United States General Accounting Office

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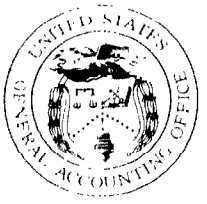
Report to Congressional Committees

January 1992

MEDICARE

Third Status Report on Medicare Insured Group Demonstration Projects



GAO/HRD-92-53

GAO

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

Human Resources Division

B-247140

January 29, 1992

The Honorable Lloyd Bentsen, Chairman
The Honorable Bob Packwood, Ranking Minority Member
Committee on Finance
United States Senate

The Honorable John D. Dingell, Chairman
The Honorable Norman F. Lent, Ranking Minority Member
Committee on Energy and Commerce
House of Representatives

The Honorable Dan Rostenkowski, Chairman
The Honorable Bill Archer, Ranking Minority Member
Committee on Ways and Means
House of Representatives

Section 4015(a) of the Omnibus Budget Reconciliation Act of 1987 authorized a demonstration project under which a maximum of three employment-related groups, such as employers or unions, could agree to pay for Medicare beneficiaries' covered health care services in exchange for a fixed-per-capita payment from Medicare. Such projects are referred to as Medicare Insured Groups (MIGs). The idea was that the MIG could combine Medicare benefits with supplemental ones offered by an employer or union, thus, reducing costs for both by managing the combined benefits better than could be done separately. Section 4015(a) also required us to monitor the MIG demonstrations and to report periodically on the status of the projects. This is our third status report.[1]

In summary, as of December 1991, three companies had completed studies about the feasibility of establishing MIGs for their retirees. Two of the companies decided not to develop MIGs because of concerns that operations might not be financially viable. The third one has submitted a proposal to develop a MIG, which was being evaluated by Medicare administrators.

Two additional MIG projects are active. A health care provider began trying in December 1990 to pool a group of employers to form a MIG, and a year later was continuing this effort. A union-related MIG project continues its efforts to develop the health network necessary for the MIG to become operational.

[1]Medicare: Status Report on Medicare Insured Group Demonstration Projects (GAO/HRD-89-64, June 27, 1989), and Medicare: Second Status Report on Medicare Insured Group Demonstration Projects (GAO/HRD-90-117, June 6, 1990).

It is not known if or when any of these projects will enroll beneficiaries and assume responsibility for their health care.

Background

Medicare is a federal insurance program that covers most elderly and some disabled people for a broad range of health services. The Health Care Financing Administration (HCFA) within the Department of Health and Human Services (HHS) administers the Medicare program. Beneficiaries of the program are responsible for paying deductibles and coinsurance for most covered services. Some employers, labor unions, and other organizations supplement Medicare benefits for affiliated retirees by paying these liabilities, and sometimes by paying for services that are not covered by Medicare.[2] Normally, Medicare is billed for services and pays its share, and then the supplemental plan is billed for its share.

In July 1987, HHS submitted a legislative proposal to the Congress to authorize Medicare to enter fixed-price per-capita contracts with employment-related health plans that would pay for all Medicare covered services. Rather than generally authorizing such contracts, the Congress permitted HHS to enter not more than three demonstrations projects to test the MIG concept. MIGs are to be paid a per-capita rate equal to 95 percent of Medicare's expected costs for their enrollees, based on their claims experience. Several other provisions were included to prevent Medicare from paying more for MIG enrollees than it otherwise would and to protect a beneficiary's access to care.

As formulated by HCFA, a MIG project would go through three phases. First, in the feasibility phase the sponsoring organization would sign an agreement to examine the historical cost of providing health care to its retirees and project the future costs for providing such services. From this analysis, the sponsor would determine whether it believes the MIG project is financially viable. Second, in the development phase the sponsor would prepare a detailed plan covering the processes and activities necessary to establish an operating MIG. This includes such activities as developing a health care delivery network and proposing a Medicare rate-setting methodology. Third, in the implementation phase the MIG would enroll beneficiaries,

[2]HHS estimated that in 1987, 10.7 million retirees and dependents were covered by employer-sponsored health benefit plans (Health Insurance Coverage of Retired Persons, National Medical Expenditure Survey, Public Health Service, Sept. 1989). We estimated that employers spent about $9 billion for retiree health benefits in 1988 (Employee Benefits: Companies' Retiree Health Liabilities Large, Advance Funding Costly, GAO/HRD-89-51, June 14, 1989). Although Medicare-eligible retirees, those age 65 or over, made up two-thirds of the retirees covered by company health plans, they received only about one-third of the benefits because Medicare pays most of their health care costs.

receive payments from Medicare, and assume responsibility for their Medicare covered and supplemental health care services.

Under the MIG-demonstration program, Medicare beneficiaries decide whether to enroll in a MIG. For beneficiaries who enroll, the MIG assumes, for a fixed-capitation payment from Medicare, the financial risk of providing the full range of Medicare-covered services. The MIG program enables employment-related groups to combine Medicare and Medicare supplemental benefits into one integrated health care plan. HHS postulated that, by managing all their retirees' health care benefits, employment-related groups could effectively monitor and control the price and utilization of benefits, thereby holding down overall costs. Under this theory, Medicare costs would be reduced and the employment-based group would have lower costs for Medicare supplemental benefits than it otherwise would. In addition, MIG enrollees would benefit from having only one party to deal with in processing their claims and from receiving any additional benefits that the MIGs may offer as incentives to them.

Objectives, Scope, and Methodology

As specified in section 4015(a)(10), our objective was to monitor the status of HCFA's implementation of the MIG demonstrations and the status of any projects awarded.

We reviewed HCFA and HHS documentation related to the MIG demonstration to determine the status of the projects. To obtain information on current developments, we discussed the demonstration program with officials in HCFA's Office of Research and Demonstrations, which is responsible for implementing the demonstration and awarding the cooperative agreements.

Our work was conducted between August and December 1991 in accordance with generally accepted government auditing standards.

Three Feasibility Studies Have Been Completed

Three potential MIG sponsors have completed feasibility analysis phases; two decided not to proceed to the development phase, while the third has submitted a proposal for it. The Chrysler Motors Corporation, which completed the feasibility analysis phase in 1989, terminated its MIG project because it found the MIG could not operate at a profit. In July 1991, the Southern California Edison Company decided not to proceed past the feasibility analysis phase, apparently because of its concern about the ability to control enrollee health costs. The company decided instead to develop a

managed care program[3] for retirees and, if that program is successful, it would consider instituting a MIG in 1995.

Deere & Company has completed the feasibility phase, and on September 24, 1991, indicated that it would like to proceed with the development of a MIG. As of December 20, 1991, HCFA was evaluating Deere & Company's application for the project's development phase.

Deere & Company with operations primarily in Illinois and Iowa, produces farm, construction, and forestry equipment. Through its wholly owned subsidiary, Heritage National Healthplan (HNH), it operates a managed-care health delivery system. HNH operates a health maintenance organization (HMO) and administers the fee-for-service health care benefits for Deere & Company employees and retirees, and for other employers in Illinois and Iowa. In 1988, Deere & Company spent about $11 million for supplemental benefits for about 15,000 Medicare-eligible retirees.

Besides the MIG project, HNH has two arrangements with HCFA. About 5,000 of Deere & Company's Medicare-eligible retirees are enrolled in an HNH operated HMO with a Medicare cost contract. For retirees in Deere & Company's fee-for-service plan, those over age 65 and/or providers can submit claims directly to HNH for payment rather than to Medicare's regular claims-processing contractors. HNH pays the retiree and/or the provider, and then submits a claim to Medicare. Hospitals and other part A providers usually submit their claims directly to the Medicare claims-processing contractor.

No Change in Status for Other Two Organizations

Since September 1988, Amalgamated Life Insurance Company has been in the development phase of its agreement with HCFA. Amalgamated is the administrator for the Amalgamated Clothing and Textile Workers Union health insurance benefit plan, which covers about 500,000 workers and their families, including approximately 130,000 retirees and spouses. Beginning in 1988, Amalgamated supplemented union retirees' Medicare benefits by covering the inpatient hospital deductible and hospital coinsurance. The union provides direct care, at subsidized rates, to its retirees and active workers through its network of health centers, one of which is in Philadelphia. Medicare-eligible retirees are responsible for part B deductibles and coinsurance for services received at these health centers. Retirees receive nothing from Amalgamated when other providers

[3]Under such a program, patients generally pick a physician who provides primary care and authorizes specialized physician services and hospital care.

are used. The union has about 12,000 Medicare-eligible retirees and spouses in the Philadelphia area, and Amalgamated has proposed this area as the initial site for its MIG-demonstration project.

HCFA has extended the development phase five times since the agreement was signed, and the phase is now scheduled to end on December 31, 1991. The reason most often cited for the delay in completing the development phase is Amalgamated's difficulties in negotiating a contract for health care delivery. A HCFA official said that Amalgamated had been unable to come to an agreement with the health care system with which it had been negotiating. However, the official said that Amalgamated is currently negotiating with another health care system, and these negotiations look more promising.

In December 1990, HCFA entered into a cooperative agreement with the Medical Center of Beaver, Pa., Inc. to explore the possibility of establishing a MIG. This proposed project is an attempt by a health care provider to pool a group of employers, so that the employers can offer their retirees health benefits under the MIG concept. When HCFA reviewed the MIG application, it was concerned about employer commitment to the MIG. As a result, before funding the feasibility phase, HCFA required that the Center obtain letters of commitment from employers willing to join the MIG and obtain information on at least 4,000 total Medicare retirees to ensure a credible experience-based analyses. HCFA committed $10,000 to this phase of the study, which was scheduled to be completed by November 30, 1991. As of December 20, 1991, HCFA was considering a request from the Center for an extension of the feasibility phase.

How Rates Will Be Updated Has Not Been Determined

At the time of our June 1989 report, HCFA planned to update MIGs' initial experience-based payment rates by using some index of cost growth, such as overall Medicare cost changes. When a MIG becomes operational, HCFA would no longer obtain cost data for MIG enrollees because it would not receive claims from them and, thus, it would not be able to directly update payment rates. We pointed out that, as time passed, it might become increasingly difficult to measure objectively whether underpayments or overpayments to MIGs were occurring. We concluded that the MIG rate-setting methodology should be thoroughly tested before general legislation authorizing MIG contracts on a nondemonstration bases was granted.

As of November 1991, HCFA had not decided how to update experience-based payment rates. HCFA officials said that they are waiting for a prospective MIG to present a payment updating method for the agency to evaluate. Under the demonstration, HCFA plans to collect data on demographics, enrollee satisfaction, and health service cost and utilization. The specifics about the data to be collected and their use had not been finalized. Cost and use of service data will be critical in determining whether a suitable method for updating rates can be found. We will continue to monitor developments in the rate-updating and data collection areas.

We discussed this report with HCFA officials and their comments have been incorporated where appropriate.

We are sending copies of this report to other congressional committees; the Director, Office of Management and Budget; the Secretary of Health and Human Services; and other interested parties. Please call me on (202) 275-5451 if you or your staffs have any questions. Other major contributors are listed in appendix I.

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