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Health, Education, and
Human Services Division

B-281231

October 9, 1998

The Honorable William F. Goodling
House of Representatives

Subject: Medicare Managed Care: Payment Rates, Local Fee-for-Service Spending, and Other Factors Affect Plans' Benefit Packages

Dear Mr. Goodling:

As of April 1998, approximately 15 percent of beneficiaries were members of Medicare health maintenance organizations (HMO) or other managed care plans--more than double the percentage enrolled in such plans in 1995.[1] Managed care plans are attractive to many beneficiaries because they typically offer more benefits and lower out-of-pocket costs than Medicare's traditional fee-for-service (FFS) arrangement. Recently, however, some plans have reduced the benefits they provide, increased the fees they charge, or both. Some affected beneficiaries have complained that they did not receive adequate advance notice of these changes. Others are upset because their plans have decided to discontinue Medicare coverage or stop serving beneficiaries in certain geographic areas.

Because of your concerns about these changes, you asked us to explain (1) the key differences between Medicare's traditional FFS and managed care programs; (2) how Medicare historically set the monthly capitation rates paid to managed care plans and why these rates varied among counties; (3) how the

[1]In this correspondence, managed care plan generally refers to an HMO or competitive medical plan that serves beneficiaries under Medicare's risk contract program. As of September 1, 1998, about 90 percent of Medicare's managed care enrollees were in risk HMOs. Other types of Medicare managed care plans include HMOs with cost contracts and health care prepayment plans (HCPP). These plans differ substantially from risk HMOs both in how they operate and how Medicare reimburses them.

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Balanced Budget Act of 1997 (BBA) affected rates and the rate-setting process; (4) how the Health Care Financing Administration (HCFA), the agency that administers Medicare, approves managed care plans' benefits and premiums; and (5) what requirements HCFA places on plans to notify beneficiaries about impending benefit and premium changes.

To respond to your questions, we relied on relevant reports that we, the Medicare Payment Advisory Commission (MedPAC), and the Congressional Research Service recently issued to the Congress. In addition, we interviewed officials from HCFA's Philadelphia Regional Office, Center for Health Plans and Providers, and Office of the Actuary. We performed our work in September and October 1998 in accordance with generally accepted government auditing standards.

In summary, most Medicare beneficiaries can choose to receive health care services through a traditional FFS arrangement or a managed care organization.[2] There are several key differences between the two health care systems. For beneficiaries, some of these differences involve trade-offs. For example, compared to Medicare FFS, managed care plans typically cover more services and impose lower out-of-pocket costs. However, a beneficiary in FFS can obtain care from any provider who receives Medicare payments, while a beneficiary in a managed care plan is typically limited to providers authorized by that plan. Another difference is how medical care is paid for. In FFS, Medicare makes a separate payment for each covered service provided, while managed care plans receive a fixed monthly capitated payment for each beneficiary they enroll.

Before 1998, payments to managed care plans were tightly linked to per capita Medicare FFS spending in each county to reflect the dramatic variation in health care costs and use. As a result, capitation rates varied with the demographic characteristics of the beneficiary and his or her county of residence. For example, in 1997, a managed care plan would receive $767 per month for serving a beneficiary in Richmond County (Staten Island), New York, compared to $221 for serving a similar beneficiary in Arthur County, Nebraska. Moreover, plans in relatively high-payment counties tend to offer a richer benefit package compared to plans in low-payment counties. BBA will likely

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[2]BBA permits the creation of additional options, such as private FFS plans, medical savings account plans, and religious fraternal benefit society plans. Collectively, the alternatives to Medicare FFS are known as Medicare+Choice plans.

gradually reduce the geographic variation in managed care payments and benefit packages. At the same time, because the legislation was designed to slow the growth of Medicare spending, benefit packages offered by managed care plans may become less generous.

Managed care plans must contract with HCFA before they can serve Medicare beneficiaries. Contracts normally begin in January and run for 1 year. At a minimum, plans must provide all FFS-covered benefits. If HCFA determines a plan's projected Medicare profits will exceed its normal profit level, the plan is required to enhance its benefit package, set aside funds for future use, or both. Although plans can increase benefits or reduce the fees they charge at any time, they do so only with HCFA approval. In addition, Medicare requires that all plans notify members 30 days before a change takes place.

BACKGROUND

Medicare is the nation's health insurance program for those age 65 and older and certain disabled individuals. In 1998, it insured approximately 39 million people. In recent years, Medicare spending has increased dramatically. Its share of the federal budget doubled from 5.4 percent in fiscal year 1980 to nearly 12 percent in fiscal year 1997. Total Medicare spending is expected to reach about $220 billion in fiscal year 1998.

All beneficiaries can receive health care through Medicare's traditional FFS arrangement. Many, however, can join a managed care plan. As of June 1997, 67 percent of all Medicare beneficiaries lived in areas served by at least one such plan and almost 60 percent lived in areas served by two or more plans. Although the vast majority of beneficiaries are in FFS, enrollment in Medicare managed care plans is growing by approximately 80,000 members per month. Currently, about 15 percent of beneficiaries are enrolled in Medicare managed care plans.

BBA's Medicare provisions generally are designed to slow the growth of Medicare spending and increase beneficiary choice of health care coverage options. By reducing payment increases to hospitals, physicians, and other providers and by establishing new payment methodologies, including those for managed care plans, BBA is expected to save Medicare $115 billion from fiscal years 1998 through 2002. To increase the choices available to beneficiaries, BBA permits the creation of new types of Medicare health plans, such as provider-sponsored organizations, preferred provider organizations, and private FFS plans. In addition, the law substantially changed the method used to set managed care payment rates. The purpose of this change is, in part, to

encourage the development of managed care in areas that have few or no such plans.

KEY DIFFERENCES BETWEEN TRADITIONAL AND MANAGED CARE MEDICARE

The choice between traditional FFS Medicare and a managed care plan typically involves certain trade-offs for beneficiaries. The key differences between the two systems are selection of providers, services covered, and out-of-pocket costs. In addition, Medicare has different mechanisms for paying FFS providers and managed care plans.

Under FFS Medicare, beneficiaries may obtain covered services from any physician, hospital, or other medical care provider that receives Medicare payments. Because most providers accept Medicare payments, FFS beneficiaries have virtually unlimited choice. American Medical Association data indicate that over 96 percent of nonfederal physicians treated Medicare beneficiaries in 1996.[3] In contrast, beneficiaries in managed care plans face a more restricted list of providers. Managed care members can generally use only that plan's network of doctors, hospitals, or other providers for nonemergency care. A managed care member who seeks nonemergency care outside of the plan's network without prior authorization may be liable for the full charges for those services.

Although it offers less flexibility in selecting a health care provider, managed care typically provides many more services. For example, Medicare managed care plans often cover routine physicals, outpatient prescription drugs, and dental care–services FFS Medicare does not cover.

Beneficiaries' out-of-pocket costs are generally higher under traditional FFS Medicare compared to managed care. FFS Medicare, which has two parts, does not pay the full costs of most covered services. Part A helps pay for hospitalization, skilled nursing facility care, home health care, and hospice care and has no premium. Part B, which is optional in FFS, helps pay for physician services, clinical laboratory services, hospital outpatient care, and some other medical services not covered by part A. Beneficiaries pay $43.80 per month to Medicare for part B coverage. In addition, beneficiaries may incur other out-of-pocket expenses. These consist of an annual part B $100 deductible and, for

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[3]Excludes residents and pediatricians, who do not normally serve Medicare patients.

most services, a share of the payment for each service. To cover out-of-pocket expenses not covered by traditional FFS Medicare, beneficiaries may purchase private supplemental insurance, known as Medigap, or may have similar insurance through a current or former employer.

Although all Medicare managed care members must pay part B premiums to Medicare, most plans do not charge a monthly premium. Among plans that do charge a premium, the monthly fee is often less than the cost of an equivalent Medigap policy. Plan members may also pay a copayment for each visit or service.

Medicare's reimbursement method is another key difference between traditional FFS and managed care. Under FFS, Medicare makes a separate payment to hospitals, physicians, and other providers for each covered medical service or course of treatment they provide. Thus, the amount Medicare spends on behalf of each beneficiary varies with the amount of medical treatment the beneficiary receives. In contrast, Medicare pays managed care plans a fixed monthly amount for each beneficiary they enroll. This amount covers the expected costs of all Medicare part A and part B services and any additional benefits specified in the plan's contract. Medicare's capitation payments do not vary with an individual's use of medical services.

HOW MEDICARE HISTORICALLY SET PAYMENTS TO PLANS

Before BBA changed the rate-setting process in 1998, the monthly amount Medicare paid managed care plans for each plan member was directly tied to local spending in the FFS program.

Although the actual rate-setting formula was complex, the methodology, in effect, was as follows. Each year, HCFA estimated how much it would spend in each county to serve the "average" FFS Medicare beneficiary.[4] Because managed care plans were assumed to be more efficient than FFS, Medicare set plan payments in each county at 95 percent of the estimated local per beneficiary FFS spending. This amount was commonly known as the adjusted average per capita cost (AAPCC).[5] Payments for individual beneficiaries were based on county of residence. Because some beneficiaries were expected to require more health care services than others, HCFA adjusted the payment for

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[4]HCFA made separate estimates for aged and disabled beneficiaries.

[5]As a result of BBA, AAPCC is now known as the Medicare+Choice capitation payment.

each beneficiary up or down from the county AAPCC depending on the beneficiary's age, sex, eligibility for Medicaid, and residence in an institution.[6]

In 1997, the average AAPCC was $395 per month,[7] but the rates varied dramatically from county to county. A plan that served an average beneficiary in Arthur County, Nebraska, would have received about $221 per month. A plan that served a similar beneficiary in Richmond County (Staten Island), New York, would have received approximately $767. Substantial rate variations also existed among neighboring counties. In Pennsylvania, for example, the 1997 payment rate was approximately $375 in York County and $403 in Cumberland County but $482 in neighboring Dauphin County.

The wide variation in capitation rates among counties reflected the underlying variation in Medicare per beneficiary FFS spending, which in turn was caused by local differences in the price and use of medical services. For example, average FFS spending in a county is affected by nurses' wages and physicians' office rents. Use of medical services is affected by physician practice patterns, the local Medicare population's health status, and beneficiaries' access to health care providers.

HOW BBA CHANGED PAYMENTS TO PLANS

Beginning in 1998, BBA changed the formula Medicare used to set managed care payments. In part, the law slowed future payment increases to respond to a decade of research that clearly indicated that plans were overcompensated for beneficiaries they served.[8] This slowing may result in fewer extra services or higher premiums in the future relative to managed care plans' current benefit packages. The law also loosened the link between the payment rate in each county and average FFS spending in that county. This change was made to

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[6]Separate rates were set for beneficiaries with end-stage renal disease (kidney failure).

[7]The average county rate weighted by the number of beneficiaries living in each county in 1997 was $468. Rates discussed here exclude rates for U.S. territories.

[8]Medicare HMOs: HCFA Can Promptly Eliminate Hundreds of Millions in Excess Payments (GAO/HEHS-97-17, Apr. 25, 1997). Managed care plans tend to attract healthier-than-average beneficiaries, but payments are based on health care spending for the average beneficiary.

reduce the wide disparity in payment rates that existed under the previous system.

Payment rates in each county are now set at the highest of three possible rates: a minimum or "floor" rate, a minimum increase rate, and a "blended" rate. BBA established a minimum payment–or floor–rate of $367 in 1998. The floor rate will be increased each year to reflect overall growth in Medicare spending. BBA also established a minimum increase rate that increases payments at least 2 percent each year in every county. Finally, BBA specified a blended rate for each county that reflects a combination of local and national average FFS spending. The blended rate is designed to reduce payment rate variation among counties.[9]

In 1998, the rate applicable in most counties–including Cumberland, Dauphin, and York Counties in Pennsylvania–was 2 percent above the 1997 rate. In counties where the 2-percent increase would not bring up the rate to the floor level, the payment was automatically increased to the $367 floor. Because of the BBA requirement to keep overall county payment changes budget neutral, no county received the blended rate in 1998.

HOW MEDICARE MANAGED CARE PLANS SET BENEFITS, PREMIUMS, AND COPAYMENTS

The level of benefits offered by each managed care plan depends on Medicare's capitation payment rates in the counties it serves, the plan's costs, and whether it decides to add benefits to attract new members or retain existing ones. Consequently, benefit packages can vary substantially for beneficiaries living in different counties, even if they belong to the same plan and use the same health care providers. Moreover, plans are permitted to enrich their benefit packages during the course of the year for some or all of the geographic areas they serve. Plans cannot, however, reduce their benefit package until the start of the next contract year.

Medicare managed care plans have wide discretion in determining their benefit packages. At a minimum, a plan must cover all benefits offered by traditional FFS Medicare. In addition, if it appears that the profits from its Medicare contract will exceed its normal profits, the plan is required to take certain

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[9]The blended rate combines a local rate with a national average in a formula currently weighted heavily toward local rates. The formula will gradually change so that in 2003, the local and national rates will be weighted equally.

actions to offset this difference. For example, a plan facing such a requirement may, at its discretion, include additional services, lower copayments, or charge a lower monthly premium. HCFA's primary role in this process is to determine, for each plan, whether additional benefits or reduced payments are necessary.

Setting Plan Benefits

HCFA approves managed care plans' benefit packages through the adjusted community rate (ACR) proposal process. After HCFA announces the capitation rates for the coming year, plans submit their ACR proposals to HCFA. These proposals detail the services the plans will cover and the copayments and monthly premiums they will charge beneficiaries in the upcoming contract year, which begins January 1. In their proposals, plans include estimates of their per-person costs, which are based on how much they would charge a commercial purchaser to provide the same benefit package if its members had the same health status and expected service utilization as Medicare beneficiaries. This amount is known as the plan's ACR and includes the plan's normal profits. Plans cannot charge fees–in the form of monthly premiums or copayments–that are higher than what a beneficiary would likely pay under traditional Medicare.

HCFA reviews each plan's ACR proposal to determine whether the plan must offer extra benefits. It compares the plan's ACR to the average per member amount that Medicare expects to pay, given the demographic mix of the plan's members and the capitation rates in its service area. If the average payment rate exceeds the ACR, the plan must provide additional benefits, reduce premiums or copayments, contribute to the Benefit Stabilization Fund,[10] or some combination of these. Nearly all plans choose to enhance their benefit packages by covering additional services, decreasing or waiving fees, or some combination of the two. Once HCFA approves a plan's ACR proposal, it effectively sets the minimum level of benefits the plan must offer and the maximum level of monthly premiums and copayments the plan may charge during the contract year.

Separately, plans can enhance their benefit packages during the current year by adding more services or reducing members' out-of-pocket costs to help attract

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[10]This fund is a non-interest-bearing escrow account into which HCFA permits plans to deposit savings from a current year's ACR for use in future years' ACR as a source of revenue.

new members or retain existing ones.[11] For example, Keystone Central Health Plan was permitted, under its approved ACR proposal, to charge beneficiaries a monthly premium of $92 in 1997. The plan, however, charged only $25 per month in 1997. HCFA may approve benefit enhancements during the year. However, the plan cannot reduce benefits or raise fees until the start of the next contract year and then only if approved during the normal ACR proposal process. HCFA requires plans to notify beneficiaries at least 30 days before any change in benefits takes effect.

Service Area and Benefits Variations

A plan defines the geographic area it will serve when it submits its ACR proposal to HCFA.[12] A service area usually consists of contiguous counties or parts of counties. Following HCFA's approval of the benefit package, a plan must provide at least the approved level of benefits to its entire service area. Through 1998, plans are allowed to enhance their benefit packages in selected portions of their service areas.[13] These selectively added benefits are known as flexible benefits. Plans facing a competitive market or seeking greater market share may take advantage of this option.

BBA requires plans to offer the same benefit package to all areas covered by an ACR proposal. However, beginning in 1999, plans can segment their service areas and submit a separate ACR proposal for each segment.[14] Thus, in essence, BBA did not eliminate flexible benefits. The same plan may continue

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[11]According to HCFA officials, plans will be allowed to make benefit package enhancements during each contract year until 2002. Beginning in that year, plans will be required to maintain their approved benefit packages for the entire contract year.

[12]According to HCFA officials, HCFA is evaluating the policy that allows each plan to determine its own service area and is considering standardizing the definition of a service area to some common geographic area.

[13]The enhancements had to apply to all beneficiaries living in the specified counties. That is, an HMO could not enhance benefits for part of a county if its service area included the entire county.

[14]For example, Humana's 1998 Florida contract had one ACR proposal with flexible benefits in several counties. For its 1999 contract, Humana divides its service area into 10 segments, each with its own ACR proposal.

to offer substantially different benefit packages for Medicare beneficiaries living in neighboring counties.

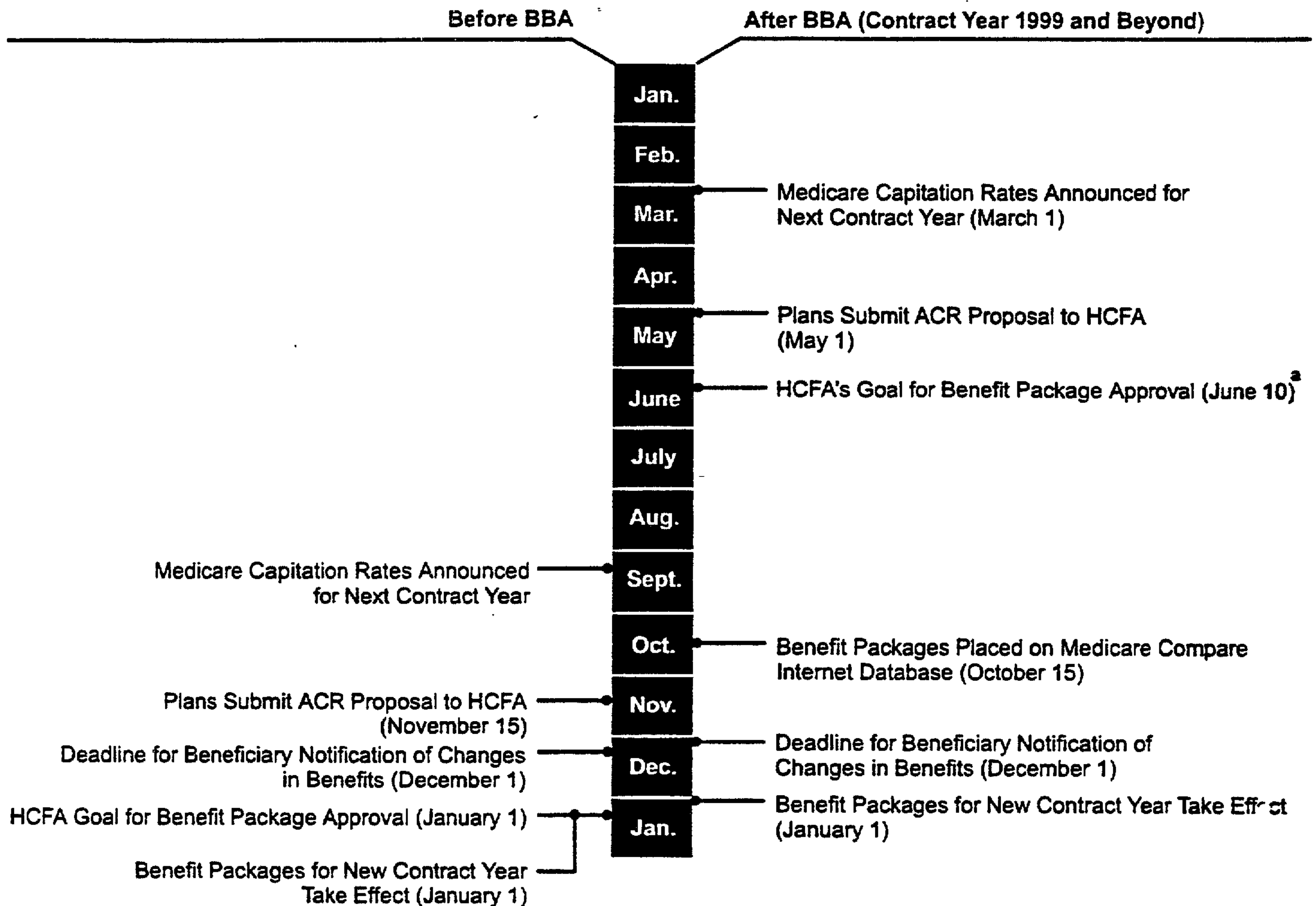
Although plans can apply for, and HCFA can approve, an expanded service area at any time during the contract year, the expansion will not be effective until the start of the next contract year. Similarly, service area reductions can be requested and approved at any time but do not take effect until the following contract year. For contract year 1999, plans were required to submit notification of service area changes to HCFA by October 1, 1998. For contract year 2000 and beyond, plans must submit the service area changes to HCFA by May 1 of the year before the changes are to take place.

Timetables for Contract Renewals Expanded

Prior to BBA, the ACR proposal and approval process was limited to a few months preceding the start of each contract year. (See fig. 1.) HCFA announced each September the Medicare capitation rates that would be in effect for the contract year beginning January 1. Plans used this information to develop their ACR proposals.[15] HCFA required plans to submit their proposals by November 15th so that the agency could review and approve them before the start of the contract year.

[15]HCFA accepts initial plan proposals throughout the year and approves them on a rolling basis. According to HCFA officials, it can take up to 9 months to approve new contracts.

Figure 1: Pre- and Post-BBA Timetables for ACR Proposal and Approval Process



[a]This was HCFA's goal for approval of the 1999 contract year benefits in order to meet the printing deadline for the beneficiary information materials.

The compressed pre-BBA deadlines allowed HCFA little advance notice of plans' planned benefit changes from one contract year to the next. Moreover, the agency had little time to review and approve ACR proposals. According to HCFA officials, the agency did not always approve ACR proposals before the start of the contract year. In some cases, HCFA did not approve ACR proposals until February. When HCFA approval was not timely, plans began the new contract year with their proposed benefit packages but informed beneficiaries that these packages were still subject to HCFA approval.

HCFA introduced changes in 1998 that substantially increased the time between the ACR approval process and the start of the new contract year. HCFA now announces in March the capitation rates for the next calendar year and requires plans to submit their ACR proposals by May 1. HCFA intends to complete the approval process by mid-June so that a summary of each plan's benefit package can be included in a fall mailing to beneficiaries.

HCFA REQUIREMENTS GOVERNING BENEFICIARY NOTIFICATION OF BENEFIT CHANGES

HCFA requires managed care plans to notify their members 30 days prior to the effective date of a change in the benefit package. For example, plans had to notify their members by December 1, 1997, about decreases in benefits and increases in premiums and copayments for the new contract year that began January 1, 1998. Although plans now submit their ACR proposals 8 months before the start of the contract year, and HCFA approves them more than 6 months before the start of the contract year, plans are not required to give members more than 30 days' notice of an impending benefit change.

Beneficiaries may be aware of approved benefit changes before they receive official notification, however. HCFA has developed a comparative database, known as Medicare Compare, available on the Internet, that summarizes the benefit packages offered by Medicare plans. HCFA officials said that information on plans' 1999 benefit packages should be available on the Internet by October 15, 1998. In addition, HCFA will begin this fall to phase in a process of mailing this information directly to beneficiaries. In 1999 and subsequent years, HCFA will mail this information in the October preceding the start of the contract year. Nonetheless, because plans can enhance their benefit packages throughout the year, the information HCFA distributes through the Internet and by direct mailing could be inaccurate, reflecting only the minimum benefit package approved by HCFA.

Finally, a plan may terminate its Medicare contract during the year with 60 days' written notification to its members. Affected beneficiaries can enroll in another managed care plan, if available, or return to traditional FFS Medicare. However, Medicare beneficiaries with preexisting conditions who choose to return to FFS may be limited in their choice of supplemental insurance plans and could face exclusion periods for preexisting conditions.

AGENCY COMMENTS

In commenting on a draft of this correspondence, officials from HCFA's Office of the Actuary, the Center for Health Plans and Providers' Health Plan Purchasing and Administration Group, and the Office of Financial Management's Program Integrity Group said that we have accurately presented the information. They also made technical suggestions, which we incorporated where appropriate.

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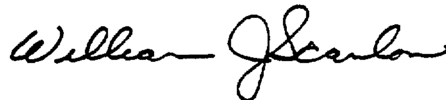
We are sending copies of this report to the Secretary of Health and Human Services and other interested parties, and we will make copies available to others on request.

If you or your staff have any questions, please call me at (202) 512-7114 or James Cosgrove, Assistant Director, at (202) 512-7029. Other major contributors to this report include George Duncan and Keith Steck.

Sincerely yours,



William J. Scanlon
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