United States General Accounting Office

GAO

Report to Congressional Requesters

June 1999

MEDICARE+CHOICE

Reforms Have Reduced, but Likely Not Eliminated, Excess Plan Payments

GAO/HEHS-99-144

GAO

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

Health, Education, and
Human Services Division

B-282937

June 18, 1999

The Honorable Daniel Patrick Moynihan
Ranking Minority Member
Committee on Finance
United States Senate

The Honorable John D. Dingell
Ranking Minority Member
Committee on Commerce
House of Representatives

The Honorable Fortney (Pete) Stark
Ranking Minority Member
Subcommittee on Health
Committee on Ways and Means
House of Representatives

The Balanced Budget Act of 1997 (BBA) created the Medicare+Choice program to expand beneficiaries' health plan options, both by encouraging the wider availability of health maintenance organizations (HMO) and by permitting other types of health plans, such as preferred provider organizations, to participate in Medicare. BBA also modified the methodology used to determine plan payments, in part because of concerns that (1) many health plans were overcompensated for the beneficiaries they served and (2) Medicare's managed care program had not, as originally anticipated, saved the program money. The new methodology is designed to both slow the growth of aggregate payments and more closely align per capita payments with the expected health care costs of plan members. BBA's creation of Medicare+Choice represents one important means of helping to address the growing challenge of financing the Medicare program. The Congressional Budget Office (CBO) has estimated that BBA's fee-for-service (FFS) and Medicare+Choice reforms will lower program spending by $386 billion over the next 10 years.

Some health plan and industry representatives believe that BBA's health plan payment changes were too severe and will reduce beneficiaries' access to plans and additional benefits, such as outpatient prescription drug coverage, that are not available under FFS. The American Association of Health Plans (AAHP) contends that Medicare will spend substantially less on health plan enrollees than for FFS beneficiaries, a discrepancy it terms a "fairness gap." To assist congressional consideration of these concerns,

you asked us to (1) review the extent to which health plans currently provide additional benefits and whether they could continue to provide additional benefits if payments were reduced, (2) summarize the evidence regarding managed care's effect on Medicare spending, and (3) assess whether BBA provisions will eliminate excess plan payments. To answer these questions we analyzed data that plans submitted to the Health Care Financing Administration (HCFA) and synthesized findings from our previous reports and studies by HCFA, CBO, and others. Our work was done from May to June 1999 in accordance with generally accepted government auditing standards.

Results in Brief

Although all health plans are required to provide at least the package of benefits available in traditional FFS, most plans provide many more benefits—such as coverage for outpatient prescription drugs, routine physical exams, and dental care.[1] The extra benefits result, in part, because projected Medicare payments tend to exceed plans' estimated costs of providing the FFS package of benefits, and the program requires that the difference between payments and plan costs be used to fund additional benefits.[2] Data submitted by health plans indicate that they were required, on average, to provide additional benefits equivalent to nearly 13 percent of Medicare's payments in 1997. For competitive reasons, many health plans voluntarily enrich their benefit packages beyond Medicare's requirements. In 1997, the average enrollee in a health plan received more than $90 per month in required and voluntary additional benefits. Thus, even if plan payments were reduced, the typical plan could provide the FFS package of benefits as well as some additional benefits and still earn a profit.

Health plans have not, however, produced the expected savings for the Medicare program. Until 1997, Medicare plans were paid 95 percent of the expected FFS cost of beneficiaries. The 5-percent discount was established to allow the program to benefit from the efficiencies commonly associated with managed care. However, numerous studies conducted by us, the Physician Payment Review Commission (PPRC)—which has been incorporated into the Medicare Payment Advisory Commission—HCFA, and others demonstrated that the Medicare program spent more on

[1]Except where otherwise noted, this report uses the term "plan" to refer to organizations that receive a fixed monthly payment—known as a capitation payment—for each beneficiary they enroll regardless of that beneficiary's costs. Before BBA created the Medicare+Choice program, these organizations were known as risk-contract HMOs.

[2]Plans can provide additional benefits in the contract year or contribute to a stabilization fund, which the plan can draw on in future years to avoid fluctuations in its benefit package.

beneficiaries enrolled in health plans than it would have if the same individuals had been in FFS. This unexpected result occurred because Medicare payments were based on the estimated cost of FFS beneficiaries in average health and were not adequately adjusted to reflect the fact that plans tended to enroll beneficiaries with better-than-average health who had lower health care costs—a phenomenon known as favorable selection.

BBA's new formula for paying health plans—implemented in 1998—takes steps to lower, but probably not eliminate, excess plan payments. Among other changes, the new formula slows the growth of plan payment rates relative to FFS spending growth for 5 years. More importantly, BBA mandates the implementation of a health-based "risk adjustment" system intended to better match payments to beneficiaries' expected health care costs and reduce the excess payments caused by favorable selection. The effect of these changes is reduced, however, because BBA locked in place the excessive payment rates that existed in 1997. For example, when HCFA actuaries set 1997 payment rates, they based those rates on a forecast of 1997 FFS spending. The actuaries now know that those rates were too high because the forecast overestimated FFS spending by 4.2 percent. However, BBA specified that the 1997 rates be used as the basis for the 1998 rates. This implicit inclusion of the forecast error resulted in excess payments of $1.3 billion in 1998. Furthermore, the annual excess payments associated with the forecast error will increase each year as more beneficiaries join health plans.

Background

As of June 1, 1999, about 6.9 million people—or approximately 18 percent of Medicare's 39 million beneficiaries—were provided care through managed care plans, most of which are capitated health plans.[3] Capitated plans receive a fixed monthly amount for each beneficiary, regardless of what individual enrollees' care actually costs. The remaining 82 percent receive health care on an FFS basis, under which providers are paid for each covered service they deliver to beneficiaries.

Inherent in Medicare's FFS program is an incentive for providers to deliver more services than necessary, driving up program costs. Policymakers have, therefore, looked to managed care—namely, the use of capitated plans—to curb unnecessary spending because these plans have a financial incentive to provide care efficiently. In fact, among BBA's major reforms to

[3]About 90 percent of the 6.9 million Medicare beneficiaries were enrolled in managed care plans that receive fixed monthly capitation payments. The remainder were enrolled in plans that are reimbursed for the costs they incur, less the estimated value of beneficiary cost-sharing.

contain Medicare spending was the creation of Medicare+Choice, which was intended to increase the plan options available to Medicare beneficiaries.

Before BBA changed the rate-setting process in 1998, the monthly amount Medicare paid plans for each plan member was directly tied to local spending in the FFS program. In general terms, the pre-BBA rate-setting methodology worked as follows. Every year, HCFA estimated how much it would spend in each 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 program. 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; disability status; and residence in an institution, such as a skilled nursing facility.[4]

BBA substantially changed the method used to set the payment rates for Medicare plans. As of January 1, 1998, plan payment rates for each county are based on the highest rate resulting from three alternative methodologies: a minimum amount, a minimum increase over the previous year's payment rate, or a blend of historical FFS spending in a county and national average costs adjusted for local price levels. The changes were intended to address criticisms of the original payment system by loosening the link between local FFS spending increases and plan payment rate increases in each county. In addition, the establishment of a minimum payment rate was meant to encourage plans to offer services in areas that historically have had low payment rates and few participating plans—primarily rural counties. BBA also directed the Secretary of Health and Human Services to develop and implement a better risk-adjustment system based on beneficiary health status by January 1, 2000.

[4]Separate rates are calculated for beneficiaries who qualify for Medicare because of a disability (under age 65) and the aged. Separate rates are also set for beneficiaries with end-stage renal disease (kidney failure).

Medicare+Choice Plans Provide Additional Benefits Because Medicare Payments Exceed Plans' Costs

For many beneficiaries, health plans cost less than traditional FFS and offer a more comprehensive benefit package. For example, beneficiaries in plans often pay a small copayment each time they use an outpatient service but are generally not responsible for the deductibles and coinsurance amounts they would pay in FFS. The out-of-pocket cost for a plan enrollee is often lower than the premium for a supplemental, or Medigap, insurance policy—another way that beneficiaries obtain increased coverage. The trade-off is that beneficiaries must generally use only plan-approved providers and abide by other plan rules to receive covered services.

More than two-thirds of all beneficiaries live in areas served by at least one health plan. About 85 percent of these beneficiaries could enroll without paying a separate monthly premium, and 88 percent have access to a plan that provides coverage for outpatient prescription drugs.[5] All, or nearly all, beneficiaries who could join a plan have access to a plan that offers coverage for routine physical, eye, and hearing exams. Many of these beneficiaries have access to a plan that also provides dental care.

One reason for the enhanced benefit packages is that plans' estimated cost of providing the traditional FFS benefit package—including the amount of profit normally earned on commercial contracts—tends to be lower than Medicare's projected payment.[6] Under Medicare's payment terms, when a plan's estimated cost to provide the FFS package of benefits is less than projected payments, the plan must use the difference—an amount known as "savings"—to enhance its benefit package by adding benefits or reducing cost-sharing.[7] In 1997, plans' savings averaged nearly 13 percent of payments. Consequently, plans were required to provide additional benefits worth $60 per member per month.

Although the relationship between plans' costs and their Medicare payments may have changed since 1997, our analysis of 1999 data

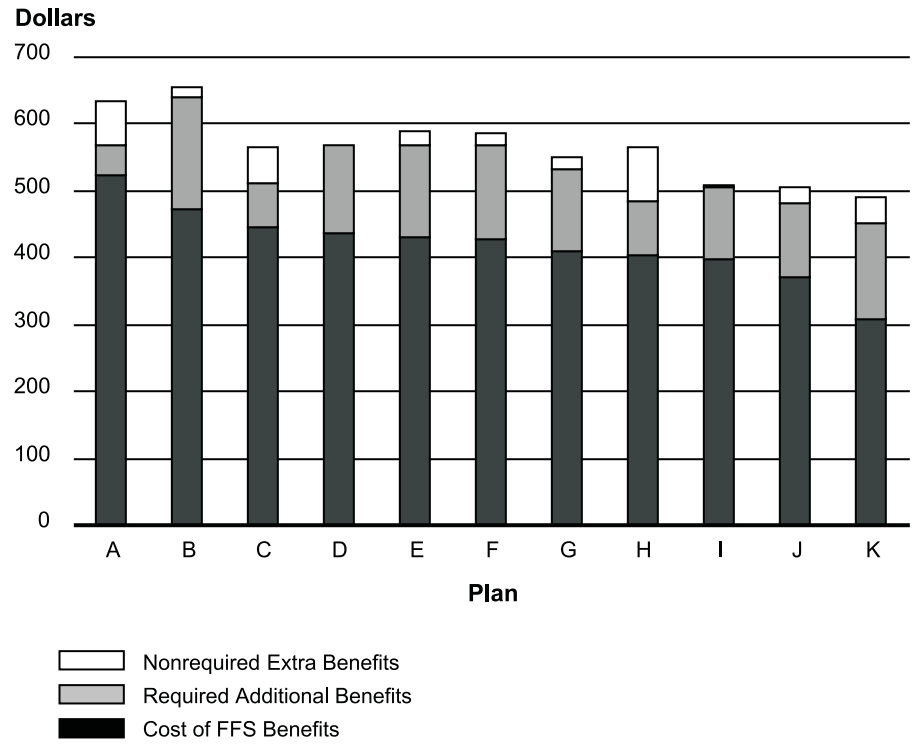
[5]Beneficiaries who wish to participate in the Medicare+Choice program must pay the Medicare part B premium of $45.50 per month. (See Medicare Managed Care Plans: Many Factors Contribute to Recent Withdrawals; Plan Interest Continues (GAO/HEHS-99-91, Apr. 27, 1999).)

[6]The accuracy of the cost data submitted by plans is unknown. Recent reports by the Department of Health and Human Services' Office of the Inspector General suggest that the administrative cost component for some HMOs may be too high and that, consequently, the amount of required additional benefits may be too low. (See Department of Health and Human Services, Office of the Inspector General, Administrative Costs Submitted by Risk-Based Health Maintenance Organizations on the Adjusted Community Rate Proposals Are Highly Inflated A-14-97-00202 (July 1998).)

[7]Alternatively, plans may deposit the amount in a benefit stabilization fund for use in future years. Before 1998, plans had a third option of returning the savings to Medicare. Historically, however, plans have enhanced their benefit packages in an attempt to attract members.

submitted by plans serving Los Angeles County suggests that the estimated costs of some plans continues to be well below Medicare projected payments. On average, Los Angeles plans could provide the FFS package of benefits for 79 percent of the current payment amount. They complied with Medicare's requirements by using the approximately $117 per beneficiary per month difference between Medicare payments and their costs to provide additional benefits. (See fig. 1.) This amount of additional benefits may be higher than the national average because of the historically high payment rates in the area. However, the example of Los Angeles illustrates that, in the second year of BBA's payment reforms, some plans' projected payments far exceed their estimated costs of providing the traditional FFS benefit package.

Figure 1: Los Angeles Plans' Estimated Costs of Providing Medicare FFS Benefit Package, Required Additional Benefits, and Nonrequired Extra Benefits Provided, 1999



Note: Medicare's payments vary by plan because of variations in plans' geographic service areas (although each plan's service area includes Los Angeles county) and the demographic characteristics of plans' members.

Source: GAO analysis of 1999 adjusted community rate proposal data submitted to HCFA by Medicare+Choice plans.

Plans may also choose, for competitive or other reasons, to exceed Medicare's minimum requirements and further enhance their benefit packages. Nationally, plans added more than $33 in extra benefits per member per month—in addition to the $60 in required additional benefits—in 1997.[8] The Los Angeles plans added an average of $21 per beneficiary per month in extra benefits during 1999. Although all Los Angeles plans offer some extra benefits, the dollar amount varies by plan from $0.43 per beneficiary per month to $80 per beneficiary per month.

[8]On average, plans reported voluntarily providing $33 in additional benefits. Many plans, however, further enhanced their benefit packages in certain parts of their geographic service areas. The dollar amount of these enhancements is not included in the $33.

The ability of plans to provide additional benefits (both required and voluntary) suggests that planned cuts in rate increases may not threaten the typical plan's ability to earn a profit while providing a benefit package that is more comprehensive than the one available in Medicare FFS.

Plans' benefit packages may be especially attractive to beneficiaries when contrasted with private supplemental insurance, known as Medigap.[9] Medigap policies generally cost beneficiaries $95 per month or more and provide less extensive coverage than many plans. For example, although most of the 10 standard Medigap policies cover Medicare's coinsurance and hospitalization deductible amounts, only three of the standard policies cover outpatient prescription drugs. These policies require a $250 deductible with a 50-percent copayment, and coverage is capped at a fixed annual dollar amount. In contrast, some managed care plans offer unlimited coverage for prescription drugs with minimal copayments and no deductible. These differences suggest that even if plans charged a significant premium, they may still be cheaper and provide more comprehensive coverage than a Medigap policy for many beneficiaries.

Medicare's Managed Care Option Substantially Increased Program Spending

Although Medicare's pre-BBA payment methodology based plan payments on FFS spending discounted by 5 percent, beneficiary enrollment in plans did not produce savings for the program. In fact, evidence from several studies shows that Medicare's managed care option substantially increased program spending. In general terms, this result occurred because plans enrolled healthier-than-average beneficiaries while Medicare's methodology based payments on the estimated FFS cost of serving the average beneficiary and the payment adjustments did not adequately reflect this favorable enrollment.

On average, Medicare beneficiaries enrolled in plans are in better health and need less care than beneficiaries in the FFS program. In a 1996 beneficiary survey, approximately 81 percent of HMO enrollees report their health status as good or better while 19 percent indicated that their health was fair or poor.[10] Among the beneficiaries in FFS, 70 percent assessed their health as good or better, while 30 percent responded that their health was fair or poor. Moreover, 11.7 percent of FFS beneficiaries reported that

[9]Approximately 34 percent of beneficiaries in FFS purchase Medigap policies. Approximately an additional 53 percent have coverage through an employer-sponsored plan or other plan or the Medicaid program.

[10]Medicare Current Beneficiary Survey, 1996, as reported in HCFA, A Profile of Medicare: Chartbook 1998 (May 1998).

they had three or more activity of daily living (ADL) limitations (ADLs include such activities as eating and bathing), whereas only 4.9 percent of HMO enrollees reported a similar number of ADLs. The survey also found that better health translates into lower health care costs. In 1996, average FFS spending per beneficiary in excellent to good health ranged from about $2,130 to $4,430. In contrast, average FFS spending was approximately $7,030 for a beneficiary in fair health and $11,740 for a beneficiary in poor health.

The problem is not that beneficiaries in plans tend to be healthier than beneficiaries in FFS, but that Medicare's current risk adjustment methodology—based on simple demographic characteristics, such as age and sex—does not sufficiently adjust payments to reflect that fact.[11] For example, the estimated FFS cost of an average 74-year-old male not living in an institution or receiving Medicaid was about $581 per month in Los Angeles County in 1997. Of course, some 74-year-old males suffer from serious chronic conditions and need much more care, while others may experience only occasional minor ailments and need much less care. Plans that attracted a disproportionate number of healthier 74-year-olds would be overcompensated because they would incur much lower costs but still receive about $552 (95 percent of $581) per month per member. Alternatively, plans that attracted the less healthy, higher-cost 74-year-olds would be undercompensated. Because relatively few beneficiaries account for the majority of Medicare spending (10 percent of the elderly beneficiaries account for 63 percent of Medicare spending on the elderly), a plan's costs can be greatly affected to the extent that it enrolls beneficiaries from this group.

The financial consequences of a poor risk adjustment methodology in the presence of favorable selection are huge. For example, in our 1997 study of Medicare payment rates in California, we estimated that the program paid about $1 billion in excess payments to health plans in that state in 1995.[12] On average, Medicare overpaid plans by about 16 percent, but this percentage varied by county. For example, we estimated that plans in Los Angeles were overpaid by nearly 21 percent. About one-quarter of the excess payments occurred because HCFA's methodology for setting base rates in each county did not take into account the effect of favorable selection. In the presence of favorable selection, HCFA's method tended to

[11]HCFA has long recognized the inadequacies of the current risk adjustment system and has funded research on alternative approaches.

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

overestimate per-beneficiary average cost because it included the costs of the generally less healthy, more expensive FFS beneficiaries and excluded the costs of the generally healthier, less expensive plan enrollees. Our study found that, partly as a result of this flawed methodology, excess payments as a percent of total payments tended to be highest in counties with a large proportion of beneficiaries in managed care plans. This finding suggests that aggregate excess payments likely increased since 1995 as managed care enrollment grew.

Other studies have also concluded that Medicare's current risk adjustment methodology does not adequately reflect the generally healthier status of plan enrollees and results in excess payments to plans. For example, in a 1996 study based on 1994 data, HCFA researchers estimated that managed care enrollees' expected FFS costs were 12 to 14 percent below average, after adjusting for their demographic characteristics. Based on those findings, PPRC in its 1997 Annual Report to Congress estimated that an improved risk adjustment method could save Medicare $2 billion per year.[13] A comprehensive study by Mathematica Policy Research, Inc., based on 1990 data found that enrollees' costs were approximately 11 percent below average, after adjusting for demographic traits. Moreover, Mathematica's results may underestimate the cost differences because its study excluded the costs of beneficiaries who died during the year. Because end-of-life health care is expensive and mortality rates in plans are much lower than in FFS, the exclusion of this group of beneficiaries likely reduced the estimated per-beneficiary cost differences between plans and FFS.

In contrast to almost all other studies, a 1996 study commissioned by AAHP and conducted by Price Waterhouse (PW) found little favorable selection among Medicare enrollees, concluding that health plans enroll both healthy, low-cost beneficiaries and chronically ill, high-cost beneficiaries.[14] However, a CBO analyst in a 1996 memorandum argued that ". . . the findings in the PW study are not credible because of flaws in the data and methods used. Adjustment for obvious biases in the PW results would more than quadruple its estimate of favorable selection."[15]

[13]PPRC's 1996 Annual Report to Congress contains a detailed table of studies on favorable selection (table 15-1).

[14]Jack Rodgers and Karen Smith, Is There Biased Selection in Medicare HMOs? (Washington, D.C.: Health Policy Economics Group, Price Waterhouse LLP, Mar. 14, 1996).

[15]Biased Selection in Medicare's HMOs, CBO memorandum dated July 17, 1996.

BBA Payment Revisions Likely Have Not Eliminated Excess Payments

Beginning in 1998, BBA substantially changed the method used to set health plan payments. Some of the new payment provisions are designed to reduce excess payments, while others are designed for different purposes—such as increasing plan participation in geographic areas that had low payment rates. The most important of the cost-reducing changes is a new health-based risk adjustment system, to be implemented in 2000. Substantial excess payments may persist, however, because the excess that existed in 1997 was incorporated into the base rates.

One way BBA aims to reduce the excess in Medicare's health plan payments is by holding down per capita spending increases for 5 years. Specifically, BBA sets the factor used to update managed care payment rates to equal the 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. This across-the-board type of approach can produce savings. The cumulative reduction of less than 3 percent, however, is considerably smaller than the prior estimates of excess payments, which generally exceed 10 percent. Moreover, this approach does not address the problem that the excess payments can vary among geographic areas and plans. In our study of California health plans, we found that excess payments tended to be much higher in some counties than in others.

BBA also provides for a methodological approach known as "blending," which is designed to reduce the geographic disparity in payment rates and encourage more widespread plan participation.[16] Blending will work over time to move all rates closer to a national average by providing for larger payment increases in low-rate counties and smaller payment increases in high-rate counties. According to a 1997 PPRC study, there is some evidence that excess payments are more likely to occur in high-payment-rate counties. Thus, blending may indirectly reduce excess payments by holding down payment increases in high-rate counties.

BBA's mandated health-based risk adjustment system is the provision that most directly targets the excess health plan payment problem. BBA requires HCFA to implement, beginning January 1, 2000, a method to adjust plan payments based on beneficiary health status. Although HCFA's proposed interim health-based risk adjustment method uses only hospital inpatient data to gauge beneficiary health status, it still represents a major

[16]Because of low growth in Medicare spending and BBA's budget neutrality and minimum payment requirements, no county received a blended rate in 1998 or 1999. According to HCFA actuaries, the blending provision could not be funded because BBA's minimum payment requirements resulted in total plan spending that exceeded BBA's mandated budget neutrality provision by $95 million in 1998 and $80 million in 1999. Blending will occur for the first time in 2000.

improvement over the current method.[17] For the first time, plans can expect to be paid more for serving Medicare beneficiaries with serious health problems and less for serving relatively healthy ones.

HCFA proposes to phase in the new interim risk adjustment system 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 interim system. In 2004, HCFA intends to implement a more accurate risk adjuster that uses medical data from physician offices, hospital outpatient departments, and other health care settings and providers—in addition to inpatient hospital data. This type of risk adjustment system cannot be implemented now because many health plans report that they do not have the capability to provide such comprehensive information. 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.

BBA may not eliminate excess payments, however, in part because the law specified that 1997 county rates be used as the basis for all future county rates beginning in 1998. In effect, BBA tended to lock in prior excess payments. As we reported in 1997, HCFA's then current methodology ignored the effects of favorable selection and resulted in county rates that were generally too high.[18] In addition, excess payments are built into the current rates because BBA did not allow HCFA to adjust the 1997 county rates for previous forecast errors. Such adjustments had been a critical component of the pre-BBA rate-setting process. HCFA actuaries now estimate that the forecast error resulted in 1997 managed care rates that were 4.2 percent too high. While BBA 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, according to HCFA actuaries, about $1.3 billion in excess payments were built into plans' annual payment rates in 1998. Furthermore, these excess payments remain in the base rates and will grow over time as health plan enrollment grows.

Conclusions

Beneficiaries who enroll in health plans typically reduce their out-of-pocket costs and receive coverage for benefits, such as outpatient prescription drugs, that FFS Medicare does not cover. If these extra benefits resulted exclusively from the efficiencies of health plans, then

[17]Medicare Managed Care: Better Risk Adjustment Expected to Reduce Excess Payments Overall While Making Them Fairer to Individual Plans (GAO/T-HEHS-99-72, Feb. 25, 1999).

[18]GAO/HEHS-97-16.

there would be no cause for taxpayers to be concerned. However, the evidence shows that Medicare's payments are too high and that plans turn these excess payments into extra benefits to attract beneficiaries. Instead of producing savings as originally envisioned, Medicare's managed care option has added substantially to program spending.

Fortunately, extra benefits for Medicare beneficiaries and program savings are not mutually exclusive goals. According to their own data, some plans could make a normal profit and provide enhanced benefit packages even if Medicare payments were reduced. The resulting benefit packages may not be as rich as they are today, but they could still be more generous than the FFS package and cost beneficiaries less than an equivalent Medigap policy.

Achieving program savings while preserving extra benefits for beneficiaries enrolled in plans requires an improved risk adjustment system that more closely matches plan payments to the expected health care costs of the beneficiaries they serve. HCFA is working on implementing an improved risk adjustment system in 2000. However, achieving the two goals also requires that the base payment rate accurately reflects the cost of serving the average beneficiary. Our work indicates that the current base rates are too high because they incorporate the excess payments that were present in 1997. Thus, as we previously reported, correcting the base rates is necessary to prevent continuing excess payments.

In 1997, we recommended that the Secretary of Health and Human Services take action to reduce excess plan payments by directing the HCFA Administrator to revise the agency's methodology for establishing base payment rates in each county. Shortly after we made our recommendation, the Congress enacted BBA. The new law included several provisions, such as reduced annual updates and health-based risk adjustments, that will help to reduce excess payments. However, by specifying that the 1997 rates be used to determine future rates, it also tended to lock in place the pattern of excess payments that existed in 1997.

Matters for Congressional Consideration

To avoid unnecessary Medicare spending, the Congress may wish to consider revising each county's base rate to more accurately reflect the estimated fee-for-service cost of serving the average Medicare beneficiary. Such a revision would eliminate Medicare+Choice and FFS spending disparities caused by (1) flaws in the methodology HCFA used to set base rates in each county before BBA, (2) the incorporation of the 1997 forecast error in 1998 and future rates, and (3) the annual payment rate update

reductions mandated by BBA. If the Congress wishes to share in the efficiencies of Medicare+Choice plans, base rates should be set below estimated average FFS costs as they were under the Medicare risk-contract program. The Congress may also want to consider maintaining a minimum base rate to encourage greater participation by Medicare+Choice plans in rural areas.

Agency Comments

In commenting on our report, HCFA agreed that the available evidence indicates that Medicare's managed care option has substantially increased program spending. HCFA stated that the most recent evidence of favorable selection and excess plan payments can be found in its March 1999 report to the Congress on risk adjustment. The agency also agreed with our finding that the typical plan could continue to provide benefits beyond those covered by part A and part B of Medicare, even if payments are reduced. Finally, HCFA concurred that excess payments will be lowered, but not completely eliminated, by BBA's new formula for paying health plans.

In response to our matters for congressional consideration regarding revising base rates, HCFA suggested that careful consideration first be given to the potential impact on beneficiaries and plan participation in Medicare+Choice. It noted that some BBA payment revisions, including the new risk adjustment system, have yet to be implemented. The agency agreed, however, that correcting the forecast error built into the 1997 rates would help reduce excess payments.

BBA reflects the Congress' intentions of achieving Medicare savings, partly by reducing excess plan payments. Revising base rates so that they more accurately reflect the cost of serving beneficiaries is an important step in reaching that goal. Although we agree that the impact on beneficiaries and plans should be carefully considered, we believe that base rate revisions could be accomplished with minimal disruptions by phasing in the changes—in much the same way that the interim risk adjustment system will be phased in.

HCFA also provided a number of technical comments, which we incorporated as appropriate. HCFA's comments are reprinted in the appendix.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution until 30 days from the date of this letter. We will then make copies available to others who are interested.

Please call me on (202) 512-6806 or William J. Scanlon, Director, Health Financing and Public Health Issues, on (202) 512-7114 if you or your staff have any questions about this report. Major contributors to this report are James C. Cosgrove, George M. Duncan, Hannah F. Fein, and Beverly Ross.

Richard L. Hembra
Assistant Comptroller General

Contents

Abbreviations

AAHP	American Association of Health Plans
ADL	activity of daily living
BBA	Balanced Budget Act of 1997
CBO	Congressional Budget Office
FFS	fee-for-service
HCFA	Health Care Financing Administration
HMO	health maintenance organization
PPRC	Physician Payment Review Commission
PW	Price Waterhouse

Comments From the Health Care Financing Administration

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

JUN 17 1999

TO: Laura A. Dummit, Associate Director
Health Financing and Public Health Issues, GAO

FROM: Nancy-Ann Min DeParle
Administrator, HCFA

SUBJECT: General Accounting Office (GAO) Draft Report, "Medicare+Choice: Reforms Have Reduced, But Likely Not Eliminated Excess Plan Payments" (GAO/HEHS-99-144)

One of the Health Care Financing Administration's highest priorities is ensuring the provision of the highest quality service to Medicare beneficiaries in a cost-efficient manner. To this end, HCFA continues to look for ways to improve the Medicare+Choice program and the original fee-for-service program.

We appreciate the opportunity to review your draft report to Congress concerning the issue of excess payments to health care plans. The overall findings seem consistent with our belief that there is evidence demonstrating that Medicare's payments are too high and that plans use these excess payments to provide extra benefits for beneficiaries.

Regarding the General Accounting Office's suggestion that the Congress examine alternative methods for reducing excess payments, HCFA believes that any such changes should be carefully considered, given the potential impact on beneficiaries and on plan participation in the Medicare+Choice program. Also, under the Balanced Budget Act of 1997, HCFA has taken steps to improve the methodologies used to pay plans. We will continue to review this situation carefully, and we look forward to working with GAO on this issue.

Thank you again for preparing such a valuable overview on this important topic.

Ordering Information

The first copy of each GAO report and testimony is free. Additional copies are $2 each. Orders should be sent to the following address, accompanied by a check or money order made out to the Superintendent of Documents, when necessary. VISA and MasterCard credit cards are accepted, also. Orders for 100 or more copies to be mailed to a single address are discounted 25 percent.

Orders by mail:

U.S. General Accounting Office
P.O. Box 37050
Washington, DC 20013

or visit:

Room 1100
700 4th St. NW (corner of 4th and G Sts. NW)
U.S. General Accounting Office
Washington, DC

Orders may also be placed by calling (202) 512-6000 or by using fax number (202) 512-6061, or TDD (202) 512-2537.

Each day, GAO issues a list of newly available reports and testimony. To receive facsimile copies of the daily list or any list from the past 30 days, please call (202) 512-6000 using a touchtone phone. A recorded menu will provide information on how to obtain these lists.

For information on how to access GAO reports on the INTERNET, send an e-mail message with "info" in the body to:

info@www.gao.gov

or visit GAO's World Wide Web Home Page at:

http://www.gao.gov

United States
General Accounting Office
Washington, D.C. 20548-0001

Bulk Rate
Postage & Fees Paid
GAO
Permit No. G100

Official Business
Penalty for Private Use $300

Address Correction Requested