

GAO

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

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# MEDICARE MANAGED CARE

## Growing Enrollment Adds Urgency to Fixing HMO Payment Problem







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

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**Health, Education, and  
Human Services Division**

B-265995

November 8, 1995

The Honorable William M. Thomas  
Chairman  
Subcommittee on Health  
Committee on Ways and Means  
House of Representatives

Dear Mr. Chairman:

Medicare has not yet harnessed the cost-saving potential of its managed care option. In fact, Medicare has paid health maintenance organizations (HMO) more for serving Medicare beneficiaries than it would have spent, on average, had those same beneficiaries received care in the fee-for-service sector.<sup>1</sup>

Proposals to reduce or even reverse these Medicare losses have been discussed for roughly a decade. Lately, these proposals have received even more interest because of recent deficit reduction proposals aimed at slowing Medicare spending growth by moving more beneficiaries into managed care.

As you requested, this report expands on our recent testimony before the Committee on these issues.<sup>2</sup> Specifically, we discuss (1) current trends in Medicare beneficiary enrollment in HMOs, (2) flaws in Medicare's rate-setting method preventing Medicare from realizing potential savings from HMOs, (3) strategies to enable Medicare to realize HMO savings, and (4) the Health Care Financing Administration's (HCFA) efforts to test HMO payment reforms.<sup>3</sup> Our findings derive from examinations of Medicare program data, reviews of the literature, interviews with industry experts, discussions with HCFA officials, and our previous reports on this subject. Our work was performed from April to September of 1995 in accordance with generally accepted government auditing standards. A list of related GAO products appears at the end of this report.

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<sup>1</sup>This overpayment applies to HMOs that participate in the risk contract program. Medicare pays risk contract HMOs a fixed amount (a capitation payment) in exchange for providing a comprehensive set of services to a beneficiary for a year. Most Medicare HMO enrollees belong to risk contract HMOs.

<sup>2</sup>See Medicare Managed Care: Program Growth Highlights Need to Fix HMO Payment Problems (GAO/HEHS-95-174, May 24, 1995) and Medicare: Opportunities Are Available to Apply Managed Care Strategies (GAO/HEHS-95-81, Feb. 10, 1995).

<sup>3</sup>References to Medicare managed care or Medicare HMOs in this report are directed only at the participants of the Medicare risk contract program. Only under risk contracts does Medicare pay HMOs a prospective capitated payment for each enrollee.

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## Results in Brief

Recently, enrollment of Medicare beneficiaries in HMOs has grown rapidly, concentrated in certain states and areas. Although to date Medicare HMOs have enrolled less than one-tenth of beneficiaries nationwide, since 1994 enrollment growth has exceeded 20 percent annually. In 1994, double-digit enrollment growth occurred in 15 states, but growth was virtually nil in the remaining 35 states. This rapid growth in HMO enrollment highlights the urgency of correcting Medicare's excessive payment rates to HMOs—particularly in some areas. Likewise, enrollment stagnation elsewhere highlights the need to examine the causes of payment rate disparities among states and counties.

As we have reported,<sup>4</sup> for 10 years, Medicare has used an HMO rate-setting method with several flaws. Specifically, because HMO payment rates are fixed—linked to the average cost of Medicare fee-for-service care—Medicare cannot lower rates through competition among HMOs or negotiate a share in any savings that HMOs achieve through greater efficiency. Also, HMO payment rates are not adequately “risk adjusted” to reflect cost differences deriving from beneficiaries health status. Although HMO enrollees typically have been healthier (and therefore less costly to care for) than average beneficiaries, Medicare has paid HMOs on the basis of average costs. Consequently, Medicare has paid HMOs more than it would have for the same patients' care under fee for service. Finally, HMO payment rates are based on county fee-for-service costs, which can vary considerably because of utilization differences. As a result, Medicare's low rates deter HMO participation in some areas, while its high rates cause overpayments in other areas. While overpayments can result in lower premiums or expanded benefits to HMO enrollees, preventing overpayments can potentially realize significant budget savings.

We have identified three promising strategies that Medicare with new legislative authority could use concurrently, tailoring strategies to market conditions prevailing in an area. First, in some areas, Medicare could set HMO payment rates through competitive bidding among HMOs—as the Arizona Medicaid program has done—or by negotiating with HMOs—as the California Public Employees Retirement System (CalPERS) has done. Second, HCFA, which oversees Medicare, could modify its HMO rate-setting formula to include a health status risk adjuster. More accurate risk adjustment can both increase savings from a formula-based rate-setting methodology and strengthen a competitive bidding approach. Third, HCFA could quickly reduce payments to HMOs by requiring larger discounts

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<sup>4</sup>Medicare: Changes to HMO Rate Setting Method Are Needed to Reduce Program Costs (GAO/HEHS-94-119, Sept. 2, 1994).

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(more than the statutory 5 percent) from HMOs in areas where market data indicate that HMO payment rates are too high. This is a cruder way to adjust rates to market conditions than competitive bidding is but is appropriate where bidding is problematic or when immediate budget savings are desired.

HCFA is planning demonstration projects using the first two strategies—competitive bidding and improved risk adjustment—but results of a full-scale evaluation of these projects are at least several years away. In the interim, HCFA should act promptly to gather and use valuable design and implementation information as it becomes available. HCFA's legislative authority to conduct these projects does not address managed care options explicitly, however, which raises questions about HCFA's authority to mandate HMO participation in the projects. Unless HMO participation is mandatory, HCFA may find it difficult to complete meaningful demonstration projects involving managed care options. HCFA may wish to seek from the Congress additional legislative authority. In the near term, HCFA could also introduce a more accurate risk adjuster to stem growing losses.

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## Background

The Congress created the Medicare risk contract program in 1982 to capitalize on the potential cost savings associated with HMOs. Under this program, HMOs are paid a flat fee for each Medicare beneficiary enrolled. The law sets HMO payments for comprehensive care at 95 percent of the estimated average cost (to Medicare) of treating the patient in the fee-for-service sector. HCFA calculates these payment rates using a three-step process in which it determines the following:

- The base rate: HCFA calculates the projected Medicare expenses nationwide for the average beneficiary in the next year.
- The adjusted average per capita cost (AAPCC): HCFA adjusts the base rate for differences in medical costs among geographic areas, generally counties, and multiplies the result by 0.95.
- The capitation rate after adjusting for health status risk: HCFA adjusts the AAPCC for enrollees' demographic characteristics—age, sex, Medicaid eligibility, and residence in an institution such as a nursing home. This risk adjustment attempts to prevent HMOs from benefiting from favorable selection of health risks, which occurs when HMOs enroll beneficiaries who are healthier—and therefore less costly to care for—than those in the fee-for-service sector.

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Although in existence for over a decade, the risk contract option remains a relatively small part of the Medicare program. As of May 1995, about 7 percent of Medicare beneficiaries were enrolled in plans offered by the 164 HMOs participating in the program.

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## Beneficiary Enrollment Growing in Medicare's Risk Contract Program

Enrollment in the Medicare risk contract program may grow substantially in the next few years. HCFA reports that three-fourths of all Medicare beneficiaries now live in areas where they could enroll in a risk contract HMO. Although beneficiary enrollment in these HMOs is relatively low, the program has grown dramatically in recent years in both beneficiary enrollment and HMO participation.

As of May 1995, about 2.6 million beneficiaries—about 7 percent of the total Medicare population—were enrolled in the risk contract program.<sup>5</sup> Figure 1 shows that the percentage of Medicare beneficiaries enrolled is significantly higher than the national average in only a few states. HMO enrollment is further concentrated in urban areas. The 5 metropolitan statistical areas (MSA) with the largest risk contract enrollments accounted for 34 percent of nationwide risk program enrollment in 1995, and the top 10 MSAs accounted for 51 percent of nationwide risk program enrollment. Enrollment data for the top 100 MSAs appear in appendix II.

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<sup>5</sup>Another 2 percent of Medicare beneficiaries belong to HMOs that either have cost contracts or are Health Care Prepayment Plans. These programs reimburse HMOs on a cost basis and lack the financial incentives of risk contracts to reduce costs. Consequently, cost contract HMOs are not relevant to proposals that would expand Medicare's use of capitated health plans.

Figure 1: Percent of Beneficiaries Enrolled in HMOs With Risk Contracts, by State, 1994



Note: Data used to construct figure 1 appear in appendix I.

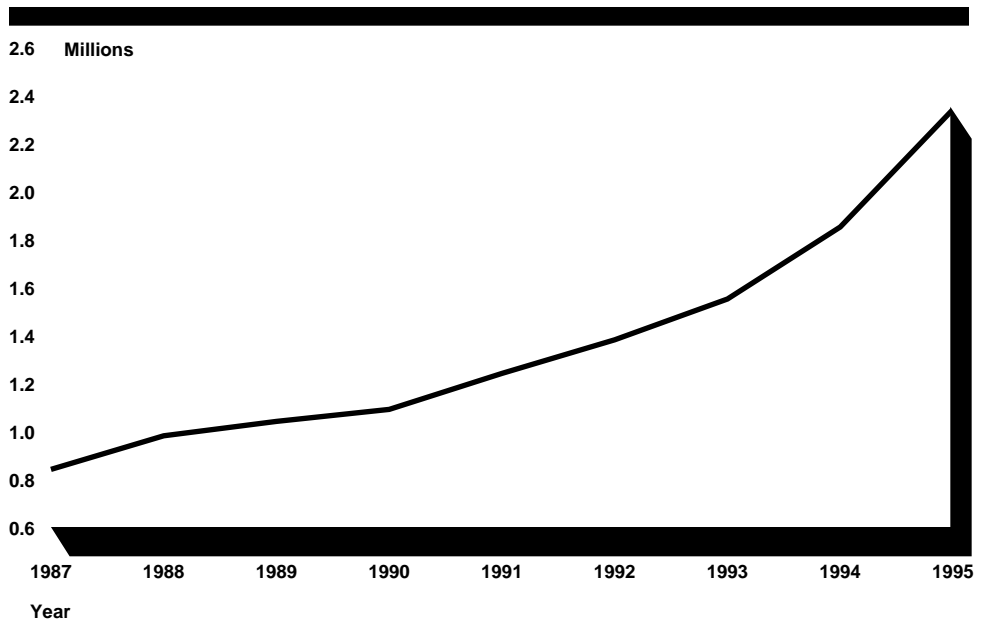
Source: HCFA Bureau of Data Management and Strategy. Enrollment information based on computer runs using the Denominator File.

Although the HMO share nationwide is small, recent HMO enrollment of Medicare beneficiaries has grown rapidly. From 1990 through 1992, enrollment grew by about 13 percent annually but, during 1993 and 1994, grew by an annual average of 23 percent.<sup>6</sup> Preliminary data for 1995

<sup>6</sup>Based on HCFA data. Growth for 1993-1994 is defined as the percent change in enrollment from January 1, 1993, through December 31, 1994.

suggest a growth rate approaching 30 percent. Similarly, the number of risk contract HMOs, which declined substantially during the early years of the program, has nearly doubled since 1991 from 83 to the current 164. (See fig. 2.)

**Figure 2: Number of Beneficiaries Enrolled in HMOs With Risk Contracts, 1987-95**

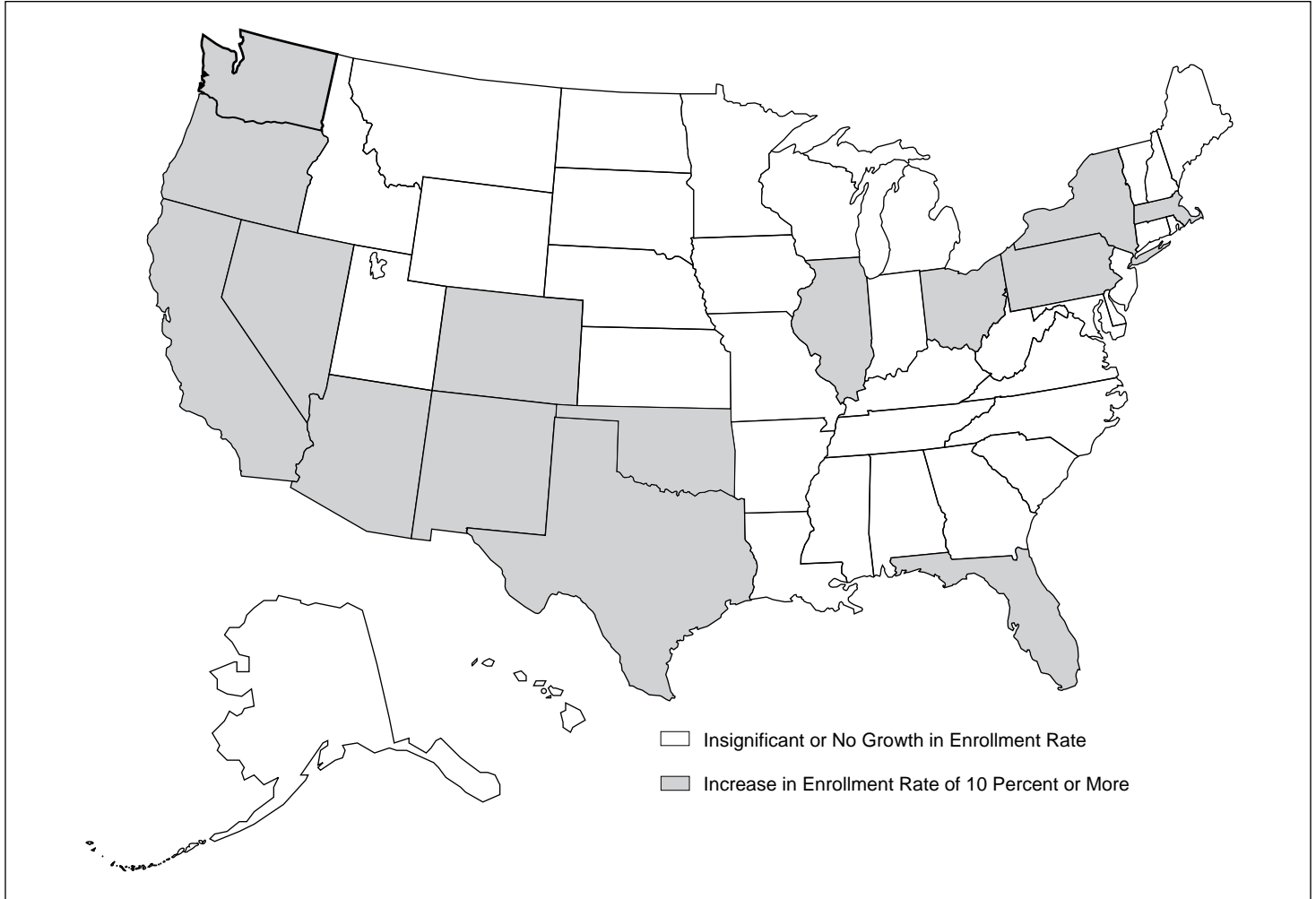


Source: HCFA Office of Managed Care.

In 1994, the HMO enrollment rate in California and 14 other states—whose enrollees account for 55 percent of all Medicare beneficiaries—experienced double-digit increases. (See fig. 3.) Enrollment rates in other states showed no growth. For the most part, these states have had extremely low HMO market penetration.



**Figure 3: Fifteen States Had Double-Digit Increases in Medicare HMO Enrollment Rates in 1994**



Note: States that had 1 percent or fewer Medicare beneficiaries enrolled in risk contract HMOs were classified as “insignificant or no growth” states. Hawaii, with a growth rate of 6 percent in 1994, was also classified in that group. Data used to construct figure 3 appear in appendix II.

Source: HCFA Bureau of Data Management and Strategy. Enrollment information based on computer runs using the Denominator File.

## HMO Rate-Setting Methodology Thwarts Medicare’s Efforts to Realize Savings

Our work suggests that Medicare’s HMO rate-setting methodology does not maximize the potential of managed care to yield cost savings and, in some cases, can even discourage HMO participation in the program. By linking HMO payments to Medicare costs in the fee-for-service sector, the current methodology causes three problems. First, the rate-setting formula

restricts potential savings and ignores the ability of competitive market forces to help produce additional savings. Second, the lack of adequate risk adjusters in the formula allows some HMOs to be overcompensated given the health status of their enrollees. Third, the formula may discourage plan participation by setting payments that are too low in some areas and by causing rates to vary greatly both among geographic areas and over time.

### Formula Encourages Competition Between HMOs That Primarily Benefits Enrollees

Under the present system, Medicare pays all HMOs in a county the same capitation (base) rate.<sup>7</sup> With the payment rate fixed and independent of both HMO costs and the competitiveness of the local managed care environment, HMOs compete only for the enrollment of Medicare beneficiaries. Efficient, low-cost HMOs may be able to offer more generous benefit packages to enrollees and still prosper under the fixed capitation rate. Because the payment rate is fixed, however, the government derives little benefit from HMOs' increased competition or increased efficiency. Moreover, Medicare beneficiaries have only limited incentives to seek care from low-cost health plans.

Medicare may be underestimating HMOs' efficiency and requiring an HMO discount from fee-for-service costs that is too modest. The HMO capitation rate is set by statute at 95 percent of the AAPCC: in other words, 5 percent below the estimated cost of serving beneficiaries in the fee-for-service sector. HMOs that can attract Medicare enrollees and provide health care for less than the capitation rate—for example, for 85 percent of fee-for-service costs—keep the difference (within limits) between their costs and the capitation payment.<sup>8</sup>

The recent surge in HMO participation indicates that many organizations now view Medicare risk contracts as potentially lucrative. In addition, in caring for Medicare beneficiaries, HMOs are estimated to achieve cost savings in excess of 5 percent. Research suggests that HMO costs for caring for their enrollees are at least 10 percent less than HCFA would have spent

<sup>7</sup>All HMOs in a county are assigned the same base payment rate per enrollee, but actual Medicare payment rates will equal the base rate adjusted up or down to account for each enrollee's demographic factors of age, sex, institutional status, and Medicaid status.

<sup>8</sup>HMOs are permitted to earn profits up to the rate earned on their non-Medicare business—the adjusted community rate (ACR). Profits earned in excess of the ACR must either be used to provide beneficiaries with additional benefits or reduced copayments and deductibles or returned to the federal government.

on fee-for-service care for them.<sup>9</sup> Finally, some experience of private-sector employers with HMOs suggests that the 5-percent discount may be too low, especially in certain urban areas with mature managed care markets. In those markets, even a larger discount (lower capitation rate) might not significantly discourage HMOs' participation in Medicare risk contracts.<sup>10</sup>

## Risk Adjustment Methodology Inadequate to Prevent Overcompensation

HCFA's capitation payment to HMOs is currently risk adjusted for only four demographic factors: beneficiary age, sex, Medicaid status, and institutional status. These adjustments are designed to modify HMO payments for expected variations in medical costs. For example, the capitation payment is higher for older beneficiaries because they are expected to require more medical care than younger beneficiaries. This risk adjustment is inadequate, however, because it does not specifically adjust for the health status of enrollees. By enrolling the healthier individuals, HMOs deliver less health care but are compensated as if they had enrolled a costlier clientele of both the healthier and the sicker individuals.<sup>11</sup>

Our review of studies on risk selection shows that, because most HMOs benefit from favorable selection (the healthier individuals typically enroll in HMOs), Medicare has paid HMOs more than it would have paid for the same patients' care by fee-for-service providers.<sup>12,13</sup> Estimates of the excess payments range from almost 6 percent to 28 percent. However, these estimates have been criticized as too high for various technical reasons, such as the data analyzed (from 1991) no longer reflect current

<sup>9</sup>Randall S. Brown and others, "Do Health Maintenance Organizations Work for Medicare?" *Health Care Financing Review*, Vol. 15, No. 1 (1993), p. 14.

<sup>10</sup>However, a lower capitation rate could result in reduced additional benefits or higher premiums to be paid by HMO enrollees and possibly discourage some Medicare beneficiaries from joining risk-based HMOs.

<sup>11</sup>HCFA uses administrative means, such as prohibiting HMOs from refusing to enroll beneficiaries with preexisting conditions and monitoring HMO marketing materials, to lessen the ability of HMOs to purposely attract healthier than average beneficiaries.

<sup>12</sup>Medicare: Changes to HMO Rate Setting Method Are Needed to Reduce Program Costs, pp. 21-23.

<sup>13</sup>Favorable selection—combined with Medicare's linkage of HMO rates to average Medicare costs in the fee-for-service sector—can increase Medicare outlays in two related ways. First, because Medicare HMO beneficiaries are healthier on average, their treatment costs the HMOs less, on average, than the capitation rate Medicare pays HMOs—even after that base rate is risk adjusted by HCFA for demographic factors. (In other words, Medicare pays more for HMO enrollees than if they had remained in fee for service.) Second, favorable selection causes the average fee for service costs to increase as healthier (than average) beneficiaries leave fee for service to join the HMOs. Because the average fee for service costs are now higher, the HMO base payment rate increases.

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conditions.<sup>14</sup> Nonetheless, our review suggests that favorable selection persists despite HMO enrollment expansion. HCFA officials agree that the risk contract program displays favorable selection, though they believe that excess payments are at the lower end of this range.

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### Formula Produces Capitation Rates That Vary Considerably Within Market Areas

Capitation rates are set separately for each U.S. county and vary considerably nationwide among regions and states, urban and rural counties, and even neighboring counties. This variation may discourage some HMOs from participating in risk contracts. For example, under the present system, an HMO is paid 27 percent less for serving a beneficiary living in Montgomery County, Maryland, than for serving an otherwise identical beneficiary living in neighboring Prince George's County, Maryland—even if the two individuals are treated in the same facility by the same doctor.<sup>15</sup> The disparity of payment rates among counties leads some HMOs to enroll beneficiaries from a limited portion of their service area.

The formula's link to local fee-for-service spending, which reflects local variations both in the price and volume of medical services used by Medicare beneficiaries, causes the disparity of the capitation rates among areas. Much of the occurring variation may, however, be attributable to underutilization of health care in some areas and overutilization in others instead of differences in the cost of providing appropriate health care. If fee-for-service beneficiaries use a large volume of services (either because beneficiaries demand these services or because their doctors order additional services), then HMO payment rates will be relatively high in that county. In contrast, if Medicare fee-for-service beneficiaries use few services—perhaps because of inadequate transportation or a lack of providers in rural areas—then HMO payment rates will be relatively low. As a result, rates in some areas are too low to induce HMO participation in the risk contract program, while rates in other areas are too high for Medicare to realize the potential cost savings generated by capitated payments.

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<sup>14</sup>For example, Laurance Baker, *Can Managed Care Control Health Care Costs: Evidence From the Medicare Experience*, The National Institute for Health Care Management (June 1995) suggests that Medicare HMOs drive down Medicare costs in the fee-for-service sector, offsetting the effects of favorable selection. Other research finds that the proportions of chronically ill individuals in HMOs and in the fee-for-service sector are roughly comparable (see Group Health Association of American, *HMOs and Medicare: Myths and Realities* (Washington, D.C.: 1995).

<sup>15</sup>Capitation payments are based upon beneficiary residence, not medical care delivery site.

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## Strategies Exist for Medicare to Realize Savings

Modifying the present payment system could help generate Medicare savings. Our review of the private sector's experience, reforms in other public health care programs, and empirical research suggests that several strategies hold promise. These strategies fall into three broad categories: fostering price competition among HMOs, developing better risk adjusters, and revising the AAPCC-based capitation rate.

In our view, HCFA could generate the most Medicare savings if it would pursue strategies in all three categories concurrently. Trying to address all obstacles in a uniform way in all regions of the country is likely to fail. This is because the predominant challenges to saving costs in large cities are not necessarily the same ones that exist in rural counties and because the challenges vary from region to region even for otherwise similar communities. Consequently, a variety of strategies is warranted; local conditions would determine the particular strategies for any specific area.

The details of implementing any strategy are important. Changing Medicare's rates for paying HMOs could affect their decision to participate in risk contracts and the benefits they provide. This, in turn, could affect Medicare beneficiaries' decisions to enroll in managed care plans and the quality of care they receive in those plans. Thus, estimating the dollar savings and determining the best method of implementing specific strategies would be possible only after quickly conducting and evaluating demonstrations.

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## Fostering Price Competition Among HMOs

Requiring qualified HMOs to submit competitive bids could encourage price competition that would enlist market forces to help contain Medicare costs. The accepted bid would set the capitated rate at which HMOs would provide comprehensive care to Medicare enrollees in an area. This approach completely decouples capitation rates from average fee-for-service spending. Under a competitive bidding system, HMOs would have an incentive to submit bids that reflect their actual costs of providing health care to Medicare enrollees. Low bidders would be rewarded with risk contracts. High bidders could be excluded, included if they accepted the winning bid amount, or included but subject to a financial penalty.

A competitive bidding strategy would be most effective in locations likely to attract many bidders—typically urban areas with well-developed managed care markets. Table 1 indicates that competitive bidding looks promising in at least 17 urban areas (accounting for about 50 percent of all risk contract beneficiaries) because each has 10 or more participating

HMOs. Competitive bidding might not be viable, however, in at least 47 other urban areas (accounting for about 11 percent of enrollees) where three or fewer HMOs participate in Medicare. Unless the competitive bidding structure were to attract additional HMOs, many locations likely would not be good candidates for determining HMO rates through competitive bidding.<sup>16</sup> Consequently, an alternative rate-setting methodology would need to coexist with a competitive bidding approach.

**Table 1: Distribution of HMO Risk Contract Plans in Urban Areas**

HMO risk contract plans per urban area	Number of urban areas	HMO risk contract enrollment as percent of total risk enrollment (Dec. 1994)
1	13	.8
2	22	3.3
3	12	5.7
4	9	4.5
5	11	12.1
6	4	2.7
7-9	9	17.5
10 and over	17	50.4
<b>Total</b>	<b>97</b>	<b>97.0</b>

Source: Our analysis of HCFA data. March 1995 data, adjusted to exclude plans with fewer than 100 enrollees, were used to determine the count of plans per area. Urban areas are MSAs.

Competitive bidding, rate negotiation, and beneficiary incentive approaches have been used successfully in other public health insurance programs. Arizona, for example, since 1982 has delivered health care to its indigent population mostly through capitated managed care organizations in which the capitation rates are set through a competitive bidding process. A recent study concluded that, compared with traditional Medicaid programs (predominately fee for service), Arizona achieved significant cost savings and a lower rate of expenditure growth.<sup>17</sup> CalPERS, serving about 1 million members, also relies on price competition among health plans and consumer incentives to control costs. Negotiating rates with HMOs has helped CalPERS to reduce premiums in each of the past 3

<sup>16</sup>If competitive bidding results in reducing HMO payment rates from current levels, as is expected, plans currently outside the risk contract program will be less likely to participate. Nonetheless, even nonparticipating HMOs can help increase competitive pressures but only if other HMOs believe that the nonparticipating ones might enter the bidding.

<sup>17</sup>Managed Medicaid Cost Savings: The Arizona Experience, Laguna Research Associates (San Francisco: 1994).

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years; reductions ranged from 0.4 percent in 1993-94 to 5.2 percent in 1995-96.<sup>18</sup>

Designing a good competitive bidding system requires attention to many issues, such as whether beneficiaries in plans that lose the bidding must shift to the winning plan. In addition, savings may not be realized immediately because of high initial start-up costs—for example, developing the bidding process and establishing the necessary management information systems. Administrative expenses may be high as well.

Arizona’s experience illustrates these points. Arizona spends on Medicaid administration an amount equal to over 7 percent of its program’s acute care medical costs. This is more than comparable states spend on administering their traditional fee-for-service Medicaid programs. This suggests that the effective use of managed care may require strong administrative structures to adequately oversee and efficiently manage program resources.<sup>19</sup> Even so, Arizona’s experiment with competitive bidding has succeeded in providing health care to beneficiaries while saving the state money.

Other strategies besides competitive bidding could introduce market forces. These include strategies to encourage Medicare enrollees to be more price sensitive. Such strategies range from requiring newly eligible Medicare beneficiaries who choose a fee-for-service plan to pay slightly more than beneficiaries who choose a managed care plan to approaches that would allow beneficiaries to “price shop” from a list of approved HMOs and share a portion of any cost savings with the government. Because these strategies are so far untried, the extent to which they would increase beneficiaries’ price sensitivity and help control Medicare costs is unknown. As with competitive bidding, a wide variety of approaches may

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<sup>18</sup>Health Insurance: California Public Employees’ Alliance Has Reduced Recent Premium Growth (GAO/HRD-94-40, Nov. 22, 1993) and Responsible Choices for Achieving Reform of the American Health System, eds. Paul Ellwood and Alain Enthoven, Jackson Hole Group (Jackson Hole: 1995).

<sup>19</sup>Our work on the Medicare risk contract program emphasizes the importance of effective mechanisms, whether administrative or market based, to ensure quality, resolve beneficiaries’ complaints, and deter and pursue fraud and abuse.

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be used to implement these strategies. A fuller discussion of such approaches, however, is beyond the scope of this report.<sup>20</sup>

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## Improving Risk Adjusters

In earlier reports, we noted that researchers have proposed several alternative risk adjustment methods to reduce HMOs' incentives to enroll only relatively healthy Medicare beneficiaries. Each of these alternative methods attempts to measure the health status of enrollees more fully than HCFA's method and can be judged according to several generally accepted operational criteria. For example, a good risk adjuster would be inexpensive to administer, reduce favorable selection, create incentives for HMOs to provide appropriate care, and not be subject to manipulation by participating HMOs. No single risk adjuster is likely to exhibit all these positive traits, however, because these criteria have trade-offs. For example, a more complex risk adjuster may better succeed in reducing favorable selection but may do so only at a high administrative cost.

Recently, we evaluated 10 possible risk adjusters.<sup>21</sup> None emerged as the definitive solution to the current method's problem. However, 4 of the 10 adjusters we examined were potentially superior to the current method and seemed to entail less administrative burden than the most sophisticated risk adjusters. One of these adjusters—clinical indicators—would adjust capitation rates for the presence or absence of a particular chronic health condition (such as heart disease, stroke, or cancer). Two other promising clinically based risk adjusters include information not only on a beneficiary's specific condition but also on its severity.<sup>22</sup> In the fourth approach, HMO capitation payments would be linked to beneficiaries' own views of their physical and emotional health.

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## Improving the AAPCC Capitation Rate

With new legislative authority, HCFA could require steeper discounts from HMOs than the present 5-percent discount off the estimated local fee-for-service cost. Although this would lower payments to HMOs, it may not necessarily have a large impact on their participation in Medicare risk

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<sup>20</sup>For example, under several proposals, beneficiaries could be given a voucher that would allow them to choose between traditional Medicare or among several qualified HMOs. HMOs would compete for enrollees on both price and benefits offered (subject to a minimum benefits requirement). Beneficiaries who choose a less expensive health plan would be allowed to keep a part of the difference between the premium cost and voucher amount; the rest would return to the federal Treasury. However, Medicare has tried neither vouchers nor other proposals with similar consumer incentives.

<sup>21</sup>Medicare: Changes to HMO Rate Setting Method Are Needed to Reduce Program Costs.

<sup>22</sup>The two risk adjustment measures are Ambulatory Care Groups (ACG) and Diagnostic Cost Groups (DCG).



contracts. Previous research indicates that enrollment of healthier than average beneficiaries, combined with an imperfect method of risk adjustment, results in excessive payments to HMOs—even after factoring in the 5-percent discount. Recent evidence suggests that HMOs find participation in the risk contract program to be lucrative under current payment rates. Specifically, the number of HMOs obtaining risk contracts has increased from 109 to 164 in less than a year and a half, and the percentage of risk contract HMOs charging Medicare beneficiaries a zero premium has increased from 28 (23 plans) in 1993 to 49 (77 plans) in 1995.<sup>23</sup> Thus, HMOs may continue to find Medicare risk contracts attractive—even at a somewhat larger discount. However, if health plans react by offering less generous benefit packages, fewer seniors may be attracted to HMOs, and some current enrollees may disenroll.<sup>24</sup>

The method used for calculating the AAPCC could also be improved by assigning a greater weight to the influence of local medical prices and a lesser weight to the influence of local service utilization patterns in the fee-for-service sector. Modifications could also be made so that the AAPCC would reflect HMO market areas rather than artificial political boundaries. For example, defining a single capitation rate for a metropolitan area would eliminate the possibility that an HMO would receive more for serving a senior in one county than it would for serving an otherwise identical senior in an adjacent county. These changes would also tend to reduce the volatility of the AAPCC over time and consequently increase HMO participation in the risk contract program.<sup>25</sup>

## HCFA Plans Tests of HMO Payment Reforms

HCFA is planning to conduct demonstration projects to examine several proposals for modifying or replacing the current method of determining payment rates to HMOs. Early results from some demonstrations could emerge during fiscal year 1996, but we believe that a thorough assessment of the demonstrations is, at best, several years away. The projects are at various stages, from solicitation of proposals from private contractors to

<sup>23</sup>The weighted (by number of beneficiaries) average monthly premium charged to Medicare enrollees by participating HMOs was about \$26 in 1993 and fell 32 percent to about \$18 by 1995. In 1993, nearly 726,000 beneficiaries paid no premium for HMO risk contract services; in 1995, more than 1.4 million paid no premium. An HMO may lower the premium it charges to comply with statutory requirements to return to Medicare or its Medicare enrollees any profits from its risk contract business that exceed its profit rate on its non-Medicare enrollment. Compared to giving the excess profits to the U.S. Treasury, reducing beneficiary premiums has obvious advantages for the HMO.

<sup>24</sup>We anticipate issuing a report in late 1995 that uses econometric methods to estimate the extent to which HMO enrollment would drop if Medicare payment rates were reduced.

<sup>25</sup>Annual Report to Congress 1995, Physician Payment Review Commission (Washington, D.C.: 1995).

implementation of the demonstration. Table 2 summarizes information about the demonstration projects.

**Table 2: Ongoing and Planned HCFA Demonstration Projects Under the Risk Contract Program**

<b>Project</b>	<b>Objective</b>	<b>Status</b>
Amend current prospective risk adjustment methodology by introducing outlier pools. (This retrospective approach entails giving HMOs additional payments for very high-cost beneficiaries or "outliers.")	Supplement current risk adjustment of rates to further reduce incentive of plans to avoid high-cost beneficiaries.	Demonstration about to enter implementation phase.
Medicare Choices project offers flexibility in contracting requirements and payment methods for health plans and other organized delivery systems seeking to participate in the Medicare program.	Test receptivity of beneficiaries and evaluate suitability for Medicare of delivery system innovations such as preferred provider organizations, open-ended HMOs, point-of-service plans, integrated delivery systems, and primary care case management systems.	Pre-applications received August 1995. Awards should be made in early 1996.
Use competitive bidding to set rates, combined with a coordinated open enrollment process. (Beneficiaries select an HMO or fee-for-service option during a single open season, perhaps once a year, rather than throughout the year.)	Introduce competitive market forces into HMO rate setting and examine the advantages of coordinating the enrollment process.	Design work began in 1995. Demonstration likely in 1996.
Research on the risk adjustment potential of two health status measures (versions of ACGs and DCGs).	Reduce potential for favorable or adverse selection of beneficiaries.	Demonstration anticipated to begin in 1996.

While hopeful that these demonstrations will provide valuable information on alternative payment approaches, HCFA officials believe that the design and results for some projects could be improved if the legislative authority to conduct demonstrations were expanded. HCFA's legislative authority, established in 1967 and modified in 1972, does not discuss Medicare managed care options explicitly. This limits HCFA's ability, for example, to mandate that HMOs remaining in the Medicare program participate in a demonstration.

In our view, these demonstration projects are steps in the right direction. Nonetheless, in light of Medicare's current losses due to the risk contract program—estimated at between \$0.8 billion and \$4.0 billion per year—HCFA might take other, more immediate steps to stem losses.<sup>26</sup> For example, the Congress could grant HCFA authority to increase the HMO discount from its current 5 percent in certain areas. These might be areas where Medicare HMO enrollment is growing rapidly or where most HMOs do not currently charge beneficiaries a premium for expensive extra benefits.

## Conclusions

HMOs appear to provide care to Medicare beneficiaries at lower cost than traditional fee-for-service care, but Medicare's method of paying HMOs has limited the program's ability to save money for the federal budget and the taxpayer. The potential savings from fixing Medicare's payment method have grown along with the number of Medicare HMO enrollees, which has risen rapidly in certain urban areas.

To realize these savings requires redesigning Medicare's HMO payment method by correcting three flaws. First, the rigidity of the formula-based fixed payment rate does not allow Medicare to capitalize on the competition among HMOs that, in the private market, leads to lower rates. Second, rate adjustment for differences in beneficiaries' health status are so imprecise that Medicare overpays HMOs that enroll beneficiaries in good health. Third, the method's reliance on a county's fee-for-service health care costs to establish a payment rate produces rates that vary considerably within market areas. The government does not benefit from the low rates because they deter HMOs from enrolling Medicare beneficiaries. Moreover, the government incurs excess costs because high rates overcompensate HMOs that do participate.

With respect to pricing capitated health plans in Medicare, we believe that one size does not fit all. Market conditions vary too much and in important ways, even among metropolitan areas.

A sensible approach would be to pursue three promising strategies concurrently—foster price competition among HMOs, improve risk

<sup>26</sup>These annualized estimates of the dollar value of excess payment were derived from (1) HCFA data on costs of only the risk contract program for the first quarter of fiscal year 1995, and (2) the estimated excess payments as a percent of current outlays presented in previous studies (which range from 5.7 to 28 percent). (See *Medicare: Changes to HMO Rate Setting Method Are Needed to Reduce Program Costs*, pp. 21-23.) These estimates probably understate the amount of excess payments since December 1994 because both HMO enrollment and HMO payment rates have increased since the end of 1994.

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adjusters' accuracy, and allow for adjustments in the current formula to reflect market competition and HMOs' local health care costs.

Recently, HCFA initiated two steps to correct the current payment method. First, it solicited proposals from private contractors to plan a demonstration project on competitive bidding. Second, it began work on two demonstration projects on improved risk adjustment—one soon to be implemented, the other to begin in 1996.

These HCFA projects are steps in the right direction, but considerable time will elapse before the results are fully evaluated. Consequently, HCFA needs to complement longer term improvements with quick action to mitigate Medicare losses as risk contract HMO enrollment grows. For example, HCFA needs to implement a better risk adjuster quickly. HCFA can select from four risk adjusters that we identified last year as showing promise in accuracy and administrative feasibility. Furthermore, in implementing a new risk adjuster, or testing any new rate-setting approach, HCFA could adopt a strategy to reduce its response time to lessons learned from project results. This would entail developing information on the design and implementation of the new approach while testing is under way, without waiting for comprehensive evaluation results.

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## Matters for Consideration

In light of the increasingly urgent need to realize savings from the Medicare HMO program and to develop viable new methods of paying HMOs, Congress may wish to

- consider giving the Secretary of the Department of Health and Human Services authority to selectively reduce Medicare HMO payment rates (the AAPCC rate) in areas where market data indicate that the Medicare rates are too high and
- expand HCFA's authority to mandate HMO participation in demonstration projects in order to conduct more meaningful studies of alternative payment methods.

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## Agency Comments

The Department of Health and Human Services reviewed a draft of this report and provided written comments. All of the comments were of a technical or clarification nature and have been addressed in the report where appropriate.

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Copies of this report are being sent to the Secretary of Health and Human Services, the Administrator of HCFA, and other interested parties. We will also make copies available to others upon request.

Please call me at (202) 512-7119 or Scott Smith, Assistant Director, at (202) 512-5713 if you or your staff have any questions about this report.

A handwritten signature in black ink that reads "Jonathan Ratner". The signature is written in a cursive, flowing style.

Jonathan Ratner  
Associate Director  
Health Financing Issues

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**Abbreviations**

AAPCC	adjusted average per capita cost
ACG	Ambulatory Care Group
ACR	adjusted community rate
CalPERS	California Public Employees' Retirement System
DCG	Diagnostic Cost Group
HCFA	Health Care Financing Administration
HMO	health maintenance organization
MSA	medical savings account
MSA	metropolitan statistical area

# Enrollment in Medicare Risk Contract HMOs by State

<b>State</b>	<b>Number of beneficiaries enrolled in a risk HMO, December 1994</b>	<b>Rate of enrollment in a risk HMO, December 1994</b>	<b>Percent change in rate of enrollment in a risk HMO (Dec. 1993-Dec. 1994)</b>
California	929,849	26.30	27.87
Florida	366,003	14.30	13.38
Arizona	151,162	26.00	15.50
New York	103,427	4.00	27.99
Oregon	93,248	20.40	10.32
Texas	82,103	4.10	51.13
Washington	80,669	12.10	14.21
Illinois	66,449	4.20	11.25
Minnesota	60,770	9.90	-1.68
Pennsylvania	55,455	2.70	77.13
Colorado	49,175	12.00	17.90
Massachusetts	42,019	4.60	31.26
Hawaii	40,886	28.20	6.03
Nevada	35,514	19.40	23.24
New Mexico	27,569	13.50	48.49
Ohio	19,790	1.20	12.72
Oklahoma	12,663	2.70	26.08
Missouri	11,606	1.40	4.27
Rhode Island	8,328	5.10	-16.37
Michigan	7,335	0.60	-0.03
New Jersey	6,785	0.60	224.84
Kansas	6,526	1.70	4.64
Indiana	3,568	0.40	8.65
Nebraska	2,980	1.20	-2.04
Kentucky	2,466	0.40	2.94
Louisiana	2,416	0.40	1,419.38
Virginia	1,938	0.20	215.17
Alabama	1,838	0.30	675.15
Maryland	1,592	0.30	61.59
Wisconsin	664	0.10	0.38
Connecticut	640	0.10	35.96
Georgia	618	0.10	-3.26
Iowa	546	0.10	8.61
North Carolina	471	0.00	13.21
South Carolina	412	0.10	21.70

(continued)



**Appendix I**  
**Enrollment in Medicare Risk Contract**  
**HMOs by State**

<b>State</b>	<b>Number of beneficiaries enrolled in a risk HMO, December 1994</b>	<b>Rate of enrollment in a risk HMO, December 1994</b>	<b>Percent change in rate of enrollment in a risk HMO (Dec. 1993-Dec. 1994)</b>
Utah	327	0.20	6.37
Tennessee	301	0.00	4.22
Arkansas	296	0.10	10.95
Idaho	258	0.20	4.18
New Hampshire	248	0.20	12.75
Montana	174	0.10	-5.44
District of Columbia	148	0.20	543.76
Maine	147	0.10	11.41
Delaware	137	0.10	166.54
Mississippi	113	0.00	-17.87
Wyoming	112	0.20	6.60
West Virginia	83	0.00	1.04
North Dakota	78	0.10	18.74
South Dakota	68	0.10	-6.82
Alaska	62	0.20	17.49
Vermont	62	0.10	8.09
<b>U.S. total</b>	<b>2,280,403</b>	<b>6.3</b>	<b>22.8</b>

# Enrollment in Medicare Risk Contract HMOs by MSA (Top 100 MSAs Ranked by Number of Medicare Enrollees)

<b>MSA</b>	<b>Number of beneficiaries enrolled in a risk HMO, December 1994</b>	<b>Rate of enrollment in a risk HMO, December 1994</b>	<b>Percent change in rate of enrollment in a risk HMO (Dec. 1993-Dec. 1994)</b>
Los Angeles-Long-Beach, Cal.	299,784	32.59	11.11
Riverside-San Bernardino, Cal.	154,510	47.50	8.54
San Diego, Cal.	125,901	41.50	12.04
Phoenix-Mesa, Ariz.	104,440	30.89	12.97
Orange County, Cal.	93,312	37.31	11.40
Fort Lauderdale, Fla.	85,216	33.86	8.05
Miami, Fla.	83,622	29.69	9.95
Portland-Vancouver, Ore.-Wash.	83,161	40.08	6.86
Tampa-St. Petersburg-Clearwater, Fla.	68,221	15.10	12.57
Chicago, Ill.	66,105	7.17	11.18
Minneapolis-St. Paul, Minn.-Wis.	60,049	20.70	-2.30
New York-Newark, N.Y.-N.J.-Pa.	59,517	5.23	34.91
West Palm Beach-Boca Raton, Fla.	54,344	24.53	10.61
Seattle-Bellevue-Everett, Wash.	52,984	21.39	10.01
Philadelphia, Pa.-N.J.	49,986	6.86	69.48
San Francisco, Cal.	49,651	21.39	64.94
Denver, Colo.	43,647	23.40	32.69
Boston-Brockton-Nashua, Mass.-N.H.	41,851	5.04	30.95
Tucson, Ariz.	41,123	37.32	14.46
San Antonio, Tex.	37,672	22.75	17.30
Oakland, Cal.	37,523	14.79	219.94
Las Vegas, Nev.-Ariz.	35,622	24.13	21.89
Sacramento, Cal.	32,004	17.90	290.91
Daytona Beach, Fla.	31,018	29.89	6.16
Honolulu, Hawaii	29,096	27.42	3.98
Nassau-Suffolk, N.Y.	28,900	7.51	25.36
San Jose, Cal.	27,383	18.48	157.95
Orlando, Fla.	25,970	13.64	14.87
Houston, Tex.	25,312	8.80	210.96
Albuquerque, N.M.	24,950	31.82	39.43
Ventura, Cal.	23,906	32.63	20.03
Bakersfield, Cal.	20,690	30.77	19.90
Cleveland-Lorain-Elyria, Ohio	16,527	4.71	10.30

(continued)

**Appendix II**  
**Enrollment in Medicare Risk Contract**  
**HMOs by MSA (Top 100 MSAs Ranked by**  
**Number of Medicare Enrollees)**

<b>MSA</b>	<b>Number of beneficiaries enrolled in a risk HMO, December 1994</b>	<b>Rate of enrollment in a risk HMO, December 1994</b>	<b>Percent change in rate of enrollment in a risk HMO (Dec. 1993-Dec. 1994)</b>
Kansas City, Mo.-Kans.	13,759	6.54	1.74
Santa Barbara-Santa Maria-Lompo, Cal.	13,083	26.03	48.42
Modesto, Cal.	11,354	23.18	575.25
Santa Rosa, Cal.	9,427	15.99	405.91
Jacksonville, Fla.	8,898	7.39	1,523.71
Providence-Warwick, R.I.	8,328	5.05	-16.45
Salem, Ore.	8,310	17.53	10.54
Rochester, N.Y.	8,134	5.27	6.83
Tulsa, Okla.	7,823	8.09	24.95
San Luis Obispo-Atascadero-Paso, Cal.	7,816	22.26	420.68
Buffalo-Niagara Falls, N.Y.	6,020	2.96	12.81
Fresno, Cal.	5,935	6.08	696.43
Dallas, Tex.	5,756	2.20	42.84
Corpus Christi, Tex.	4,672	10.75	-9.91
Oklahoma City, Okla.	4,544	3.74	26.33
Vallejo-Fairfield-Napa, Cal.	4,080	7.69	899.13
Lansing-East Lansing, Mich.	3,623	7.65	-2.88
Tacoma, Wash.	3,582	4.95	12.11
Boulder-Longmont, Colo.	3,556	15.53	10.54
Fort Worth-Arlington, Tex.	3,421	2.38	37.26
Omaha, Nebr.-Ia.	3,229	4.05	-2.29
Olympia, Wash.	3,176	13.67	6.37
Chico-Paradise, Cal.	3,033	8.62	58.48
Detroit, Mich.	2,997	0.51	3.66
Eugene-Springfield, Ore.	2,682	6.00	392.17
Louisville, Ky.-Ind.	2,669	1.86	1.92
Austin-San Marcos, Tex.	2,517	3.06	127.07
Pittsburgh, Pa.	2,405	0.54	111.32
Scranton-Wilkes Barre-Hazleton, Pa.	2,302	1.74	5,637.94
Stockton-Lodi, Cal.	2,261	3.66	496.32
Indianapolis, Ind.	2,221	1.20	7.39
Medford-Ashland, Ore.	2,126	7.42	1,861.33
Wichita, Kans.	2,096	3.16	-11.12
Akron, Ohio	1,841	1.88	7.53

(continued)

**Appendix II**  
**Enrollment in Medicare Risk Contract**  
**HMOs by MSA (Top 100 MSAs Ranked by**  
**Number of Medicare Enrollees)**

<b>MSA</b>	<b>Number of beneficiaries enrolled in a risk HMO, December 1994</b>	<b>Rate of enrollment in a risk HMO, December 1994</b>	<b>Percent change in rate of enrollment in a risk HMO (Dec. 1993-Dec. 1994)</b>
St. Louis, Mo.-Ill.	1,831	0.50	56.05
Ocala, Fla.	1,652	2.89	707.63
Birmingham, Ala.	1,607	1.25	4,168.92
Bremerton, Wash.	1,599	6.88	11.10
New Orleans, La.	1,593	0.95	2,643.68
Santa Fe, N.M.	1,591	11.19	745.50
Yolo, Cal.	1,438	9.16	249.76
Norfolk-Virginia Beach-Newport News, Va.	1,353	0.86	231.25
Gainesville, Fla.	1,221	5.39	592.90
Allentown-Bethlehem-Easton, Pa.	1,149	1.10	45.20
Santa Cruz-Watsonville, Cal.	1,095	3.93	948.90
Baltimore, Md.	1,076	0.34	28.71
Washington, D.C., Md., Va., W.Va.	1,057	0.26	370.33
Bergen-Passaic, N.J.	1,015	0.51	161.03
Monmouth-Ocean, N.J.	1,008	0.54	80.84
Galveston-Texas City, Tex.	989	3.59	201.80
Spokane, Wash.	972	1.75	316.86
Sarasota-Bradenton, Fla.	958	0.63	230.39
Colorado Springs, Colo.	915	2.13	-60.03
Salinas, Cal.	717	1.84	619.39
Yuba City, Cal.	666	3.88	119.57
Baton Rouge, La.	619	1.07	5,394.31
Bellingham, Wash.	589	3.20	20.45
Toledo, Ohio	544	0.63	260.46
Newark, N.J.	527	0.20	142.64
Fort Pierce-Port St. Lucie, Fla.	492	0.75	6.95
Merced, Cal.	460	2.48	340.32
Atlantic City-Cape May, N.J.	432	0.76	408.50
Gary, Ind.	406	0.48	72.34
Middlesex-Somerset-Hunterdon, N.J.	392	0.30	67.33
Trenton, N.J.	375	0.75	931.23
Cincinnati, Ohio-Ky.-Ind.	347	0.16	160.14
Lakeland-Winter Haven, Fla.	344	0.42	13.04
<b>Top 100 MSAs</b>	<b>2,222,702</b>	<b>12.0</b>	<b>22.7</b>
<b>U.S. total</b>	<b>2,280,403</b>	<b>6.3</b>	<b>22.8</b>

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**Appendix II**  
**Enrollment in Medicare Risk Contract**  
**HMOs by MSA (Top 100 MSAs Ranked by**  
**Number of Medicare Enrollees)**

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# Related GAO Products

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Medicare: Opportunities Are Available to Apply Managed Care Strategies  
(GAO/T-HEHS-95-81, Feb. 10, 1995).

Health Care Reform: Considerations for Risk Adjustment Under  
Community Rating (GAO/HEHS-94-173, Sept. 22, 1994).

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

Managed Health Care: Effect on Employers' Costs Difficult to Measure  
(GAO/HRD-94-3, Oct. 19, 1993).

Medicare: HCFA Needs to Take Stronger Actions Against HMOs Violating  
Federal Standards (GAO/HRD-92-11, Nov. 12, 1991).

Medicare: PRO Review Does Not Assure Quality of Care Provided by Risk  
HMOs (GAO/HRD-91-48, Mar. 13, 1991).

Medicare: Increase in HMO Reimbursement Would Eliminate Potential  
Savings (GAO/HRD-90-38, Nov. 1, 1989).

Medicare: Reasonableness of Health Maintenance Organization Payments  
Not Assured (GAO/HRD-89-41, Mar. 7, 1989).

Medicare: Health Maintenance Organization Rate Setting Issues  
(GAO/HRD-89-46, Jan. 31, 1989).

Medicare: Physician Incentive Payments by Prepaid Health Plans Could  
Lower Quality of Care (GAO/HRD-89-29, Dec. 12, 1988).

Medicare: Experience Shows Ways to Improve Oversight of Health  
Maintenance Organizations (GAO/HRD-88-73, Aug. 17, 1988).

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

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

Problems in Administering Medicare's Health Maintenance Organization  
Demonstration Projects in Florida (GAO/HRD-85-48, Mar. 8, 1985).

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