

GAO

Testimony

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MEDICARE MANAGED  
CARE

Program Growth Highlights  
Need to Fix HMO Payment  
Problems

Statement of Jonathan Ratner, Associate Director  
Health Financing and Policy Issues  
Health, Education, and Human Services Division



Mr. Chairman and Members of the Committee:

We are pleased to be here today to discuss opportunities to improve Medicare's method of paying health maintenance organizations (HMO) that enroll Medicare beneficiaries. As we stated this past February in testimony to this Committee, Medicare's current HMO option, known to providers as the risk contract program, has not harnessed the cost-saving potential of managed care.<sup>1</sup> In fact, Medicare has paid HMOs more for beneficiaries' treatment than it would have spent, on average, had those same beneficiaries received care in the fee-for-service sector.

A small portion--about 7 percent--of the Medicare population is enrolled in HMOs under the risk contract program. However, recent deficit reduction proposals aimed at slowing Medicare spending growth call for moving a greater portion of beneficiaries into HMOs. In view of increasing congressional interest in the Medicare HMO program, you asked us to discuss (1) recent trends in Medicare beneficiary enrollment in HMOs, (2) the obstacles preventing Medicare from realizing potential savings from HMOs, (3) the strategies that could enable Medicare to realize HMO savings, and (4) the Health Care Financing Administration's (HCFA) efforts to test HMO payment reforms. Our findings derive from examinations of Medicare program data, reviews of the literature, interviews with industry experts, discussions with HCFA officials, and our reports on this subject. (See the app. for a list of related GAO products.)

In brief, we found that recent enrollment growth in Medicare HMOs has been rapid, increasing the urgency of correcting rate-setting flaws that result in unnecessary Medicare spending. By not tailoring its HMO capitation payment to how healthy or sick HMO enrollees are, HCFA cannot realize the savings that private-sector payers are able to capture from HMOs. In addition, we derive two lessons from our review of ways to fix Medicare's HMO capitation payment:

-- First, with respect to rate-setting, one size does not fit all, so a multipronged approach makes sense. The large disparities in market conditions between states--from California to Maine--call for solutions keyed to market conditions. Several broad strategies--increasing price competition among HMOs, using better risk adjustors, and revising Medicare's capitation rate--show promise for enabling Medicare to realize these savings.

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<sup>1</sup>Medicare: Opportunities Are Available to Apply Managed Care Strategies (GAO/HEHS-95-81, Feb. 10, 1995).

- Second, with respect to achieving the promise of such initiatives, details matter. How these strategies would be designed and implemented could mean the difference between success and failure.

Although HCFA is planning demonstration projects to study ways to correct its HMO rate-setting method, results are likely to be years away. We believe that, in the short term, HCFA can mitigate its capitation rate problem by introducing a better health status risk adjuster. HCFA also should proceed promptly to test competitive bidding and other promising approaches to setting HMO rates that reduce Medicare costs. Given the recent acceleration in Medicare's HMO enrollment growth, we believe that correcting Medicare's HMO payment rate problems should become a HCFA priority.

#### BACKGROUND

In 1982, the Congress created the Medicare risk contract program to capitalize on the potential cost savings associated with HMOs. Under this program, HMOs are paid a flat fee for each Medicare beneficiary enrolled. The law sets HMO payments for comprehensive care at 95 percent of the estimated average cost to Medicare of treating the patient in the fee-for-service sector. HCFA, which oversees the Medicare program, calculates these payment rates using a three-step process. HCFA determines:

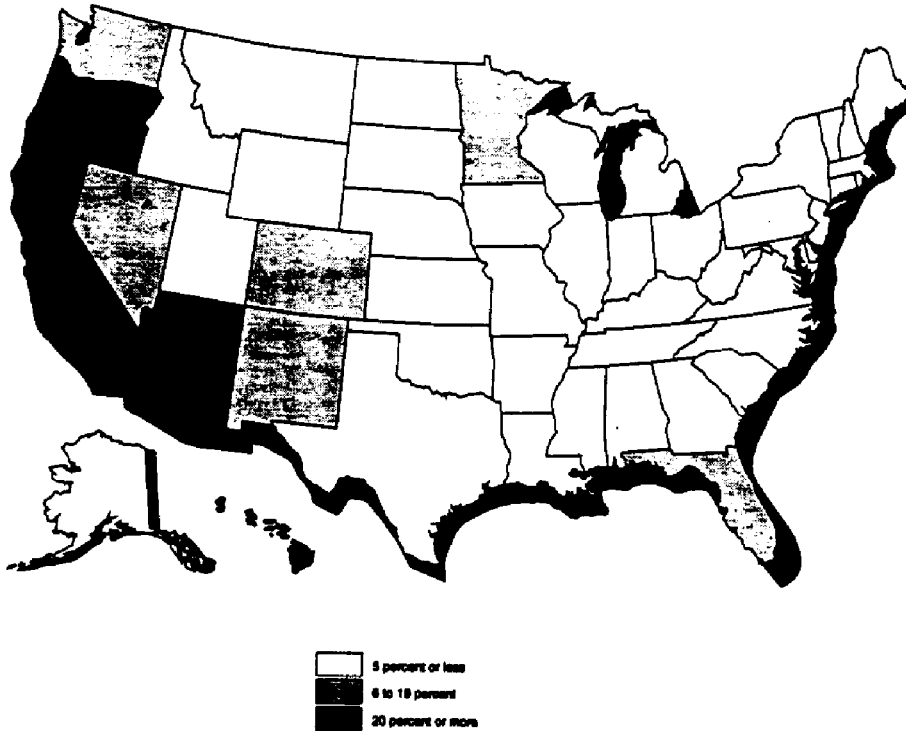
- The base rate. HCFA calculates the projected Medicare expenses nationwide for the average beneficiary in the next year.
- The adjusted average per capita cost (AAPCC). HCFA adjusts the base rate for differences in medical costs among the counties and multiplies the result by 0.95.
- The capitation rate after adjusting for health status risk. HCFA adjusts the AAPCC for enrollees' demographic characteristics--age, sex, Medicaid eligibility, residence in an institution such as a nursing home. This "risk adjustment" attempts to prevent HMOs from benefiting from favorable selection of health risks, which occurs when HMOs enroll beneficiaries that are healthier--and therefore less costly to care for--than those in the fee-for-service sector.

Although in existence for over a decade, the risk contract option remains a relatively small part of the Medicare program. As of May 1995, about 7 percent of Medicare beneficiaries were enrolled in plans offered by the 164 HMOs currently participating in the program.

**BENEFICIARY ENROLLMENT GROWING IN  
MEDICARE'S RISK CONTRACT PROGRAM**

The Medicare risk contract program may be poised for substantial growth in enrollment during the next few years. HCFA reports that three-fourths of all Medicare beneficiaries now live in areas where they could enroll in a risk contract HMO. Although beneficiary enrollment in these HMOs is relatively low, in recent years the program has grown dramatically in both beneficiary enrollment and HMO participation.

**Figure 1: Percent of Beneficiaries Enrolled in HMOs With Risk Contracts, By State, 1994**



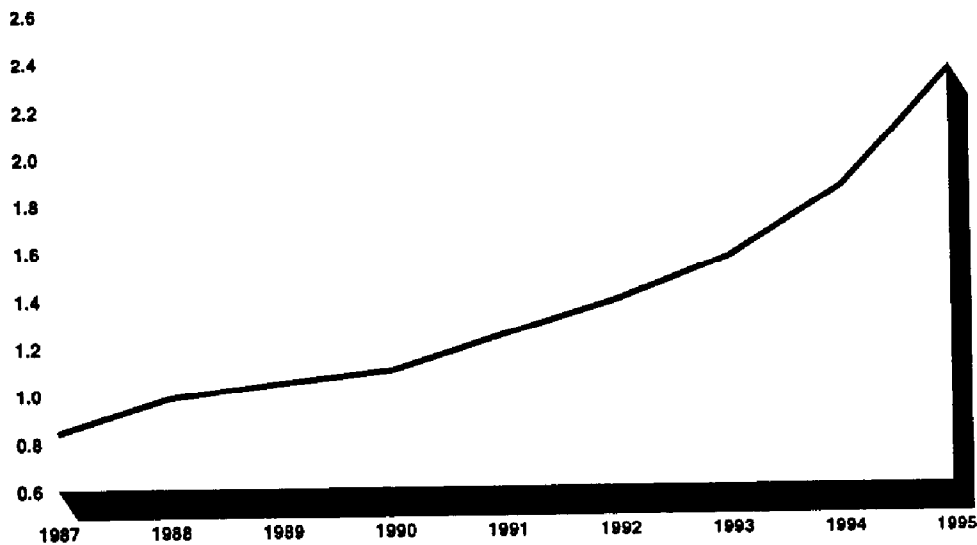
Source: HCFA, Bureau of Data Management and Strategy. Enrollment information based on computer runs using the Denominator File.

As of May 1995, about 2.6 million beneficiaries were enrolled in the risk contract program--about 7 percent of the total Medicare population.<sup>2</sup> Although this share is small,

<sup>2</sup>Another 2 percent of Medicare beneficiaries belong to HMOs that either have cost contracts or are Health Care Prepayment Plans. These programs reimburse HMOs on a cost basis and lack the financial incentives of risk contracts to reduce costs. Consequently, these cost contract HMOs are not relevant to proposals that would expand Medicare's use of capitated health plans.

recent HMO enrollment of Medicare beneficiaries has grown rapidly. From 1990 through 1992, enrollment grew by about 13 percent annually but then, during 1993 and 1994, grew by an annual average of 23 percent. Preliminary data for 1995 suggest a growth rate approaching 30 percent. Similarly, the number of risk contract HMOs, which declined substantially during the early years of the program, since 1991 has nearly doubled from 83 to the current 164.

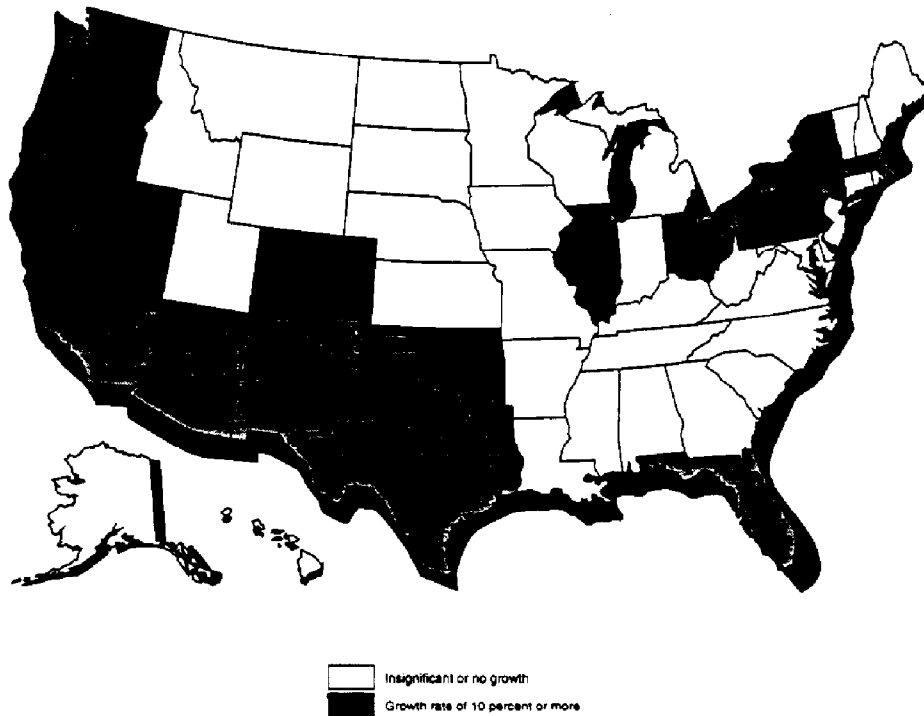
Figure 2: Number of Beneficiaries Enrolled in HMOs With Risk Contracts (in millions), 1987-1995



Source: HCFA, Office of Managed Care

In 1994, HMO enrollment in California and 14 other states-- which account for 55 percent of all Medicare beneficiaries-- experienced double-digit growth. The other states showed no enrollment growth. For the most part, these are states where HMO market penetration has been extremely low.

**Figure 3: Fifteen States Had Double-Digit Growth in HMO Enrollment in 1994**



Source: HCFA, Bureau of Data Management and Strategy. Enrollment information based on computer runs using the Denominator File.

Note: States that had 1 percent or fewer Medicare beneficiaries enrolled in risk contract HMOs were classified as "insignificant or no growth" states. Hawaii, with a growth rate of 6 percent in 1994 was also classified in that group. Ohio, with a growth rate of 9.1 percent, was classified as a double-digit growth state.

HMO RATE-SETTING METHODOLOGY THWARTS  
MEDICARE'S EFFORTS TO REALIZE SAVINGS

Our work suggests that Medicare's HMO rate-setting methodology does not maximize the potential of managed care to yield cost savings and, in some cases, can even discourage HMO participation in the program. By tying HMO payments to Medicare costs in the fee-for-service sector, the current methodology causes three problems. First, the rate-setting formula restricts potential savings and ignores the ability of competitive market forces to help produce additional savings. Second, the lack of adequate risk adjustors in the formula allows some HMOs to be overcompensated, given the health status of their enrollees. Third, the formula may discourage plan participation by setting payments that are too low in some areas and by causing rates to vary greatly both across geographic areas and over time.

Formula Encourages Competition Between HMOs  
That Primarily Benefits Enrollees

Under the present system, all HMOs in an area are paid the same capitation rate. With the payment rate fixed and independent of both HMO costs and the competitiveness of the local managed care environment, HMOs compete only for the enrollment of Medicare beneficiaries. Efficient, low-cost HMOs may be able to offer more generous benefit packages to enrollees and still prosper under the fixed capitation rate. However, because the payment rate is fixed, the government derives little benefit from either increased competition between HMOs or increased efficiency of HMOs. Moreover, Medicare beneficiaries have only limited incentives to seek care from low-cost health plans.

Medicare may be underestimating the efficiency of HMOs, and requiring an HMO "discount" from fee-for-service costs that is too modest. The HMO capitation rate is set by statute at 95 percent of the AAPCC, in other words, 5 percent below the estimated cost of serving beneficiaries in the fee-for-service sector. HMOs that can attract Medicare enrollees and provide health care for less than the capitation rate--for example, for 85 percent of fee-for-service costs--keep the difference (within limits) between their costs and the capitation payment.<sup>3</sup>

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<sup>3</sup>HMOs are permitted to earn profits up to the level earned on their non-Medicare business--the adjusted community rate (ACR). Profits earned in excess of the ACR must either be returned to HCFA or used to provide beneficiaries with additional benefits or reduced copayments and deductibles.

The recent surge in HMO participation indicates that many organizations now view Medicare risk contracts as potentially lucrative. In addition, in caring for Medicare beneficiaries, HMOs are estimated to achieve cost savings in excess of 5 percent. Research suggests that HMO costs in caring for their enrollees are at least 10 percent less than HCFA would have spent on fee-for-service care for them.<sup>4</sup> Finally, some experience of private-sector employers with HMOs suggests that the 5-percent discount may be too low, especially in certain urban areas with mature managed care markets. In those markets, even a larger discount (lower capitation rate) might not significantly discourage HMOs' participation in Medicare risk contracts.

#### Risk Adjustment Methodology Inadequate to Prevent Overcompensation

Currently, HCFA's capitation payment to HMOs is "risk adjusted" only for four demographic factors: beneficiary age, sex, Medicaid status, and institutional status. These adjustments are designed to modify HMO payments for expected variations in medical costs. For example, the capitation payment is higher for older beneficiaries, since they are expected to require more medical care than younger beneficiaries. However, this risk adjustment is inadequate because it does not specifically adjust for the health status of enrollees. By enrolling the healthier individuals, HMOs need deliver less health care but are compensated as if they enrolled a costlier clientele--both the healthier and the sicker individuals.<sup>5</sup>

Our review of studies on risk selection shows that, because most HMOs benefit from favorable selection (the healthier individuals typically enroll in HMOs), Medicare has paid HMOs more than it would have paid for the same patients' care by fee-for-service providers.<sup>6</sup> Estimates of the excess payments range from almost 6 percent to 28 percent. Although these estimates are based on 1991 data, our review suggests that favorable selection

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<sup>4</sup>Randall S. Brown and others, "Do Health Maintenance Organizations Work for Medicare?" Health Care Financing Review, Fall 1993, Volume 15, Number 1, p. 14.

<sup>5</sup>HCFA uses administrative means, such as prohibiting HMOs from refusing to enroll beneficiaries with pre-existing conditions and monitoring HMO marketing materials, to lessen the ability of HMOs to purposely attract healthier-than-average beneficiaries.

<sup>6</sup>Medicare: Changes to HMO Rate Setting Method Are Needed to Reduce Program Costs. GAO/HEHS-94-119, pp. 21-23.



persists despite HMO enrollment expansion. HCFA officials agree that the risk contract program displays favorable selection, though they believe that excess payments are at the lower end of this range.

Formula Produces Capitation Rates That Vary Considerably Within Market Areas And Over Time

Capitation rates are set separately for each U.S. county and vary considerably nationwide among regions and states, among urban and rural counties, and even among neighboring counties. This variation may discourage some HMOs from participating in risk contracts. For example, under the present system, an HMO is paid 27 percent less for serving a beneficiary living in Prince George's County, Maryland, than for serving an otherwise identical beneficiary living in neighboring Montgomery County, Maryland--even if the two individuals are treated in the same facility by the same doctor.<sup>7</sup> The inconsistency of payment rates across county lines leads some HMOs to enroll beneficiaries from a limited portion of the HMO's service area.

The geographic problems in the capitation rates are caused by the formula's tie to local fee-for-service spending, which reflects local variations both in the prices and volume of medical services used by Medicare beneficiaries. Much of this variation may, however, be attributable to underutilization of health care in some areas and overutilization in others instead of differences in the cost of providing appropriate health care. If fee-for-service beneficiaries use a large number of services (either because beneficiaries demand these services or because their doctors order additional services), then HMO payment rates will be relatively high in that county. In contrast, if Medicare fee-for-service beneficiaries use few services--perhaps because of inadequate transportation or a lack of providers in rural areas--then HMO payment rates will be relatively low. As a result, rates in some areas are too low to induce HMO participation in the risk contract program, while in other areas rates are too high for Medicare to realize the potential cost savings generated by capitated payments.

HMOs also can be discouraged from participating in risk contracts because payment rates can increase or decrease dramatically from year to year. This problem is most prevalent in rural counties. Because of the small number of Medicare beneficiaries in such counties, a few very expensive illnesses can drive up the following year's capitation rate, while an especially "healthy" year will have the opposite effect. HMO

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<sup>7</sup>Capitation payments are based upon where the beneficiary lives, not where he or she receives medical care.

officials complain that rate instability hurts their ability to conduct long-term planning--for example, by complicating decisions about investing in new clinics and expanding physician networks--and can cause wide swings in enrollees' premiums from year to year.

#### STRATEGIES EXIST FOR MEDICARE TO REALIZE SAVINGS

By modifying the present payment system, HCFA could help generate savings for Medicare. Our review of the experience of the private sector, reforms in other public health care programs, and empirical research suggests that a number of strategies hold promise. These strategies can be grouped into three broad categories: increasing price competition among HMOs, developing better risk adjustors, and revising the AAPCC-based capitation rate.

In our view, potential Medicare savings will be greatest if strategies in all three categories are concurrently pursued. An attempt to address all obstacles in a uniform way across all regions of the country is unlikely to be successful. This is because the predominant challenges to saving costs in large cities are not necessarily the same ones that exist in rural counties and because the challenges vary from region to region, even for otherwise similar communities. Consequently, a variety of reforms is warranted; local conditions would determine the particular mix of solutions for any specific area.

The details of how any reform is implemented matter. Changing the Medicare policies for paying HMOs could affect their decision to participate in risk contracts and the benefits they provide. This, in turn, may affect Medicare beneficiaries' decisions to enroll in managed care plans and the quality of care they receive in those plans. Thus, estimating the potential dollar savings and determining the best method of implementing specific reforms may be possible only after quickly conducting and evaluating demonstrations.

#### Increasing Price Competition Among HMOs

Price competition that would enlist market forces to help contain Medicare costs could be encouraged by requiring qualified HMOs to submit competitive bids. The accepted bid would set the capitated rate at which HMOs would provide comprehensive care to Medicare enrollees in an area. This approach completely decouples capitation rates from average fee-for-service spending. Under a competitive bidding system, HMOs would have an incentive to submit bids that reflect their actual costs of providing

health care to Medicare enrollees. Low bidders would be rewarded with risk contracts. High bidders could be excluded, included if they accepted the winning bid amount, or included but subject to a financial penalty.

A competitive bidding strategy may be most effective in urban areas with well-developed managed care markets. The details for implementing such a strategy would determine the strength of incentives driving HMOs to submit low bids and the amount of choice available to beneficiaries. For example, excluding high bidders from participating in risk contracts would maximize HMOs' incentives to submit low bids, but reduce the choice of plans available to beneficiaries. Allowing high bidders to participate but with a penalty--perhaps having to charge the difference between their bid and the accepted bid as a premium to seniors--would create a weaker incentive for low bids but would allow beneficiaries a wider choice of plans.

Competitive bidding, rate negotiation, and beneficiary incentive approaches have been used successfully in other public health insurance programs. Arizona, for example, since 1982 has delivered health care to its indigent population mostly through capitated managed care organizations where the capitation rates are set through a competitive bidding process. A recent study concluded that, compared to traditional Medicaid programs (predominately fee-for-service), Arizona achieved significant cost savings and a lower rate of expenditure growth.<sup>8</sup> The California Public Employees Retirement System (CalPERS), serving about 1 million members, also relies upon price competition among health plans and consumer incentives to control costs. Negotiating rates with HMOs has helped CalPERS to achieve reductions in premiums in each of the past 3 years, ranging from 0.4 percent in 1993-4 to 5.2 percent in 1995-96.<sup>9</sup>

Designing a good competitive bidding system requires attention to many issues, such as whether beneficiaries in plans that lose the bidding must shift to the winning plan. In addition, savings may not be realized immediately because of high initial start-up costs--for example, developing the bidding process and establishing the necessary management information systems. Administrative expenses may be high as well.

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<sup>8</sup>Managed Medicaid Cost Savings: The Arizona Experience, Laguna Research Associates (San Francisco: 1994).

<sup>9</sup>Health Insurance: California Public Employee's Alliance Has Reduced Recent Premium Growth (GAO/HRD-94-40, November 1993). Jackson Hole Group, Responsible Choices for Achieving Reform of the American Health System, eds. Paul Ellwood and Alain Enthoven, (March 1995).

Arizona's experience illustrates these points. Arizona spends on Medicaid administration an amount equal to over 11 percent of its program's acute care medical costs. This is about twice as much as comparable states spend administering their traditional fee-for-service Medicaid programs. This suggests that the effective use of managed care may require strong administrative structures that can provide adequate oversight and manage program resources efficiently.<sup>10</sup> Even so, Arizona's experiment with competitive bidding seems to have paid off, providing health care to beneficiaries while saving the state money.

Market forces could be introduced in other ways besides requiring competitive bidding. These include approaches that would encourage Medicare enrollees to be more price sensitive-- they range from requiring newly eligible Medicare beneficiaries who choose fee-for-service to pay slightly more than those beneficiaries who choose a managed care plan, to approaches that would allow beneficiaries to "price shop" among a list of approved HMOs and share a portion of any cost savings with the government. Because they are so far untried, the extent to which these schemes would increase beneficiaries' price sensitivity and help control Medicare costs is unknown. As with competitive bidding, there is a wide variety of ways in which these Medicare reforms could be implemented. However, a fuller discussion is outside of the scope of this statement.<sup>11</sup>

#### Improving Risk Adjustors

In earlier reports, we noted that researchers have proposed several alternative risk adjustment methods to reduce HMOs' incentives to enroll only relatively healthy Medicare beneficiaries. Each of these alternative methods attempts to measure the health status of enrollees more fully than HCFA's method. These proposals can be judged according to a number of

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<sup>10</sup>Our work on the Medicare risk contract program emphasizes the importance of effective mechanisms, whether administrative or market based, to ensure quality, resolve beneficiaries' complaints, and deter and pursue fraud and abuse.

<sup>11</sup>For example, under several proposals, beneficiaries could be given a voucher that would allow them to choose between traditional Medicare or among several qualified HMOs. HMOs would compete for enrollees on both price and benefits offered (subject to a minimum benefits requirement). Beneficiaries who choose a less expensive health plan would be allowed to keep a part of the difference between the premium cost and voucher amount; the rest would return to the federal treasury. However, neither vouchers, nor other proposals with similar consumer incentives, have been tried in Medicare.

generally accepted operational criteria. For example, a good risk adjustor would be inexpensive to administer, reduce favorable selection, create incentives for HMOs to provide appropriate care, and would not be subject to manipulation by participating HMOs. However, no risk adjustor is likely to exhibit all these positive traits because these criteria have tradeoffs. For example, a more complex risk adjustor may be more successful in reducing favorable selection but may do so only at a high administrative cost.

Recently, we evaluated 10 possible risk adjustors.<sup>12</sup> None emerged as the definitive solution to the problem of the current system. However, 4 of the 10 adjustors we examined were potentially superior to the current system and seemed to entail less administrative burden than the most sophisticated risk adjustors. One of these adjustors--clinical indicators--would adjust capitation rates for the presence or absence of a particular chronic health condition (such as heart disease, stroke, or cancer). Two other promising clinically-based risk adjustors include information not only on whether a beneficiary has a specific condition but also on the severity of the illness.<sup>13</sup> In the fourth approach, HMO capitation payments would be linked to beneficiaries' own views of their physical and emotional health.

#### Improving the AAPCC Capitation Rate

HCFA could require steeper discounts from HMOs than the present 5-percent discount off the estimated local fee-for-service cost. Although this would lower payments to HMOs, it may not necessarily have a large impact on their participation in Medicare risk contracts. Previous research indicates that enrollment of healthier-than-average beneficiaries, combined with an imperfect system of risk adjustment, results in excessive payments to HMOs--even after factoring in the 5-percent discount. The number of HMOs seeking risk contracts has increased from 109 to 164 in less than a year and a half. Thus, HMOs may continue to find Medicare risk contracts attractive--even at a somewhat larger discount. However, if health plans react by offering less generous benefit packages, fewer seniors may be attracted to managed care.

The method used for calculating the AAPCC could also be improved by assigning a greater weight to the influence of local medical prices and a lesser weight to the influence of local

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<sup>12</sup>Medicare: Changes to HMO Rate Setting Method Are Needed to Reduce Program Costs (GAO/HEHS-94-119, Sept. 2, 1994).

<sup>13</sup>The two risk adjustment measures are Ambulatory Care Groups (ACGs) and Diagnostic Cost Groups (DCGs).

service utilization patterns in the fee-for-service sector. Modifications could also be made so that the AAPCC reflected HMO market areas, rather than artificial political boundaries. For example, defining a single capitation rate for a metropolitan area would eliminate the possibility that an HMO would receive more for serving a senior in one county than it would for serving an otherwise identical senior living in an adjacent county. These changes would also tend to reduce the volatility of the AAPCC over time and consequently increase HMO participation in the risk contract program.<sup>14</sup>

#### HCFA PLANS TESTS OF HMO PAYMENT REFORMS

HCFA is planning to conduct demonstration projects that will examine several proposals for modifying or replacing the current method of determining payment rates to HMOs. Some results of these demonstrations could emerge during fiscal year 1996, but we believe that a thorough assessment of the demonstrations is, at best, several years away. The proposals are at various stages, from solicitation of proposals from private contractors to implementation of the demonstration itself.

Specific projects that HCFA is pursuing include: (1) a study of "outlier pools" as a way of adjusting for health risk retrospectively; (2) a demonstration of competitive bidding as a means of setting the capitation rate; (3) a demonstration of a sophisticated health status risk adjustor; and (4) an open-ended demonstration project that would study one or more proposals for improving Medicare managed care.

In our view, these demonstration projects are steps in the right direction, though somewhat overdue. In light of Medicare's current losses due to the risk contract program--estimated at between 0.5 billion and 2.5 billion per year--there may be other steps that HCFA could take immediately to stem losses. For example, HCFA could increase the HMO "discount" from its current 5 percent in selected areas. These might be areas where Medicare HMO enrollment is growing rapidly or where most HMOs do not currently charge beneficiaries a premium.

#### CONCLUDING OBSERVATIONS

Several factors are at work that change the context of Medicare managed care:

-- the recent and anticipated growth in risk contract enrollments,

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<sup>14</sup>Annual Report to Congress 1995, Physician Payment Review Commission (Washington, DC: 1995).

- broad congressional interest in expanding Medicare's use of managed care, and
- HCFA's recent steps toward undertaking demonstration projects on expanded managed care options and improved Medicare HMO pricing.

These factors lend a new momentum to efforts that would fix Medicare's method of paying HMOs, to stem Medicare's losses under the risk contract program, and then turn them into savings.

Our work drives home two points that would make success more likely if the Congress pursues expansion of Medicare managed care and better pricing of capitated health plans: First, one size does not fit all--at least with respect to pricing capitated health plans in Medicare. Market conditions vary too much and in important ways, even among metropolitan areas. Second, details matter. How programs are designed and implemented often means the difference between success and failure.

As a result, we believe a sensible approach would concurrently pursue the three major strategies--increasing price competition among HMOs, making risk adjustors more accurate, and correcting the pricing of HMO plans by modifying the existing AAPCC approach. Moreover, by adopting a "try and track" stance, Medicare could benefit from early action while gaining more information on how well these strategies work and how they might be better implemented.

In particular, we believe that HCFA should move quickly to implement a better risk adjustor. Last year, we recommended that HCFA promptly undertake demonstration projects on four risk adjustors that we have identified as promising in accuracy and administrative feasibility. Today the increased urgency of fixing the HMO capitation rate may argue for an alternative approach: HCFA could select one of these risk adjustors to implement as a near-term fix. Meanwhile, HCFA could devote its resources to refining and implementing a more sophisticated risk adjustor. As another interim measure, HCFA could also increase, in selected areas, the HMO 5-percent discount.

Finally, we believe that HCFA should move forward without delay in implementing demonstration projects on competitive bidding. By trying competitive bidding in different regions, HCFA can obtain valuable information about how the structure of the bidding process affects outcomes--such as the tradeoff between maximizing HMOs' incentives to submit low bids and ensuring the widest possible choice of plans for beneficiaries. Moreover, Medicare can likely reap some of the potential gains from competitive pricing of health plans.

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Mr. Chairman, this concludes my testimony. I would be glad to answer any questions you and the committee members may have.

For more information on this testimony, please call Jonathan Ratner, Associate Director, at (202) 512-7107. Other contributors included James Cosgrove, Hannah Fein, Richard Lipinski, Patrick Redmon, and Scott Smith.

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RELATED GAO PRODUCTS

Medicare: Opportunities Are Available To Apply Managed Care Strategies (GAO/T-HEHS-95-81, Feb. 10, 1995).

Health Care Reform: Considerations for Risk Adjustment Under Community Rating (GAO/HEHS-94-173, Sept. 22, 1994).

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

Managed Health Care: Effect on Employers' Costs Difficult to Measure (GAO/HRD-94-3, Oct. 19, 1993).

Medicare: HCFA Needs to Take Stronger Actions Against HMOs Violating Federal Standards (GAO/HRD-92-11, Nov. 12, 1991).

Medicare: PRO Review Does Not Assure Quality of Care Provided by Risk HMOs (GAO/HRD-91-48, March 13, 1991).

Medicare: Increase in HMO Reimbursement Would Eliminate Potential Savings (GAO/HRD-90-38, Nov. 1, 1989).

Medicare: Reasonableness of Health Maintenance Organization Payments Not Assured (GAO/HRD-89-41, Mar. 7, 1989).

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

Medicare: Physician Incentive Payments by Prepaid Health Plans Could Lower Quality of Care (GAO/HRD-89-29, Dec. 12, 1988).

Medicare: Experience Shows Ways to Improve Oversight of Health Maintenance Organizations (GAO/HRD-88-73, Aug. 17, 1988).

Medicare: Uncertainties Surround Proposal to Expand Prepaid Health Contracting (GAO/HRD-88-14, Nov. 2, 1987).

Medicare: Issues Raised by Florida Health Maintenance Organization Demonstrations (GAO/HRD-86-97, July 16, 1986).

Problems in Administering Medicare's Health Maintenance Organization Demonstration Projects in Florida (GAO/HRD-85-48, March 8, 1985).