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United States General Accounting Office
Washington, DC 20548

November 27, 2000

The Honorable Michael M. Hash
Acting Administrator
Health Care Financing Administration

Subject: Medicare+Choice: Oversight Lapses in HCFA's Review of Humana's 1998 Florida Contract

Dear Mr. Hash:

Last year, we reported that a large, experienced Medicare+Choice plan provided a prescription drug benefit with a coverage limit below the amount listed in its 1998 Medicare+Choice contract.[1] We identified the plan, Humana, Inc., in our subsequent discussions with staff from the Health Care Financing Administration (HCFA) and the Department of Health and Human Services' (HHS) Office of Inspector General (OIG). Specifically, we found that Humana's Medicare+Choice Florida contract indicated a $1,200 annual coverage limit for brand name drugs. However, in 22 Florida counties, Humana advertised and provided a brand name prescription drug benefit with effective annual coverage limits ranging from $600 to $1,020.

In response to our report, the HCFA Administrator asked us to provide additional information about Humana's Florida contract discrepancies. HHS' OIG made a similar request. We subsequently met with HCFA and OIG officials to discuss our findings. We agreed to investigate further the circumstances surrounding Humana's contract submission and HCFA's review process and to report these findings to both HCFA and OIG. This letter, which summarizes the results of our investigation during the spring of 1999 and the summer of 2000, (1) provides additional details about the drug benefit discrepancies in Humana's contract and the plan's use of a prohibited method to estimate its drug benefit cost, (2) describes the breakdowns that occurred in HCFA's contract approval process, and (3) discusses how subsequent HCFA contracting process changes affect the likelihood of similar breakdowns occurring in the future. To complete this work, we reviewed Humana's contract documents and supporting materials; interviewed Humana representatives and HCFA officials involved with the development and review of the 1998 contract; and reviewed related agency policies, procedures, and documents. In addition, we spoke with

[1]See Medicare+Choice: New Standards Could Improve Accuracy and Usefulness of Plan Literature (GAO/HEHS-99-92, Apr. 12, 1999).

representatives of Ernst & Young, the accounting firm hired by HCFA to review Humana's contract submission, and examined the firm's review documentation. We performed our work in accordance with generally accepted government auditing standards.

In summary, more than 100,000 of Humana's Medicare enrollees lived in Florida counties where the plan's brand name prescription drug coverage limit was below the basic benefit amount listed in Humana's 1998 Medicare+Choice contract. Because of a series of oversight lapses, HCFA did not spot certain discrepancies in Humana's contract submission and the discrepancy between the contract and the prescription drug benefit the plan provided. Ernst & Young, the firm hired by HCFA to review Humana's contract submission, did not fully follow HCFA's prescribed review procedures and thus missed discovering the discrepancies. Similarly, HCFA staff responsible for reviewing plan marketing materials took shortcuts that impaired their ability to detect the drug benefit inconsistency.

Changes made to HCFA's contracting and marketing material review processes since 1998 may have reduced the likelihood of similar problems occurring in the future. However, legislative changes that took effect in 1999 have increased the number of Medicare+Choice contract submissions that must be reviewed and thus have placed additional burdens on the process. Moreover, any future problems could still go undetected if HCFA or contract staff do not fully follow the new processes. Thus, we believe that a careful consideration of the breakdowns described in this letter could help guide HCFA's efforts to improve the agency's oversight processes. In addition, these findings may help both HCFA and OIG determine whether further investigations or remedial actions are warranted in this specific case.

BACKGROUND

The benefit package that a Medicare+Choice plan is obligated to provide largely depends upon the relationship between Medicare payments to the plan and the plan's cost of providing benefits.[2] All plans are required to provide the services covered under the traditional fee-for-service program. If Medicare's payment is expected to exceed a plan's cost of providing Medicare-covered services, however, that plan is required to make up the difference by covering additional services, charging lower fees to beneficiaries, or contributing to a benefit stabilization fund.[3] Many plans offer benefit packages that exceed these minimum requirements in an effort to retain existing members or attract new ones. HCFA's approval of a plan's cost estimates and proposed benefit package establishes the plan's contractual obligation for the following calendar year. The process that was in place when 1998 Medicare+Choice contracts were being developed and approved is described below.

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[2]Plans are paid a fixed monthly amount per beneficiary, known as a capitation payment. In 1998, payment rates varied by county and were adjusted for the demographic mix of a plan's members.

[3]A benefit stabilization fund is a non-interest-bearing escrow account that may be used to finance benefits in future years. Typically, however, plans choose to provide additional benefits or charge lower fees to beneficiaries.

Before the start of the contract year, each plan estimated its per person cost of providing Medicare-covered services. These costs were calculated on the basis of how much a plan would charge a commercial customer to provide the same benefit package if its members had the same expected use of services as Medicare beneficiaries.[4] If these costs, known as a plan's adjusted community rate (ACR), were less than expected Medicare payments, plans were required to offset the difference. Plans typically proposed to offer additional benefits by covering more services (thereby adding to their costs) or reducing beneficiary fees. Many plans provided not only these required additional benefits, but also included extra benefits in their basic benefit packages for marketing or other reasons. Plans submitted their cost estimates and proposed benefit packages—documents collectively referred to as an ACR proposal—to HCFA for review and approval.

Before 1999, HCFA permitted plans to enhance their basic benefit packages in selected portions of their contracted service areas.[5] A plan that charged beneficiaries a $20 monthly premium might, for example, waive the premium for beneficiaries living in specific counties in an attempt to be more competitive in those counties. Such benefit package enhancements were known as "flexible benefits." Under no circumstances could flexible benefits be less generous to beneficiaries than the basic benefit package.

Each plan was required to describe the details of its proposed benefit package in a document known as the benefit information form (BIF) and submit it as part of the ACR proposal. This form contained the details of the basic benefit package, including services covered, annual limits, copayments, premiums, and any benefit restrictions. The BIF also contained a section where flexible benefits, if offered, were to be listed.

HCFA reviewed each plan's ACR proposal to verify that Medicare's expected payment did not exceed the plan's estimated cost of providing its proposed benefit package. The review process was also intended to ensure that plans complied with all Medicare policies in establishing their benefit packages. Reviewers were specifically instructed to scrutinize the cost calculations of what the plan determined to be required and extra benefits. Often, because of staffing constraints, HCFA used a contractor to conduct these reviews. Once HCFA approved a plan's ACR proposal, the plan had to offer the basic benefits and flexible benefits indicated in its proposal.[6]

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[4]Costs include the profit a plan would normally earn on its commercial business.

[5]A provision of the Balanced Budget Act of 1997 that became effective in 1999 required each plan to offer uniform benefits throughout its service area. To comply with this provision while allowing plans some flexibility to vary benefits across geographic areas, HCFA allowed plans to divide their service areas into segments and submit separate ACR proposals for each segment.

[6]In general, contracts ran on a calendar year basis, and ACR proposals were submitted approximately 6 months before the start of the contract year. For example, ACR proposals for the 1998 contract year were submitted in 1997. With HCFA approval, plans could add coverage or lower fees during the contract year, but under no circumstances could plans change benefit packages to make them less generous for beneficiaries.

HUMANA'S 1998 MEDICARE+CHOICE FLORIDA CONTRACT CONTAINED DISCREPENCIES

In its 1998 ACR proposal for the 28 Florida counties it served, Humana estimated that Medicare's payments would exceed the plan's costs of providing Medicare-covered benefits and allowed profits. Humana offset this difference, and even slightly exceeded Medicare's minimum benefit requirements, by reducing beneficiary fees and adding coverage for outpatient prescription drugs and other services. In its BIF—one component of the ACR proposal—Humana listed the prescription drug benefit that it would provide to all beneficiaries as part of the basic benefit package:

- coverage for brand name prescription drugs up to a monthly limit of $130, or an annual limit of $1,200, and
- unlimited coverage for generic drugs.

Humana's BIF also indicated that beneficiaries living in certain Florida counties would receive enhanced prescription drug benefits—a flexible benefit because it was offered in only a portion of the contract service area.

The drug coverage limits that Humana specified in a separate flexible benefit schedule attached to its ACR proposal, however, did not conform to Medicare's requirement that flexible benefits enhance the basic package. According to the BIF Humana submitted, the basic benefit covered $1,200 of brand name prescription drugs annually.[7] However, the separate flexible benefit schedule listed coverage limits for 22 counties that effectively ranged from $600 to $1,020 annually—less than the BIF's coverage limit. Thus, for the approximately 130,000 plan members living in these 22 counties, Humana reduced rather than enhanced its basic prescription drug coverage. In only three counties—Broward, Dade, and Palm Beach—was the listed coverage above the contract's $1,200 minimum. In these three counties, where several plans competed to enroll Medicare beneficiaries, Humana offered unlimited coverage for brand name prescription drugs.

According to Humana representatives responsible for the preparation of the ACR proposal, the $1,200 coverage limit for brand name prescription drugs specified in the BIF was a mistake and related to information on one of Humana's high-option benefit packages. These representatives told us that the coverage limits specified in the flexible benefit schedule were correct and reflected the plan's intention to set its basic brand name prescription drug benefit at a $50 monthly coverage limit (which equals $600 annually).

Humana representatives said that Humana staff had not checked the BIF prior to submitting it to HCFA to ensure that its information was consistent with the information contained in other ACR proposal documents. The representatives told us that HCFA had not previously emphasized the importance of having an accurate BIF.

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[7]Humana posted a $1,200 limit for Orange, Oceola, and Seminole counties.

They also initially stated that the ACR proposal and the BIF were prepared by separate Humana units, but that they did not know which individuals in those units had prepared the documents. During a second interview, however, plan officials told us that Humana staff had reviewed the documents for consistency but had not caught the discrepancy. They also advised us that the same individuals prepared both the ACR proposal and the BIF.

Humana officials confirmed that the plan had provided brand name prescription drug coverage in each county up to the annual limit specified in the flexible benefit schedule, instead of the generally higher $1,200 annual limit indicated in the BIF. However, in their opinion the plan had fulfilled its contracted obligation because they said that the calculations underlying Humana's ACR proposal were based on a $600 annual limit.

Nevertheless, worksheets that Humana submitted as part of its ACR proposal suggest that the ACR calculations were based on annual drug coverage limits far higher than $600. Our comparison of Humana's cost estimates with competing plans' ACR proposals also suggests that Humana's estimates were based on a higher annual coverage limit. Although Humana officials advised us that upon learning of the discrepancy between the BIF and the benefit Humana provided they promptly notified HCFA, the agency has no record of receiving such notification. HCFA officials did state that Humana notified the agency that the plan had developed a new internal ACR review process designed to ensure consistency among its contract documents.

Another problem with Humana's 1998 ACR proposal was that the plan developed the proposal using a cost estimation method that HCFA had previously instructed Humana not to use. In preparing its 1997 ACR proposal, Humana had based its cost estimate on the experience of a selected group of enrollees. HCFA informed Humana in writing that this was an unacceptable practice. However, because of tight deadlines and the amount of work that would have been required of Humana to recalculate its ACR, HCFA allowed Humana to use the prohibited method for 1997 but clearly stated that the plan should not use it in future years.

SHORTCUTS IN OVERSIGHT PROCEDURES PREVENTED THE DETECTION OF HUMANA CONTRACT DISCREPANCIES

The inconsistencies among Humana's contract, marketing materials, and benefits provided remained undetected until our 1999 analysis because of breakdowns in HCFA's contract review, approval, and oversight processes. HCFA hired Ernst & Young to review many 1998 ACR proposals, including Humana's. Our examination of HCFA's contract with Ernst & Young and the firm's review documentation indicate that the firm did not perform all the required steps. For example, despite the required procedure to ensure that the BIF specify the flexible benefit copayment rates, Ernst & Young's records showed that firm staff marked this step as "not applicable." If Ernst & Young staff had completed this step, they would have crosschecked the

coverage limits posted in the BIF against those posted in a separately attached schedule and detected the benefit limit discrepancy. Ernst & Young reviewers also failed to notice Humana's use of the prohibited cost estimation method.

HCFA's contractor oversight procedures also broke down. According to HCFA officials, agency staff responsible for approving the ACR proposals were focused on reviewing those proposals not assigned to contractors. Given their deadlines and resources, HCFA officials believed it was all staff could do to complete their own reviews and that there was little time to evaluate the contractor's work. According to these officials, HCFA's approval of the contractor's reviews was generally automatic.

HCFA's review of plan marketing materials constituted another missed opportunity to identify and correct discrepancies regarding Humana's drug benefit descriptions. HCFA reviewers were instructed to consult the plans' contracts to determine whether each plan's marketing materials accurately reflected the benefits and fees contained in its contract with HCFA. However, as discussed in our April 1999 report, HCFA staff who reviewed Humana's marketing materials did not use the contract's BIF and instead relied on a summary sheet provided by the plan.[8] This practice is contrary to HCFA policy. In Humana's case, crosschecking the plan's consumer information with the plan's BIF would have shown that the flexible drug benefits for most of Florida' counties were lower than the limit specified in the contract.

LIKELIHOOD OF FUTURE CONTRACT PROBLEMS IS UNCERTAIN; IMPROVEMENTS IN HCFA'S CONTRACTING PROCESS HAVE BEEN ACCOMPANIED BY INCREASED WORKLOAD

Since the 1998 ACR proposals were submitted, HCFA has improved a key element of its review process. Specifically, HCFA has replaced the BIF with a much more comprehensive electronic form that makes it easier for plans to list, and for HCFA staff to review, proposed benefit information.[9] The new form improves on the BIF by standardizing and expanding the benefit information collected from each plan. In addition, the new form automatically generates the first two sections of a three-section benefit summary that is sent to HCFA regional staff to assist their reviews of plans' marketing materials.

At the same time, however, a provision contained in the Balanced Budget Act of 1997 (BBA) has added to HCFA's ACR proposal review workload. Beginning in 1999, plans were required to offer uniform benefits throughout their service areas. This provision effectively eliminated flexible benefits and accompanying problems like those associated with Humana's 1998 prescription drug benefit. To allow plans some flexibility while meeting the BBA requirement, HCFA has allowed plans to segment their service areas and offer benefits that are uniform within each segment but vary among segments. However, plans must file separate ACR proposals for each

[8]GAO/HEHS-99-92 (Apr. 12, 1999).

[9]The new form is known as the plan benefit package or PBP.

segment. As a consequence of this BBA provision, the number of ACR proposals tripled in 1999. It remains unclear whether the net effect of these changes was to increase or decrease the total amount of time necessary for HCFA and its contractors to conduct thorough reviews of plans' ACR proposals.

CONCLUSIONS

HCFA now has revised processes and procedures for monitoring the accuracy of the information in Medicare+Choice plans' contracts and consumer information. The question remains as to whether HCFA will monitor plans' contracts effectively in the future. The Humana case shows that the agency did not follow procedures that could have highlighted the contract discrepancies that ultimately resulted in some beneficiaries receiving less coverage for brand name prescription drugs than the amount specified in their plan's basic package. In addition, the contractor reviewing ACR proposals skipped the key step of matching two documents in Humana's proposal that specified benefit levels and restrictions, and HCFA overlooked the contractor's missed step. Therefore, HCFA's future success at ensuring that beneficiaries receive the benefits for which the government contracted and paid will likely depend upon the extent to which the agency adheres to its revised monitoring procedures.

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We are sending copies of this correspondence to the Honorable Donna E. Shalala, Secretary of HHS, and have referred this matter to the HHS OIG for further review. In addition, we are sending copies to the Honorable Charles E. Grassley, Chairman; the Honorable John B. Breaux, Ranking Minority Member; and the Honorable Jack Reed, all of the Senate Special Committee on Aging, and other interested parties. We will also make copies available to others upon request.

If you or your staff have any questions, please call me at (202) 512-7114.

Sincerely yours,

(Signed)
William J. Scanlon
Director, Health Care Issues

GAO CONTACT AND STAFF ACKNOWLEDGMENTS

GAO CONTACT

James Cosgrove, 202-512-7029

STAFF ACKNOWLEDGEMENTS

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