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Report to Congressional Committees

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MEDICARE

Status Report on Medicare Insured Group Demonstration Projects

GAO/HRD-89-64

GAO

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

Human Resources Division

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June 27, 1989

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)[1] to provide Medicare benefits to retirees. Section 4015(a) requires that we monitor contracts with these MIGs and report on the status of the projects and the effect on them of OBRA's requirements for the demonstration. This is our first report.

MIGs must agree to provide the full range of Medicare-covered services to its Medicare-eligible retirees for a per capita rate of payment. The MIG's loss or surplus for servicing these retirees would depend on whether its costs to provide the Medicare services are more or less than the capitation payment.

We previously reported on unresolved issues in HHS's proposal to contract with employer-related groups on a capitation basis.[2] Because the MIG concept had not been tested and HHS had problems implementing previous capitation initiatives, we urged caution in proceeding with the proposal and recommended 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.

[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 employer-related groups, such as employers and unions, were the entities most likely to participate.

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

Results in Brief

HHS's Health Care Financing Administration (HCFA) has entered into cooperative agreements with Chrysler Motors Corporation, Southern California Edison Company (SCEC), and Amalgamated Life Insurance Company[3] to establish the three MIG projects authorized by OBRA. In April 1989, we were advised by HCFA officials that it was not certain when any of the three projects would become operational.

The Chrysler and SCEC MIGs were in the planning stage in March 1989. Amalgamated was developing its health care delivery system and had not yet enrolled any Medicare beneficiaries. Because there is no certainty that all three projects will become operational, HCFA is continuing to negotiate with other prospective sponsors.

Under the payment provision of section 4015(a), Medicare generally would pay 95 percent of what it would pay under fee-for-service for Medicare beneficiaries, thus realizing a 5-percent cost saving. However, HCFA has interpreted the section in a way that would permit use of payment formulas other than that set out in section 4015(a). As a result, a MIG project could end up increasing the costs to Medicare of servicing those who choose to enroll.

As of April 1989, a final decision had not been made by HCFA on how to apply section 4015(a) limits on the amount of surplus[4] MIGs can retain. However, one way that was being considered could result in Medicare subsidizing non-Medicare benefits previously provided and funded by the employer.

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

[3]Amalgamated Life Insurance Company is a wholly owned subsidiary of the Amalgamated Insurance Fund and provides insurance and retirement benefits to participating members of the Amalgamated Clothing and Textile Workers Union. The Amalgamated MIG will serve retired union workers and their spouses who are beneficiaries of two employee benefit funds—the Amalgamated Insurance Fund and the Amalgamated Cotton Garment and Allied Industries Fund. Contributions to the funds are made by employers. Each fund is managed by a board of trustees with equal representation by labor and management.

[4]A surplus will occur if Medicare payments to the MIG exceed the MIG's expenses.

services. In 1988, Medicare benefits totaled about $51.9 billion for part A and $33.7 billion for part B for about 32 million beneficiaries.

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.[5] 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 the 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, 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. This proposal ultimately led to the OBRA provisions authorizing three MIG demonstrations.

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. 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.[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.

Under the MIG demonstration program, Medicare beneficiaries can elect to enroll in a MIG. For beneficiaries who elect to enroll, the MIG assumes,

[5]HCFA also has risk contracts with competitive medical plans that 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.

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

[7]Employee Benefits: Company Actions to Limit Retiree Health Costs (GAO/HRD-89-31BR, Feb. 1, 1989).

for a fixed capitation payment from Medicare, the financial risk of providing health care benefits. According to HHS, the MIG program would enable employer-related groups to combine Medicare-covered and employer-sponsored Medicare supplemental benefits into one integrated health care plan. In theory, 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. Section 4015(a) envisions at least a 5-percent savings over fee-for-service for Medicare. The employer-based group would, under this theory, have lower costs for Medicare supplemental benefits then it otherwise would. 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 with officials in HCFA's Office of Research and Demonstration, which is responsible for implementing the demonstration and awarding the cooperative agreements. We interviewed HCFA's chief actuary to ascertain how HCFA calculated an experience-based rate for the Amalgamated MIG.

In addition, we reviewed OBRA requirements for MIG projects. We also reviewed prior GAO work on HCFA's capitation initiatives under the Medicare and Medicaid programs.

Our work was conducted between February 1988 and January 1989 in accordance with generally accepted government auditing standards.

Status of Chrysler MIG Project

HCFA finalized a cooperative agreement with Chrysler Motors Corporation in May 1988. Under this agreement, Chrysler began a feasibility analysis phase, during which it will analyze Medicare claims data and its own supplemental benefits data to determine historical cost and utilization and to simulate benefit designs, provider payment arrangements, and delivery system parameters. If, at the end of this phase, Chrysler and HCFA decide implementation of a MIG is feasible, Chrysler will enter a

9-month operational development phase followed by an implementation phase, which would involve enrolling beneficiaries and beginning operations.

According to Chrysler, a major objective of its MIG proposal is to help control the rising health expenditures for approximately 62,000 retired employees under its Medicare supplemental benefits program.[8] The MIG is a joint project between Chrysler and the International Union (United Automobile, Aerospace and Agriculture Implement Workers). Chrysler's union contract requires that retirees receive the same health care benefits as current employees. Chrysler's 1988 Medicare supplemental 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.

Under the cooperative agreement, HCFA budgeted $225,835 for its share of the cost of the feasibility analysis phase and $202,432 for the operational development phase. HCFA officials advised us in April 1989 that the feasibility analysis phase was still under way and the method of setting capitation rates for the Chrysler project had not been determined. Also as of that date, the scope of the project had not been established, nor had the benefit package or service delivery system been determined. We were advised that whether or when operations would begin was not known.

Status of SCEC MIG Project

In January 1989, HCFA entered into a cooperative agreement with SCEC to explore establishing a MIG. 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 5,400 of whom are Medicare eligible. The combined cost of health care and life insurance benefits for SCEC retirees and dependents was about $18 million in 1987.

SCEC retirees can choose to obtain their health care services from an HMO or from SCEC's provider organization—called PrimeCare. Nearly all retirees have selected PrimeCare, which pays in full for covered services at participating providers, including clinics operated by SCEC. If the retirees

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

go to a nonparticipating provider, PrimeCare pays 80 percent of charges. PrimeCare covers inpatient, outpatient, substance abuse, mental health, and chiropractic services; 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 is also in the process of establishing three geriatric health care centers.

SCEC proposes to use the PrimeCare plan for its MIG project with the possibility of additional 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 Medicare eligible because of a disability. SCEC proposed a Medicare payment rate of 95 percent of its experienced-based rate. The amount of this rate has not yet been determined, nor has the operational date been established.

Status of Amalgamated MIG Project

Amalgamated Life Insurance Company is the administrator of 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 lower 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 deductibles and 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 located in Philadelphia. Medicare-eligible retirees are responsible for part B coinsurance and deductibles for services provided at these health centers; they receive nothing from Amalgamated when other providers are used.

In September 1988, HCFA and Amalgamated finalized a cooperative agreement to establish a MIG demonstration project, which is expected to last 5 years. The union has about 12,000 Medicare-eligible retirees and spouses in the Philadelphia area, and Amalgamated has proposed it as the initial site for its demonstration project.

As part of the negotiations with Amalgamated, HCFA approved a capitation rate for the Amalgamated MIG equal to 95 percent of the AAPCC for the counties in which enrollees reside. HCFA approved a preliminary budget of $222,992 for developmental funding. In September 1988, Amalgamated submitted a draft operational protocol to HCFA for approval. HCFA is reviewing the proposal and has raised a number of questions. Meanwhile, Amalgamated is investigating various options for

its service delivery system. Once the delivery system is finalized, the newly formed Amalgamated MIG will have to be certified as a Medicare provider. HCFA officials told us in April 1989 that it was not certain if and when the MIG will become operational.

Planned Amalgamated Payment Method May Increase Medicare Expenditures

HHS has interpreted the OBRA provision regarding restrictions on payments to MIGs in a manner that may result in Medicare paying more for MIG enrollees than if they had stayed in the fee-for-service sector. Section 4015(a)(3)(A) of OBRA provides that the MIG per capita rate of payment under a demonstration project may be based on the HMO AAPCC methodology only with respect to the group of individuals involved (that is, experience-based) rather than that of all Medicare beneficiaries.[9] Additionally, section 4015(a)(3)(B) states that the rate of payment used may not exceed 95 percent of this experience-based rate.[10] The payment restriction thus results in a minimum 5-percent savings to Medicare.

HCFA believes it is not required to use an experience-based rate. It believes also that the 95 percent of experience-based payment restriction of section 4015(a)(3)(B) is not mandatory unless MIG capitation payments are based on the experience of the specific group to be served by the MIG. A reasonable reading of section 4015(a), we believe, is that the payment rate authorized under the section is the only payment rate that may be used for MIG projects with other than a Medicare qualified HMO. Therefore, we have requested HHS's interpretation of section 4015(a), including specific legal reasoning. We believe also that the payment restriction should apply to all MIG projects regardless of the rate-setting method used.

HCFA's original MIG legislative proposal contemplated the use of a capitation payment rate based on the experience of the Medicare beneficiaries to be served by the MIG—that is, an experience-based rate. During negotiations, Amalgamated proposed and HCFA accepted using as a capitation

[9]The health status and past utilization-of-service experience of retired Medicare beneficiaries associated with employer-related plans, such as MIGs, may differ from those of Medicare beneficiaries in general because of their particular work environment and past availability of health care services. Therefore, a rate-setting methodology based on the average costs of Medicare beneficiaries in general may not result in a payment rate that accurately reflects the Medicare costs of serving a specific retiree group.

[10]If the HMO rates are less than 95 percent of the experience-based rate, additional restrictions operate to further reduce the payment rate to that used for HMOs (95 percent of the AAPCC) by the sixth year of a project.

rate 95 percent of the AAPCC, which is based on the experience of the general Medicare population in the counties where the potential MIG enrollees reside. This is the same rate paid to risk-based HMOs.

At the time HCFA accepted the proposal, HCFA estimated that Amalgamated beneficiaries' per capita cost experience was lower than the AAPCC. HCFA's analysis of 1986 Medicare costs for Amalgamated retirees and spouses in Philadelphia County, Pennsylvania, showed their experience to be 93 percent of the AAPCC for that county. Thus, if the Philadelphia County experience were representative of Amalgamated's experience throughout the Philadelphia area, setting rates for the Amalgamated MIG using 95 percent of the AAPCC would increase Medicare costs by 2 percent rather than saving the 5 percent anticipated.

In its comments on this report, HHS said that a recent HCFA analysis of 1987 data for Amalgamated retirees in Philadelphia County showed their per capita Medicare cost experience to be higher than the AAPCC. If this later analysis is representative of experience throughout the Philadelphia area, paying Amalgamated the AAPCC-based rate would disadvantage the MIG and cause it to lose money.

The analyses discussed above illustrate the importance prior experience can have to MIG rate setting. Either Medicare or the MIG could be disadvantaged if the payment rates are not related to experience.

Excess Medicare Payments May Be Used to Subsidize Employer Supplemental Benefits

Section 4015(a)(7) of OBRA requires the MIG sponsor to continue offering and paying for benefits equivalent to any supplemental health benefits previously offered to Medicare retirees, but Medicare might end up subsidizing this sponsor responsibility. Section 4015(a)(4) requires that surpluses in excess of 5 percent of the experience-based rate be used for additional benefits for MIG enrollees or returned to HHS. In effect, this establishes a 5-percent cap on MIG profits. OBRA defines "surpluses" as payments that exceed the "costs" of the project.

HCFA officials told us that they have not decided how "costs" should be defined but that the term could be interpreted to include expenditures for all benefits provided, including supplemental benefits the MIG sponsor provides. We believe the provision is intended to count the costs of Medicare-covered expenses only, similar to what is done in the regular risk-contract HMO program. If "costs" is defined to include all MIG expenditures, any Medicare payments that exceed the costs of providing

Medicare services could be used by the MIGs to cover expenses incurred in providing benefits previously funded by the sponsor.

In our previous report we concluded that a safeguard is needed to ensure that MIG sponsors do not use savings to subsidize what they had previously obligated themselves to provide.[11] Additionally, a profit cap is a quality assurance mechanism that reduces the incentive to underserve beneficiaries in a capitated system because additional profits are not generated.[12] Such a mechanism, called the adjusted community rate (ACR) process, is used in the risk-based HMO program. The ACR process is designed to restrict surplus retention to the HMO's profit rate on its commercial enrollees.

Because of the absence of commercial enrollees in an employer-related plan, section 4015(a) substituted the 5-percent profit cap for the ACR process. This method of limiting surpluses to 5 percent of an experience-based rate for the Medicare package of services provides a needed safeguard and also allows a reasonable profit for the MIG.[13] As in the ACR process, the MIG should be required to demonstrate that any excess surplus will be used for additional services above those normally covered by Medicare or the MIG sponsor's Medicare supplemental coverage and that such services have a value commensurate with the excess surplus. Otherwise, any excess surplus should be returned to Medicare.

The HHS Office of General Counsel has advised HCFA that the surplus restriction would not apply to the Amalgamated project if rates are set using the AAPCC method because it maintains that section 4015(a)(4) applies only when an experience-based rate is used. Based on this interpretation, a MIG that is not being paid an experience-based rate could be allowed to retain any surplus as profit or use it to reduce its liability for supplemental health care benefits. We have asked HHS for clarification of its legal position on this issue.

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

[12] F. Porell and others. Medicare TEFRA Risk Contracting: A Study of the Adjusted Community Rate (ACR), Bigel Institute for Health Policy, Brandeis University, Sept. 15, 1987, pp. 44, 45, 53, and 54.

[13] According to the 1986 Annual Group Health Association of America HMO Industry Survey, the median return on revenues for responding HMOs was -1.1 percent. The average return on revenues for the 39 percent of the plans that showed a profit was 2.5 percent.

Question About How Rates Will Be Updated Remains

In our November 1987 report on HCFA's proposal, we discussed the potential advantages of basing MIG payments on an experience-based rate. At that time HCFA planned to update the 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 under- 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.

How experience-based payment rates will be updated during the demonstration had not been decided as of April 1989. 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 plan to assess the adequacy of data collection for this purpose and report on it in the future.

Conclusions

HCFA has interpreted the OBRA payment restriction provision to require application of the 95 percent of experience-based rate limitation only when an experience-based rate-setting method is used. We believe the limitation should be applied regardless of the rate-setting method used. Moreover, HCFA's two analyses of the Medicare cost experience of Amalgamated Medicare beneficiaries illustrates the importance experience can have to the rate-setting process and the use of the statutory limitation.

In addition, MIGs should not be allowed to retain surpluses in excess of the 5 percent of savings on Medicare-covered services stipulated by OBRA but should return these excesses to Medicare or the beneficiaries. We believe also that OBRA's limit on surplus retention should apply regardless of the payment method used.

Recommendation to the Secretary of HHS

We recommend 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.

Agency Comments and Our Evaluation

In commenting on our first recommendation, HHS said that HCFA intends to apply the surplus retention restriction to all MIG projects as we recommended. HHS also said that it believes that using the AAPCC method of rate setting is permissible under OBRA. We question HHS's intended application of the AAPCC method to the Amalgamated project. Furthermore, a reasonable reading of section 4015(a), we believe, is that the payment rate authorized under the section is the only payment rate that may be used for the MIG demonstration. Therefore, by separate letter, we have requested the specific legal reasoning underlying the Department's interpretation of section 4015(a).

Regarding our second recommendation to define surplus as the excess of Medicare payments over the MIG's costs of providing Medicare-covered services, HHS said that it believed the wording of the statute is unclear and it will obtain an opinion about this matter from its Office of General Counsel. As we explained on pages 8-9, we believe that a definition of surplus different from that which we recommended would be inconsistent with OBRA's prohibition of subsidizing a MIG sponsor's obligations for supplemental benefits.

Concerning our last recommendation to require any surplus exceeding 5 percent to be used for additional benefits or be returned to Medicare, HHS stated that it would require all but 5 percent of the payment rate amount to either be used for additional benefits or be returned to the Medicare program as required by OBRA. Whether or not the surplus is used in accordance with OBRA requirements depends, in our opinion, on how HHS defines "surplus." HHS's comments are included as appendix I.

We are sending copies of this report to other congressional committees; the Director, Office of Management and Budget; the Secretary of HHS; the Administrator of HCFA; and other interested parties. This report was prepared under the direction of Michael Zimmerman, Director of Medicare and Medicaid Issues. Other major contributors are listed in appendix II.

Lawrence H. Thompson

Lawrence H. Thompson
Assistant Comptroller General

Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES — Office of Inspector General

Washington, D.C. 20201

APR 18 1989

Mr. Lawrence H. Thompson
Assistant Comptroller General
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Thompson:

Enclosed are the Department's comments on your draft report, "Medicare: Status Report on Implementation of Medicare Insured Demonstration Projects." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely yours,

for Richard P. Kusserow
Inspector General

Enclosure

Comments of the Department of Health and Human Services on the General Accounting Office Draft Report, "Status Report on Implementation of Medicare Insured Demonstration Projects"

Overview

The Health Care Financing Administration (HCFA) has entered into cooperative agreements with Chrysler Motors Corporation (Chrysler), Southern California Edison Company (SCEC) and Amalgamated Life Insurance Company (Amalgamated) to establish three Medicare Insured Group (MIG) projects authorized by the Omnibus Budget Reconciliation Act of 1987 (OBRA).

GAO reports that a goal of the MIG program is for Medicare to achieve an average 5 percent cost savings for beneficiaries who enroll in a MIG. However, GAO believes that HCFA has decided on a payment method for one of the MIG demonstrations (Amalgamated) that may result in costs to Medicare that are higher than those that would otherwise be expected based on the experience of potential enrollees. This result would not be consistent with the goal of saving 5 percent for Medicare from the use of MIGs. Additionally, GAO indicates that as of February 1989, a final decision had not been made by HCFA on how the OBRA limit on the amount of surplus MIGs can retain will be applied. GAO believes that one way that is being considered could result in Medicare subsidizing non-Medicare benefits previously provided and funded by the MIG sponsor.

We believe HCFA's decision to approve Amalgamated's request for payment at 95 percent of the Adjusted Average Per Capita Cost (AAPCC) is permitted under the statute and appropriate given the information that is available on historical costs of Amalgamated's retirees. In 1986, historical costs of retirees in Philadelphia County were 93 percent of the AAPCC. There is reason to believe that Amalgamated retirees do use less medical care than other Medicare beneficiaries because of the very low level of supplemental benefits offered by their union and the lack of ability to purchase supplemental insurance because of their low retirement income.

Amalgamated was very concerned and remains concerned that once retirees are enrolled in the MIG demonstration, former barriers to health care will be removed and utilization will markedly increase. It believes that although managed care programs included in the MIG will constrain some of the increase, the projected payment rate should reflect the likelihood of unavoidable "unmet need" demands on the system.

Since the time that we approved Amalgamated's request, additional analyses of historical utilization data for Amalgamated's retirees reveal that 1987 costs are higher than the AAPCC amount in Philadelphia County. We have not, to date, compared historical costs to AAPCC amounts in other counties surrounding Philadelphia or in other geographic areas where Amalgamated may decide to conduct the demonstration. Generally, we believe that comparisons of costs, such as were done for Amalgamated in Philadelphia, are useful; however, they should not be used as a basis for selecting payment rates. If additional considerations such as prior unmet need and possible selection effects had been taken into account, the relationships reported by GAO may have been reversed.

GAO Recommendation

That the Secretary of HHS require HCFA to: apply the payment and surplus retention restrictions of OBRA to all MIG projects;

Department Comment

We believe that payment to a MIG demonstration that is based on the AAPCC is permissible under section 4015(a)(3)(A) of OBRA. HCFA intends to apply the surplus retention restriction of OBRA to all MIG projects.

GAO Recommendation

-- define surplus as the excess of Medicare payments over the costs of providing Medicare-covered services; and

Department Comment

We believe the wording of the statute is unclear with respect to this issue and will obtain an opinion from our Office of General Counsel.

GAO Recommendation

-- 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.

Page 3

Department Comment

We would require all but 5 percent of the payment rate amount to either be used for additional benefits or returned to the Medicare program. This is required by section 4015(a)(4)(A) of OBRA.

Technical Comments

Now on p. 2.

Page 3 - First Paragraph

The actual implementation dates of any of the MIGs are unknown at this time.

Now on pp. 3-4.

Page 6 - First Paragraph

The term "employer-related group" should be fully defined here. We suggest changes in wording in the third and fourth lines as follows: "the MIG receives a fixed capitation payment from HCFA and assumes the financial risk . . . ."

Now on p. 8.

Page 9 - Second Paragraph

It may be more appropriate to put this point in context by stating that the Chrysler contractor was still conducting an in-depth study on identifying a rate setting methodology, exploring various benefit packages, and collecting data.

Now on pp. 13-14.

Page 14 - Last Paragraph

The last sentence which continues onto page 15 may need clarification of the computations offered.

Major Contributors to This Report

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