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MEDICARE MANAGED CARE

Better Risk Adjustment Expected to Reduce Excess Payments Overall While Making Them Fairer to Individual Plans

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Summary

Because of problems in the way Medicare paid capitated managed care plans, the Balanced Budget Act of 1997 (BBA) changed Medicare's payment rules. The act's provisions acknowledge that the enrollment of beneficiaries in managed care plans has not saved the government money as expected. Studies by us and others show that methodological flaws have led to billions of dollars in excess payments and inappropriate payment disparities across counties.

- Medicare's capitation rates are excessive because payments are based on health care spending for the average non-enrolled beneficiary, while the plans' enrollees tend to be healthier than average.
- Excess payments continued to grow with increased enrollment, rather than diminish, as some have speculated. As a county's managed care enrollee population grew, the concentrations of high-cost beneficiaries remaining in fee-for-service also grew. Rates based on these sicker populations resulted in increasingly excessive payments relative to the better health, on average, of the managed care population. Our 1997 study of California HMO payments showed that HMOs in counties in which enrollment was high received a higher percentage of excess payments.

To correct these problems, BBA changed the rate-setting formula in 1998 and called for the Health Care Financing Administration (HCFA) to replace the current risk adjuster in 2000. (The risk adjuster is a mechanism for modifying a plan's average capitation rate to better reflect an enrollee's expected medical costs.) The BBA provisions put in place in 1998 may reduce the overpayments somewhat, but substantial excess will remain, and payment disparities will persist that could jeopardize plan participation and access for costlier seniors. The inadequacy of the current risk adjuster continues to contribute to inappropriate payments, hurting taxpayers, certain plans, and beneficiaries.

HCFA's proposed risk adjuster for 2000 is an interim step that, while not perfect, can improve estimates of Medicare enrollees' medical costs. A "next generation" of risk adjustment is scheduled for 2004. Better cost estimates producing fairer rates can reduce the unnecessary spending of taxpayer dollars but, at the same time, mitigate the financial disincentive for plans to serve a costly mix of beneficiaries. HCFA plans to phase in the use of the 2000 adjuster and, in so doing, anticipates the need to avoid sharp payment changes that could affect plans' offerings and diminish the attractiveness of the Medicare+Choice program to beneficiaries. The success of this and future risk adjustment efforts also depends on the

quality of data HCFA uses. We believe that Medicare's managed care plans should therefore aggressively pursue the collection of comprehensive encounter data on their enrollees' medical conditions and report this information promptly to HCFA.

Medicare Managed Care: Better Risk Adjustment Expected to Reduce Excess Payments

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today as you address the question of adjusting Medicare's payments to managed care plans in the Medicare+Choice program. Although the subject matter is technical, its implications are significant for Medicare's greater use of managed care. The Balanced Budget Act of 1997 (BBA) includes provisions designed to slow the growth of Medicare payments overall. BBA also encourages the expansion of managed care in its creation of Medicare+Choice, designed to offer beneficiaries more health plan options beyond those available through Medicare's health maintenance organizations (HMO). BBA provisions modify the method used to pay health plans, and it is the details for implementing these provisions—representing billions of dollars in savings—that are under discussion here today.

Managed care plans receive from Medicare a fixed monthly payment, called a capitation payment, for each beneficiary they enroll. Because the payment is fixed per enrollee, regardless of what the plan spends for each enrollee's care, health plans lack the incentive to provide unnecessary services. However, the enrollment of beneficiaries in managed care plans has not saved the government money as expected, mainly for two reasons. First, as we and others previously determined, Medicare's capitation rates are excessive because payments are based on health care spending for the average non-enrolled beneficiary, while the plans' enrollees tend to be healthier than average.[1] Second, instead of diminishing as more beneficiaries enrolled in managed care, excess payments per enrollee continued to grow. To correct these problems, BBA changed the rate-setting formula used by the Health Care Financing Administration (HCFA), the agency responsible for administering Medicare. It required that most of the rate-setting provisions be in place in 1998 and required that HCFA replace Medicare's current risk adjuster—the mechanism that modifies a plan's average capitation rate to better reflect an enrollee's expected medical costs—with a new one to be implemented in 2000. The risk adjuster in place has been widely criticized as a major factor in the HMO overpayment problem.

In considering Medicare's new rate-setting method, my comments today will focus on (1) the importance of improving the current risk adjustment

[1] Medicare HMOs: HCFA Can Promptly Eliminate Hundreds of Millions in Excess Payments (GAO/HEHS-97-16, Apr. 25, 1997).

method, (2) the implications of rate-setting changes implemented in 1998, and (3) the advantages and drawbacks of HCFA's proposed new interim risk adjuster. My comments are based on information drawn from our issued work on this subject, supplemented by relevant published studies and interviews with HCFA officials.

In summary, Medicare's current risk adjuster has failed to protect taxpayers, certain plans, and beneficiaries, underscoring the urgency of replacing it with a health-based risk adjuster.

- Studies by us and others show that methodological flaws have led to billions of dollars in excess payments and inappropriate payment disparities.
- BBA provisions now in place may reduce, but not eliminate, excess payments; and payment disparities persist that could jeopardize plan participation and access to managed care for costlier seniors.
- The new risk adjuster required to be in place by 2000 is intended to improve estimates of health plan enrollees' medical costs. Better cost estimates producing fairer rates could reduce the unnecessary spending of taxpayer dollars while minimizing the financial disincentive for plans to serve a costly mix of beneficiaries.

The use of the new risk adjuster, while not perfect, is an interim step and improves on the one now in place. In addition, HCFA plans to phase in the use of the new adjuster, thereby recognizing the need to avoid sharp payment changes that could affect plans' offerings and diminish the attractiveness of the Medicare+Choice program to beneficiaries.

Background

The long-term financial condition of Medicare is now one of the nation's most pressing problems. As the nation's largest health insurance program, Medicare's size and impact on all Americans is significant. The program covers about 39 million elderly and disabled beneficiaries at a cost of more than $193 billion in fiscal year 1998. About 83 percent of the program's beneficiaries receive health care on a fee-for-service (FFS) basis, in which providers are reimbursed for each covered service they deliver to

beneficiaries. The rest, about 6.8 million people, are provided care through more than 450 managed care plans, as of December 1, 1998.[2]

To extend the solvency of Medicare's Hospital Insurance Trust fund beyond 2008, BBA provided for substantial reforms in both the FFS and managed care components of Medicare. BBA provisions are expected to achieve estimated Medicare savings that reduce the program's average annual growth rate by more than 3 percent, representing over $100 billion over 5 years.

One way in which BBA seeks to restructure Medicare is to encourage greater participation in Medicare+Choice. Under this program, BBA permits the creation of new types of Medicare health plans, such as preferred provider organizations and provider-sponsored organizations. BBA's emphasis on Medicare+Choice reflects the perspective that increased managed care enrollment will help slow Medicare spending while expanding beneficiaries' options in choosing health plans.

BBA also sought to improve the method for setting managed care plans' payment rates. In general terms, the pre-BBA rate-setting methodology worked as follows. Every year, HCFA estimated how much it would spend in each U.S. county to serve the "average" FFS beneficiary. It would then discount that amount by 5 percent under the assumption that the managed care plans provided care more efficiently than the unmanaged FFS system. The resulting amount constituted a base county rate to be paid to the plans operating in that county. Because some beneficiaries were expected to require more health services than others, HCFA "risk adjusted" the base rate up or down for each beneficiary, depending on certain beneficiary characteristics—specifically, age; sex; eligibility for Medicaid; employment status; and residence in an institution, such as a skilled nursing facility.[3]

BBA's new payment rate method seeks to address the two main factors contributing to excess payments: (1) the disparity in expected health costs between Medicare's FFS and managed care populations built into each county's base capitation rates and (2) the failure of the risk adjuster to

[2]About 90 percent of the 6.8 million Medicare beneficiaries are enrolled in managed care plans that receive fixed monthly capitation payments. The remainder are enrolled in plans that are reimbursed for the costs they incur, less the estimated value of beneficiary cost-sharing.

[3]Separate rates, using the same demographic traits, are calculated for beneficiaries who qualify for Medicare because of a disability (under age 65). Separate rates are also set for beneficiaries with end-stage renal disease (kidney failure).

correct for that disparity on an individual enrollee level. BBA required that a county's capitation rate equal the highest of

- a blended capitation rate, which reflects a combination of local and national average FFS spending from 1997, updated for increases in national spending;
- the previous year's county rate increased by 2 percent; or
- a minimum payment amount, called a floor, set equal to $367 in 1998 and updated each year.

Loosening the link between the current cost of Medicare's FFS population and counties' base rates helps prevent the excess payments from continuing to increase as more beneficiaries join managed care plans. BBA also acknowledges the need for individual enrollee adjustments by requiring the development of a risk adjustment method based on health status. The law requires that HCFA develop and report on the new risk adjuster by March 1 of this year and the method be in place by January 2000.[4]

Medicare's Current Risk Adjustment Method Fails To Prevent Overpayments and Appropriately Target Payments To Plans

Risk adjustment is a tool to set capitation rates so that they reflect enrollees' expected health costs as accurately as possible. This tool is particularly important given Medicare's growing use of managed care and the phenomenon of favorable selection—the tendency of managed care plans to attract a population of Medicare seniors whose health costs are generally lower than those of the average program beneficiary. Our 1997 study on payments to California HMOs, which enrolled more than a third of Medicare's managed care population, found that Medicare overpaid plans by about 16 percent because HMO enrollees had costs that were lower than the average beneficiary's.[5]

Medicare's current risk adjuster cannot sufficiently lower rates to be consistent with the expected costs of managed care's healthier population. The reason is that Medicare's risk adjuster relies on demographic factors such as age and sex, which alone are poor predictors of an individual's

[4]Technically, the law requires the Secretary of the Department of Health and Human Services to develop, report, and implement the health-based risk adjustment method.

[5]GAO-HEHS-97-16, Apr. 25, 1997. This is consistent with a 1996 study by HCFA researchers finding that health plan enrollees had costs estimated at 12 to 14 percent below the average beneficiary's. (Riley and others, HCFA Review, 1996.)

health care costs. For example, two beneficiaries can be demographically identical (same age and sex), but one may experience occasional minor ailments while the other may suffer from a serious chronic condition. Without the use of health status factors to make that distinction, Medicare's risk adjuster produces excessive payments in compensating plans for their relatively lower cost enrollees.

The financial consequences of a poor risk adjuster are huge. In our 1997 study of California's payment rates, we estimated that Medicare paid about $1 billion in excess to health plans operating in California in 1995. Shortly before we issued our report, the Physician Payment Review Commission (PPRC), now a part of the Medicare Payment Advisory Commission, estimated that annual excess payments to Medicare HMOs nationwide could total $2 billion.

Some analysts have speculated that, with growing enrollment, health plans would necessarily enroll a substantially larger share of less healthy beneficiaries, which would raise plans' costs and reduce Medicare's excess payments. Our 1997 analysis, however, showed that—rather than shrinking excess payments—the rapid growth in Medicare managed care enrollment actually exacerbated the situation. The counties with higher managed care enrollment had higher, not lower, excess payments. Data indicated that the sickest beneficiaries tended to remain in FFS while the healthier beneficiaries joined managed care plans. Excess payments grew with managed care enrollment partly because HCFA based the payment rates on average FFS spending, which increased as the pool of FFS beneficiaries shrank and, as a group, became less healthy.

Better risk adjustment is also important for plans that may not be adequately compensated for serving higher cost beneficiaries who enroll. Having enrollees who are sicker than the average mix of Medicare beneficiaries can alter a plan's costs significantly. About 10 percent of Medicare beneficiaries account for 60 percent of Medicare's annual expenditures. Without adequate risk adjustment, plans with more than their share of the costly beneficiaries are at a competitive disadvantage.

BBA Provisions May Reduce Overpayments, but Substantial Excess Likely Remains

BBA contains several provisions, implemented in 1998, that are designed to improve Medicare's rate-setting method. Certain provisions seek to reduce excess payments and inappropriate geographic disparities. These changes represent steps in the right direction but do not eliminate the need for a health-based risk adjuster. Substantial excess payments likely persist, in part, because other BBA provisions tended to incorporate the excess that existed in 1997 into the current rates.

Certain BBA Provisions May Reduce Excess Payments but Are Not Substitutes for Improved Risk Adjustment

BBA aims to reduce the excess in Medicare's managed care payments in two ways. First, BBA holds down managed care per capita spending increases for 5 years. Specifically, BBA sets the factor used to update managed care payment rates equal to national per capita Medicare growth minus a specified percent: 0.8 percent in 1998 and 0.5 percent in each of the following 4 years.

BBA also provides for a methodological approach known as "blending," which may help reduce excess payments. The blended rate set for each county combines that county's 1997 rate, updated for increases in national Medicare spending, and a national average. The blending formula is currently weighted heavily toward local rates but will gradually change so that local and national rates will be weighted equally in 2003. Over time, blending will reduce the substantial variation in county payment rates that now exist. For example, county rates ranged from a low of $380 to a high of $798 in 1999. Because of BBA-mandated budget neutrality and minimum payment constraints, no county received a blended rate in 1998 or 1999. Blending is expected to occur for the first time in 2000.

Blending may help reduce excess payments because high-rate counties (where excess payments are estimated to be concentrated) will receive smaller annual increases relative to low-rate counties. Evidence on the relationship between county payment rates and excess payments is provided in a 1997 PPRC study. PPRC reported that county payment rates tend to overestimate beneficiaries' health care costs in high-payment-rate areas and underestimate their costs in low-payment-rate areas.[6] PPRC found that a comprehensive health-based risk adjustment methodology would have lowered, for example, the average Miami-area payment rate

[6]Physician Payment Review Commission, 1997 Annual Report to the Congress.

from $616 to $460 in 1995. The same methodology would have raised the average payment rate in rural Minnesota from $263 to $310.

Blending is a rather blunt tool for addressing the excess payment problem, however, and does not obviate the need for improved risk adjustment. As the PPRC results indicate, not all high-rate counties have rates that are too high and not all low-rate counties have rates that are too low. For example, PPRC's risk-adjustment methodology would have reduced the average payments in rural Michigan (a relatively low-payment-rate area) from $346 to $334. Furthermore, not all plans in high-rate counties may receive excess payments. Because payment rates are based on the expected costs of beneficiaries in average health, plans that attract costly beneficiaries may be underpaid by the current risk adjustment method.

Some BBA Provisions Have Tended to Incorporate Excess Payments From 1997 Into Current Rate Structure

BBA specified that 1997 county rates be used as the basis for all future county rates beginning in 1998. Although the law changed many aspects of the rate-setting formula, this BBA provision had the effect of incorporating the excess payments that existed in 1997 into all future rates.

As we testified before this Subcommittee in February 1997, HCFA's then current rate-setting methodology resulted in county rates that were generally too high. Simply put, instead of setting rates based on the expected cost of the average beneficiary in each county, the agency set rates based on the expected costs of serving FFS beneficiaries. If the agency had included the expected costs of serving managed care beneficiaries—who as a group tend to be healthier than FFS beneficiaries—the overall county average would have been lower. About one-quarter of the $1 billion in overpayments we estimated in our California study resulted from flaws in developing the county rate.

Excess payments are also built into current rates because BBA did not allow HCFA to adjust 1997 county rates for previous forecast errors—a critical component of the rate-setting process. Although the process for setting rates was extremely complex and involved separate adjustments for each county, annual payment rate updating was straightforward. Each fall, HCFA would forecast total Medicare spending for the following year; the estimated percentage spending increase, from the current year to the following year, was used to update the county rates. Before applying the increase, however, HCFA corrected any forecast errors from previous years. If HCFA discovered that previous forecasts had overestimated or

underestimated the current spending, the update was appropriately adjusted.

HCFA actuaries now estimate, based on FFS claims data, that the 1997 managed care rates were too high by 4.2 percent. BBA, in establishing a new methodology for setting rates in 1998 and future years, specified that HCFA use the 1997 rates as the basis for the new rates. While the law permits HCFA to correct forecasts in future years, it did not include a provision that would have allowed HCFA to correct its forecast for 1997. Consequently, about $1.3 billion in overpayments were built into plans' annual payment rates beginning in 1998.

HCFA's Proposed Risk Adjustment Approach Improves on Current Method and Minimizes Disruption for Plans and Beneficiaries

HCFA's proposed interim health-based risk adjustment method—to be implemented in 2000—represents a major improvement over the current method. For the first time, Medicare managed care plans can expect to be paid more for serving beneficiaries with serious health problems and less for serving relatively healthy ones. The interim method relies exclusively on hospital inpatient data to measure health status. Although it would be better to measure health status with complete and reliable data from other settings, such as physicians' offices, these data are not yet available. In addition, HCFA's decision to phase in the new method will likely minimize disruptive plan pull-outs and altered benefit packages, which could occur if payment rate changes were implemented too suddenly.

Proposed Risk Adjustment Method Based on Available Hospital Inpatient Data

The proposed method, known as the Principal Inpatient Diagnostic Cost Group (PIP-DCG) method, would use hospital inpatient data to more accurately match managed care payments to beneficiaries' expected total Medicare costs. PIP-DCG would assign each individual to 1 of 15 categories if during the prior year they had been hospitalized for certain diagnoses. For example, a beneficiary who had been hospitalized for congestive heart failure would be placed in one category, while a beneficiary who had been hospitalized for a kidney infection would be placed in another. Those beneficiaries who were not hospitalized and those who were hospitalized for diagnoses not included in PIP-DCG—about 88 percent of all beneficiaries—would be placed in the base category. The next year's payment rate for each enrollee would be determined by the category the individual was placed in and by certain demographic data, such as age and sex. Rates for enrollees placed in one of the 15 prior hospitalization groups would be higher than rates for those in the base category with the same demographic characteristics.

HCFA anticipated potential concerns about a risk adjustment methodology based on hospital inpatient data. Such an approach could reward plans that hospitalize patients unnecessarily or, conversely, penalize efficient plans that provide care in other, less costly settings. HCFA has attempted to address these concerns in several ways.

First, PIP-DCG would assign individuals to prior hospitalization categories only when the diagnosis is for a condition that normally requires hospitalization and is linked to further medical costs in the following year. To determine which specific diagnoses to include, HCFA relied on the advice of a clinical panel. The panel recommended that diagnoses associated with about one-third of hospital admissions be excluded because they (1) could be ambiguous, (2) were for conditions that were rarely the main cause for an inpatient stay, or (3) were not good predictors of future health care costs. For example, a beneficiary hospitalized for appendicitis would not be assigned to a higher cost category because that condition generally is not linked to further medical costs in the next year. Also, HCFA's proposal does not permit enhanced payments for hospital diagnoses associated with 1-day stays. These admissions may be more discretionary than admissions for longer stays.

Second, delaying an adjustment in payment until the following year discourages unnecessary hospitalizations that would trigger an enhanced payment. Further, the payment delay dampens any incentive to encourage higher cost enrollees who have been hospitalized to switch plans, since the plan in which the beneficiary is a member the following year receives the payment.

The PIP-DCG method assumes that admission rates for beneficiaries of similar health status are the same for FFS and managed care providers. Although the evidence on managed care admission rates is limited, findings presented by the American Association of Health Plans last month support this hypothesis. A study conducted for the Association found that hospital admission rates for managed care plans and FFS plans were comparable. These findings are consistent with those of a 1993 Mathematica Policy Research study on hospital admissions rates.

Gradual Implementation of Interim Method Will Minimize Impact on Health Plans and Beneficiaries

HCFA proposes to phase in the new interim risk adjustment method slowly. In 2000, only 10 percent of health plans' payments will be based on the new system. This percentage will be increased each year until 2003, when 80 percent of plans' payments will be based on the PIP-DCG risk-adjusted rate. In 2004, HCFA intends to implement a more accurate risk adjuster that uses medical data from physicians' offices, skilled nursing facilities, home health agencies, and other health care settings and providers—-in addition to inpatient hospital data.

Although a gradual phase-in of the interim risk adjuster delays the full realization of Medicare savings, it also minimizes potential disruptions for both health plans and beneficiaries. Rapid payment rate changes could strain the financial soundness of some plans. Rapid rate changes could also adversely affect beneficiaries if plans respond by suddenly altering their benefit packages or reconsidering their commitment to the Medicare+Choice program.

If HCFA had comprehensive patient-level data from Medicare managed care plans, it could adjust the PIP-DCG methodology to reflect any differences in practice patterns between managed care and FFS providers. Although plans currently are required to submit only hospital inpatient data, the agency intends to begin collecting more comprehensive data shortly. Therefore, it may be possible to refine the PIP-DCG methodology before the implementation of the full risk adjustment in 2004.

Conclusions

The implementation of a new health-based risk adjustment system will lead to major changes in Medicare managed care payments and will create more desirable incentives. Plans attracting healthier beneficiaries will be paid less, whereas those attracting costlier beneficiaries will be paid more. In more fairly compensating individual plans for the beneficiaries they enroll, the new method will reduce excess payments and produce savings for taxpayers. The new method represents an interim step in the use of health-based risk adjustment. We believe that to facilitate the introduction of an improved risk adjuster in 2004, plans should aggressively pursue the collection and reporting of more comprehensive data on beneficiaries' medical conditions.

Mr. Chairman, this concludes my statement. I will be happy to answer any questions you or other Members of the Subcommittee may have.

Related GAO Products

Medicare Managed Care: Payment Rates, Local Fee-for-Service Spending, and Other Factors Affect Plans' Benefit Packages (GAO/HEHS-99-9R, Oct. 9, 1998).

Medicare HMO Institutional Payments: Improved HCFA Oversight, More Recent Cost Data Could Reduce Overpayments (GAO/HEHS-98-153, Sept. 9, 1998).

Medicare HMOs: Setting Payment Rates Through Competitive Bidding (GAO/HEHS-97-154R, June 12, 1997).

Medicare Managed Care: HMO Rates, Other Factors Create Uneven Availability of Benefits (GAO/T-HEHS-97-133, May 19, 1997).

Medicare HMO Enrollment: Area Differences Affected by Factors Other Than Payment Rates (GAO/HEHS-97-37, May 2, 1997).

Medicare HMOs: HCFA Can Promptly Eliminate Hundreds of Millions in Excess Payments (GAO/HEHS-97-16, Apr. 25, 1997).

Medicare HMOs: HCFA Could Promptly Reduce Excess Payments by Improving Accuracy of the County Rates (GAO/T-HEHS-97-82, Feb. 27, 1997).

Medicare Managed Care: Growing Enrollment Adds Urgency to Fixing HMO Payment Problem (GAO/HEHS-96-21, Nov. 8, 1995).

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

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

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