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MEDICARE+CHOICE

Impact of 1997 Balanced Budget Act Payment Reforms on Beneficiaries and Plans

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Medicare+Choice: Impact of 1997 Balanced Budget Act Payment Reforms on Beneficiaries and Plans

Mr. Chairman and Members of the Committee:

We are pleased to be here as you discuss the impact of payment reforms in the Balanced Budget Act of 1997 (BBA) on the Medicare+Choice program. BBA's creation of Medicare+Choice represents one important means of helping to address the growing challenge of financing the Medicare program. Collectively, BBA reforms are expected to lower program spending by $386 billion over the next 10 years.

In creating the Medicare+Choice program, BBA furthered the use of a choice-based managed care model of providing Medicare benefits. Prior to BBA, Medicare's managed care model was limited largely to health maintenance organizations (HMO).[1] BBA expanded beneficiaries' health plan options, both by encouraging the wider availability of HMOs across areas and by permitting other types of health plans to participate in Medicare. BBA also sought to pay health plans more appropriately than Medicare had done under the program's previous HMO payment formula. A decade of research by GAO and others found that, instead of saving the government money as intended, the managed care program that preceded Medicare+Choice overpaid health plans in the aggregate—estimated to be several billions of dollars beyond what would have been paid had the enrolled beneficiaries been served under Medicare's traditional fee-for-service (FFS) program.

Some health plan and industry representatives believe that BBA's payment changes were too severe, citing plan withdrawals from Medicare+Choice as evidence of BBA's adverse effects. This hearing provides an opportunity to examine the overall effect to date of BBA payment reforms on Medicare+Choice plans. My statement today will focus on whether BBA reforms have improved Medicare's ability to pay health plans more appropriately and whether recent experience implementing these reforms suggests the need for modifications. These remarks are based on GAO's prior and ongoing work on Medicare+Choice.

In summary, the net effect of BBA payment revisions has been to reduce but not fully eliminate excess payments to health plans. Some of the provisions, such as the reduced annual updates, have already been implemented, while others, such as the health-based risk adjustment system, will be phased in over time.

[1]For the purposes of this statement, the term HMO refers to plans with Medicare risk contracts, which accounted for about 90 percent of Medicare managed care enrollment in 1997. Prior to BBA, Medicare managed care plans also included cost contract HMOs and health care prepayment plans.

Despite industry alarm over the increase in plan withdrawals in 1999, our work suggests that sweeping amendments to BBA are not yet warranted for several reasons. First, the net effect of BBA reforms on plans has been modest to date. Cuts in rate increases, for example, have held down per capita payment growth by only a little more than 1 percent. Second, data submitted by plans themselves indicate that at least some plans can provide the traditional Medicare package of benefits, offer some additional benefits, and make a profit even if they are paid less than they are today. For example, according to their own data, plans serving the Los Angeles area can provide the traditional Medicare package of benefits for about 79 percent of what they are currently paid. Third, the withdrawals we observed this year were not a reaction to BBA rate reductions alone. Market forces appear to have played a larger role.

Because of cuts in rate increases and expected improvements in risk adjustment, BBA's health plan payment reforms will reduce aggregate excess payments. As a consequence, some Medicare+Choice plans may reduce supplemental benefits and rethink their participation in the Medicare program. The continuing challenge for the Congress is to strike the appropriate balance between containing Medicare spending and fostering growth in Medicare+Choice.

Background

Medicare's use of prepaid health plans, which typically have a financial incentive to hold down costs, is intended to save the government from unnecessary spending on Medicare services without compromising the provision of covered benefits. In addition, from the beneficiary's perspective, these plans can be an attractive alternative to traditional Medicare because they usually offer more benefits and lower out-of-pocket costs. All plans serving Medicare beneficiaries are required to provide Medicare's statutorily covered benefits, and many provide additional services—such as outpatient prescription drugs, routine physical exams, hearing aids, and eyeglasses—that are not covered under traditional Medicare. In exchange for these advantages, beneficiaries give up their freedom to choose any provider.

As of March 1, 1999, about 6.7 million people—or 17 percent of Medicare's 39 million beneficiaries—were enrolled in 300 health plans, most of which were prepaid.[2] Prepaid plans receive for each beneficiary a fixed monthly amount—called a capitation rate—regardless of what a beneficiary's care

[2]About 90 percent of the 6.7 million Medicare beneficiaries were enrolled in managed care plans that receive fixed monthly payments. The remainder were enrolled in plans that are reimbursed for the costs they incur, less the estimated value of beneficiary cost-sharing.

actually costs. The remaining 83 percent of Medicare beneficiaries receive health care on a FFS basis, where providers are paid for each covered service they deliver.

Although Medicare's pre-BBA managed care program attracted an increasing number of beneficiaries, it had several serious shortcomings. First, it was overly expensive for the government. During the decade preceding BBA, a mounting body of research showed that government payments to HMOs for their Medicare enrollees exceeded spending for similar beneficiaries in the traditional FFS program, even though plan payment rates were discounted by 5 percent from estimated FFS levels. This excess spending resulted from faulty calculation of the base rate and inadequate adjustments to that rate for the healthier-than-average population enrolled in Medicare's prepaid plans. In addition, HMOs were not available everywhere. In 1996, more than 25 percent of beneficiaries lived in areas not served by HMOs. Widely disparate payment rates across geographic areas contributed to this variability in access and to sizable differences in supplemental benefits. Finally, the program did not include options, such as preferred provider organizations, that had become popular in the private sector because they offered cost management but were more flexible than HMOs.

BBA changed the capitation rate formula used to compensate the prepaid plans. Among several changes, BBA required that the Health Care Financing Administration (HCFA), the agency responsible for administering Medicare, improve Medicare's current risk adjuster—the mechanism designed to adjust a plan's capitation rates upward or downward to reflect the extent to which an enrollee's expected health care costs differ from the average beneficiary's. As we have previously reported, Medicare's current risk adjuster cannot sufficiently raise or lower rates because it is based primarily on demographic factors such as age and sex, which alone are poor predictors of an individual's health care costs. To illustrate, under Medicare's current risk adjuster, a plan would receive the same payment for two enrollees of the same age and sex, even if one is expected to incur only minimal health care costs for treatment of occasional minor ailments and the other is expected to require expensive treatment for a serious chronic condition.

Without the use of health status factors to make better adjustments, Medicare generally overcompensates health plans because they tend to enroll beneficiaries who are healthier than average. Our 1997 study on payments to California HMOs, which enrolled more than a third of

Medicare's managed care population, found that health plan enrollees had expected costs that were more than 16 percent below those for demographically similar beneficiaries in traditional Medicare.[3] Such "favorable selection" by Medicare's prepaid health plans—that is, their tendency to attract healthier-than-average enrollees—is not surprising. People with chronic or severe illnesses may not be attracted to HMOs because they have established relationships with providers and feel a need for easy access to specialists. Moreover, given the inadequacy of Medicare's risk adjuster to lower—or raise—payments appropriately, plans could put themselves out of business if they attracted significant numbers of high-cost beneficiaries.

Under BBA, Medicare's Payments to Health Plans Likely Remain Excessive in the Aggregate

Beginning in 1998, BBA substantially changed the method used to set Medicare+Choice plan payments. Some of the new payment provisions will tend to reduce excess payments. The most important of these is a new health-based risk adjustment system, to be implemented in two stages, with an interim adjuster to be introduced in 2000 followed by a more comprehensive adjuster in 2004. Substantial excess payments may persist, however, because other BBA provisions tended to incorporate some of the excess that existed in 1997 into the current rates.

One way BBA will reduce the excess in Medicare's managed care 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 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. Although these across-the-board reductions can help produce savings, the cumulative reduction of less than 3 percent 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 plans, we found that excess payments tended to be much higher in some counties than others.

BBA also provides for a methodological approach known as "blending," which is designed to reduce the geographic disparity in payment rates and

[3]Medicare HMOs: HCFA Can Promptly Eliminate Hundreds of Millions in Excess Payments (GAO/HEHS-97-16, Apr. 25, 1997). This is consistent with a 1996 study by HCFA researchers finding that health plan enrollees had costs roughly 12 to 14 percent below the average beneficiary's. (Riley and others, HCFA Review, 1996.)

encourage more widespread plan participation.[4] Blending will work 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 study by the Physician Payment Review Commission (now the Medicare Payment Advisory Commission), there is some evidence that excess payments are more likely to occur in high payment rate counties.[5] Thus, blending may indirectly reduce excess payments by holding down payment increases in high rate counties.

A more targeted reduction in plan payments resulted from the BBA provision to "carve out" of the rate that portion that previously constituted Medicare's subsidy to teaching hospitals for graduate medical education (GME). Beginning in 1999, BBA removes an increasing portion of the Medicare capitation payment attributable to GME and instead requires HCFA to pay teaching hospitals caring for Medicare+Choice plan enrollees directly. This provision was designed to address the concern that the capitation rates incorporated Medicare payments designed to cover GME expenditures, even when plans did not pass such amounts along to teaching hospitals in their payments to these facilities.

When implementation of BBA is complete, however, excess payments may not be fully eliminated. Because the law specified that 1997 county rates be used as the basis for all future county rates beginning in 1998, BBA locked in prior excess payments. As we reported in 1997, HCFA's then current methodology resulted in county rates that were generally too high.[6] 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 too high by 4.2 percent. 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, about $1.3 billion in overpayments were built into plans' annual payment rates for 1998. This error will be compounded as managed care enrollment grows.

BBA's mandated health-based risk adjustment system is the provision that most directly targets the excess payment problem. BBA requires HCFA to

[4]Because of BBA-mandated budget neutrality and minimum payment constraints, no county received a blended rate in 1998 or 1999. Blending will occur for the first time in 2000.

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

[6]GAO/HEHS-97-16.

implement, beginning January 1, 2000, a method to base plan payments on beneficiaries' health status. HCFA's proposed interim health-based risk adjustment method uses only hospital inpatient data to gauge beneficiaries' health status but still represents a major improvement over the current method.[7] For the first time, Medicare's prepaid health plans can expect to be paid more for serving beneficiaries with serious health problems and less for serving relatively healthy ones.

Nevertheless, HCFA proposes to phase in the new interim risk adjustment system slowly. In 2000, only 10 percent of health plans' payments will be adjusted using the new method. This proportion will be increased each year until 2003, when 80 percent of plans' payments will be adjusted using the interim system. In 2004, HCFA intends to implement a more finely tuned risk adjuster that uses medical data from physician offices, skilled nursing facilities, home health agencies, and other health care settings and providers—in addition to inpatient hospital data. This improved risk adjustment system cannot be implemented currently because many plans say they do not have the capability to report 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.

Recent Experience Suggests Sweeping Action Not Warranted in the Short Term

Announcements of plan withdrawals in the last year have prompted debate about whether to revise certain BBA provisions governing Medicare+Choice. As we recently reported, several factors suggest that such revisions could be premature.[8] First, although an unusually large number of managed care plans left the program in 1999, a number of plans have applied to enter the program or expand their participation. Data on approved and pending Medicare plans as of January 1999 show that, nationwide, beneficiary access to prepaid plans is likely to increase slightly this year. Although withdrawals have meant significantly diminished or no access in some localities, only 1 percent of previously covered managed care enrollees were left without any Medicare+Choice plan option.

Second, it would be inaccurate to conclude that lower payment rates alone were responsible for these plan withdrawals. The current movement of

[7]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).

[8]Medicare Managed Care Plans: Many Factors Contribute to Recent Withdrawals; Plan Interest Continues (GAO/HEHS-99-91, Apr. 27, 1999).

plans in and out of Medicare is likely to be a normal reaction to market competition and conditions. While new payment rates were certain to have been considered in plans' decisions to withdraw from certain geographic areas, other factors—including recent entry into the market, low enrollment, and the presence of large competitors—likely played a role as well. Supporting this conclusion is the fact that plan withdrawals were not limited to low payment rate counties: 10 of the 11 counties with the highest payment rates were affected by the withdrawals. Moreover, a number of new plans either have approved or pending applications to participate in the program. If all applicants are approved, slightly more beneficiaries will have access to a Medicare+Choice plan in 1999 than had access to one in 1998 before the withdrawals occurred.

Third, recent data show that, despite BBA's lowering of rate increases, Medicare's payments to plans still exceed the plans' cost of providing the traditional Medicare package and plans can continue to provide benefits well beyond that. Most Medicare+Choice plans do not charge beneficiaries a separate monthly premium and charge only a small copayment for each outpatient service.[9] Nearly all plans offer coverage for routine physical, eye, and hearing exams. Most provide coverage for outpatient prescription drugs.[10] Some provide dental care. In contrast, Medigap policies—of which there are 10 standard types—generally cost beneficiaries about $95 or more a month in premiums, while 7 of the 10 standard Medigap policies do not cover outpatient prescription drugs. Those Medigap policies offering a drug benefit require a $250 deductible with a 50-percent copayment and an upper limit on payments.

Many prepaid health plans have had considerable latitude in offering benefits because Medicare pays more than it costs them to provide the traditional FFS benefit package, even after accounting for allowable profits.[11] 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

[9]Beneficiaries who wish to participate in the Medicare+Choice program must pay the Medicare part B premium of $45.50 per month.

[10]GAO/HEHS-99-91.

[11]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 reported by some HMOs may be too high. See Administrative Costs Submitted by Risk-Based Health Maintenance Organizations on the Adjusted Community Rate Proposals Are Highly Inflated (A-14-97-00202), Department of Health and Human Services, Office of the Inspector General, July 1998.

enhance its benefit package by adding benefits or reducing fees.[12] In 1997, plan 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 submitted by plans serving Los Angeles county suggests that their costs continue to be well below Medicare payments. On average, Los Angeles plans could provide the traditional package for about 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. 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, 2 years after BBA's payment reforms were implemented, some plans receive payments that far exceed their costs of providing the traditional FFS benefit package.

Plans may choose, for competitive or other reasons, to exceed Medicare's minimum requirements and further enhance their benefit packages. In 1997, plans nationally on average added more than $33 in extra benefits per member per month—in addition to the $60 in required additional benefits. 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 almost $80 per beneficiary per month. The ability of plans to provide additional benefits (both required and voluntary) suggests that planned cuts in rate increases are not likely to 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.

Concluding Observations

In creating the Medicare+Choice program, BBA substantially changed the way plan payments are determined. Some plan and industry representatives have suggested that BBA's payment reforms were too severe. They point to the recent plan withdrawals to back up their claims that the Medicare+Choice program is in danger of floundering. We believe, for a number of reasons, that these concerns must be viewed in a broader context, as follows:

[12]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.

- The effect on plan payments to date has been modest and, on average, has removed only a portion of excess payments built into the base rates.
- Data submitted by plans suggest that many of them can provide the FFS package of benefits, offer some additional benefits, and make a profit even if they are paid less than they are today.
- The withdrawals we observed this year appear to have been influenced by external market conditions not fully attributable to Medicare+Choice provisions.

Decisions to modify Medicare+Choice need to balance industry concerns about BBA's changes to health plan payment rates against a reasoned assessment of the program's purpose and a systematic analysis of BBA's impact. Medicare managed care was instituted to save the program money. Although HMO payments before BBA were discounted by 5 percent from what was paid for traditional Medicare beneficiaries, methodological shortcomings led to Medicare's HMO enrollees costing the program and taxpayers more. The excess payments benefited plans and their enrollees as plans offered additional benefits like prescription drug coverage.

Adjusting plan payments so that the program pays no more for a Medicare+Choice enrollee than for a traditional Medicare beneficiary with equivalent health status is going to mean smaller payments and most likely lower profits for plans as well as fewer supplementary benefits for enrollees. These consequences raise for the Congress the question of whether BBA's payment changes should be modified to protect plans and the fraction of the Medicare beneficiary population enrolled—even if that protection results in Medicare's spending more on the Medicare+Choice beneficiary than for the traditional FFS Medicare beneficiary.

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

GAO Contact and Acknowledgments

For future contacts regarding this testimony, please call William J. Scanlon at (202) 512-7114. Key contributors to this testimony include James C. Cosgrove and Hannah F. Fein.

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