projected program costs for beneficiaries with similar characteristics who remain in the fee-for-service sector. HCFA computes AAPCC rates for aged and disabled beneficiaries for each county in the United States. It then adjusts these rates for a set of risk factors defined by age, sex, institutional status, and welfare status.

The HMO rate-setting process contains two potential sources of error. First, there could be problems with the data or the methodology used to project the AAPCC, causing the estimate to be too high or too low. Second, the risk factors used to adjust the AAPCC may not be adequate to account for factors affecting health costs of beneficiaries within each AAPCC category. If this were the case and, for example, the HMO enrolls beneficiaries who are healthier on average than those in their corresponding AAPCC category, the HMO will be paid too much. If enrolled beneficiaries are less healthy than average, the HMO will be paid too little. This problem is usually called "biased selection."

Proponents of raising the Medicare risk HMO reimbursement rate argue that the present reimbursement rate is too low, citing the recent dropout rate as evidence—62 HMOs with Medicare enrollees left the program

between April 1987 and January 1989. In addition, they argue that HMO enrollees receive a broader range of health care services than those covered by Medicare. Therefore, Medicare should support the program even though it may not reduce Medicare expenditures as originally expected.

We do not believe that these arguments are valid. First, the legislative materials show that the Congress expected to reduce Medicare outlays through the TEFRA risk contracts. HMOs with such contracts were required to cover at least the same benefits covered by Medicare in the fee-for-service sector. Any additional benefits were to be paid for out of HMO profits realized by providing covered services at a cost less than the payment rate. For Medicare to pay for an expanded package of services for HMO enrollees would be contrary to what the Congress originally envisioned for the TEFRA risk contracts.

Low Medicare reimbursement rates may not be the only factor that explains why HMOs drop out of the risk program. For example, most of the HMOs that dropped out had relatively few Medicare enrollees, and this may have made it financially unattractive for them to remain in the program. Inefficiency may also explain why some HMOs did not fare well under the risk contract program. Although 62 HMOs dropped out of the program between April 1987 and January 1989, 50 others joined and overall Medicare enrollment in the TEFRA risk HMO program rose from about 900,000 to about 1,040,000. These facts indicate that the rates may not have been unreasonably low.

Indeed, the results of recent studies[3] suggest that reimbursement rates for TEFRA risk contracts may be too high rather than too low. For example, as part of a HCFA-funded study, Mathematica Policy Research reviewed the health care status and treatment costs of Medicare beneficiaries enrolled between 1982 and January 1985 in HMOs with Medicare risk contracts. In a January 1989 report,[4] Mathematica concluded that, because of biased selection, Medicare HMO enrollees in the study group

[3]For example, see P.W. Eggers and R. Prihoda, "Pre-Enrollment Reimbursement Patterns of Medicare Beneficiaries Enrolled in 'At Risk' HMOs," Health Care Financing Review, Vol. 4, No. 1, September 1982, pp. 55-73; F.J. Hellinger, "Selection Bias in Health Maintenance Organizations: Analysis of Recent Evidence," Health Care Financing Review, Vol. 9, No. 2, Winter 1987, pp. 55-63; R.P. Ellis and T. McGuire, "Setting Capitation Payments in Markets for Health Services," Health Care Financing Review, Vol. 8, No. 4, Summer 1987, pp. 55-64. Each of these studies concludes that HMOs are experiencing favorable biased selection, that is, that Medicare HMO enrollees tend to be healthier and less likely to use health care services than non-HMO enrollees.

[4]Lyle Nelson and Randall Brown, The Impact of the Medicare Competition Demonstrations on the Use and Cost of Services: Final Report. Report Submitted to HCFA by Mathematica Policy Research under Contract No. 500-83-0047, January 31, 1989.

had lower expected costs than comparable non-HMO beneficiaries. Mathematica estimated that because the AAPCC risk adjustment factors (see p. 6) do not fully account for these differences, HCFA paid between 15 and 33 percent more during the study period for beneficiaries in these risk contracts than it would have if these individuals had been treated in the fee-for-service sector. If problems related to the data and methodology used in projecting the AAPCC were considered, the study estimated that Medicare's overpayments would have been even higher.

The results of the Mathematica study are consistent with those of an earlier GAO study. In 1986 we reported that the mortality rate for Medicare enrollees in 27 HMOs with Medicare risk contracts was 77 percent of that projected for this group.[5] This suggests that Medicare HMO enrollees were healthier than non-HMO enrollees. We estimated that to realize the savings envisaged by TEFRA, the HMO payment rate would have to be lowered by an additional 5 percent of the AAPCC in order to adjust for mortality differences alone.

The Mathematica and GAO studies were based on analysis of risk contracts awarded to HMOs as part of a demonstration project that preceded the implementation of the TEFRA HMO risk contract provisions in 1985. However, the demonstration contracts were similar to the TEFRA risk contracts, and the method used to calculate the AAPCC was almost identical. Because of the identified shortcomings in the AAPCC methodology, these studies raise serious questions about the accuracy of HMO payments.

Conclusions

Based on our review of the history of HMO Medicare reimbursement, we believe that raising the payment rate from 95 to 100 percent of the AAPCC would be contrary to what the Congress envisioned when authorizing TEFRA risk contracts. The Congress expected that paying HMOs 95 percent of the AAPCC would save the Medicare program 5 percent of what it would have cost had enrollees remained in the fee-for-service sector. Thus, increasing the payment rate to 100 percent of the AAPCC would eliminate any potential for such savings.

In addition, there was congressional concern that inaccuracies in the AAPCC methodology could lead to excessive payments to HMOs. This concern seems well founded in light of recent studies. These studies have

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

concluded that Medicare beneficiaries enrolled in HMOs are healthier and tend to use fewer health care services—and are thus on average less costly to treat—than non-HMO beneficiaries. The studies also found that the methodology used to calculate the AAPCC does not accurately reflect these cost differences. Thus, rather than paying less, Medicare may have paid more for HMO enrollees than had they remained in the fee-for-service sector. If, as the studies indicate, payment rates are too high, increasing the HMO payment rate to 100 percent would exacerbate the problem. We believe that HMO payment rates should not be changed until the issues raised by these studies are resolved.

We are sending copies of this report to the Secretary of HHS, the HHS Inspector General, the Administrator of HCFA, interested congressional committees, 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 to this report are listed in appendix II.

Sincerely yours,

Lawrence H. Thompson

Lawrence H. Thompson
Assistant Comptroller General

Objectives, Scope, and Methodology

As requested, our objective was to review the legislative history of the 95-percent payment rate for HMOs with TEFRA risk contracts and to evaluate the proposed increase in light of that history. To do this, we examined legislative materials related to original provisions for risk contracts with HMOs as well as the congressional committee reports related to TEFRA. We also discussed the proposal to raise the TEFRA risk-contract reimbursement rate with relevant agency officials and congressional staff. Finally, we reviewed recent studies, including prior GAO work, that address the accuracy of the AAPCC and of Medicare's HMO payment rates for the TEFRA risk contract program. Our work was performed between September 28 and October 13, 1989, in accordance with generally accepted government auditing standards.

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