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Medicare: GAO Views on Medicare Payments to Health Maintenance Organizations

Statement of
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Before the
Subcommittee on Health
Committee on Ways and Means
House of Representatives

SUMMARY

About 1.1 million Medicare beneficiaries are enrolled in Health Maintenance Organizations (HMOs), which provide care on a capitated payment basis. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) modified Medicare's authority to enter into risk contracts with HMOs and revised the payment provisions for such contracts. Under these TEFRA risk contracts, HMOs agree to provide all covered health care services to enrolled Medicare beneficiaries in return for a fixed payment amount per enrollee. The payment is set at 95 percent of Medicare's estimate of the average cost it would have incurred for HMO enrollees had they remained in the fee-for-service health care sector. This estimate is referred to as the adjusted average per capita cost (AAPCC).

The Administration has proposed increasing the HMO payment rate from 95 to 100 percent of the AAPCC. GAO evaluated this proposal in light of (1) the legislative history of the 95 percent payment rate, and (2) the results of some of GAO's reports and other analyses related to the Medicare payments to HMOs.

The history of Medicare's payment system for HMOs with risk contracts shows that the Congress intended to save Medicare program funds. The fixed payment amount for Medicare HMO enrollees was intended to be, on average, 5 percent less than the expected Medicare cost if the enrollees had remained in the fee-for-service sector. Increasing the payment rate to 100 percent would eliminate this potential savings from the HMO program.

Moreover, recent studies have found that even with the rate at 95 percent of the AAPCC, risk contracts with HMOs may not have reduced Medicare outlays. These studies show that Medicare beneficiaries enrolled in HMOs tend to be healthier and less likely to use health care services than non-HMO beneficiaries, and thus on average are less costly to treat. They concluded that the methodology used to calculate the AAPCC does not accurately reflect these cost differences. Therefore, rather than paying less, Medicare may have paid HMOs more than if the same enrollees had remained in the fee-for-service sector.

Finally, as we reported in March 1989, the adjusted community rate (ACR)--the payment safeguard mechanism intended to ensure that HMOs do not receive windfall profits from inaccuracies in the AAPCC process--was not meeting its objective.

Mr. Chairman and Members of the Committee:

We are pleased to be here today to discuss GAO's work related to Medicare payments to Health Maintenance Organizations (HMOs) and the Administration's proposal to increase the HMO payment rate from 95 to 100 percent of the adjusted average per capita cost (AAPCC).

When it enacted Medicare's current HMO risk-contract payment system, the Congress intended both to offer an HMO option to a wider set of Medicare beneficiaries and to save Medicare program funds. The fixed payment amount for Medicare HMO enrollees was intended to be, on average, 5 percent less than the expected Medicare cost if the enrollees had remained in the fee-for-service sector. Increasing the payment rate to 100 percent would eliminate this potential savings from the HMO program.

Moreover, recent studies have found that even with the rate at 95 percent of the AAPCC, risk contracts with HMOs may not have reduced Medicare outlays. These studies show that Medicare beneficiaries enrolled in HMOs tend to be healthier and less likely to use health care services than non-HMO beneficiaries, and thus on average are less costly to treat. They concluded that the methodology used to calculate the AAPCC does not accurately reflect these cost differences. Therefore, rather than paying less,

Medicare may have paid HMOs more than if the same enrollees had remained in the fee-for-service sector.

Finally, as we reported in March 1989, we found serious problems in the way the Health Care Financing Administration (HCFA) had implemented the payment safeguard mechanism--the adjusted community rate (ACR)--intended to ensure that HMOs do not receive windfall profits from inaccuracies in the AAPCC process. These problems prevented the ACR process from achieving its objective.

BACKGROUND

Most Medicare beneficiaries receive their care in the fee-for-service sector of the health care system. In that sector most inpatient hospital and hospice care is paid on the basis of prospectively determined rates, and skilled nursing facilities and home health agencies are paid on the basis of cost. Part B services are paid on a reasonable charge basis or, as in the case of laboratory and anesthesiology services, on a fee schedule basis.

About 1.1 million Medicare beneficiaries are enrolled in HMOs, which provide care on a capitated payment basis. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) modified Medicare's authority to enter into risk contracts with HMOs and revised the payment provisions for such contracts. Under these TEFRA risk contracts, HMOs agree to provide all covered health care services to enrolled Medicare beneficiaries in return for a

fixed payment amount per enrollee. The payment is set at 95 percent of Medicare's estimate of the average cost it would have incurred for HMO enrollees had they remained in the fee-for-service health care sector. This estimate is referred to as the adjusted average per capita cost (AAPCC). Within certain limits, the HMO can profit if its cost of providing services is less than the pre-determined amount, but it risks a loss should its costs be higher.

HMO REIMBURSEMENT BEFORE TEFRA

Although the current method of paying risk HMOs was established by TEFRA in 1982, the HMO payment provisions had their genesis in legislation initially reported by the House Committee on Ways and Means in May 1970 and again in May 1971. The original Medicare statute, enacted in 1965, did not explicitly provide for reimbursing HMOs. Until 1972, HMOs were paid under the legislative authority contained in section 1833 of the Social Security Act. This section provided for reimbursement of group practice prepayment plans for part B services to Medicare eligibles enrolled in such plans on a reasonable charge or reasonable cost basis.

The Congress was concerned, however, that by paying HMOs in this manner Medicare was not taking advantage of the savings that HMOs might offer if paid on a prospective per capita basis. Paying HMOs prospectively gives them strong incentives to

institute utilization controls and efficient management practices because their profitability is influenced by their ability to provide services at less cost, on average, than the prospectively determined rates.

Accordingly, the Congress adopted a revised HMO coverage provision in the Social Security Act Amendments of 1972 (Public Law 92-603), which added section 1876 to the act. This section created two options for paying HMOs for all Medicare covered services--a cost reimbursement option and a capitation option. Under the capitation option, an HMO's cost per member was compared to the AAPCC for all Medicare beneficiaries in the HMO's service area. If the HMO's cost was higher than the AAPCC, it had to absorb the loss or carry it over to be offset by future savings. If the HMO's cost was less than its AAPCC, it shared the savings with Medicare on a 50-50 basis with the HMO's profits limited to 10 percent of the AAPCC.

The Congress was also concerned about potential quality-of-care problems. To minimize these concerns, and assure financial stability and an adequate mix of enrollees, the 1972 amendments added several requirements that HMOs generally had to meet before entering into a Medicare contract. These included a minimum 25,000 enrollment of which at least half were under 65 years of age, and an operating history of at least 2 years.[1]

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[1]The Secretary could waive the 25,000-member requirement if the HMO operated in a sparsely populated area, and had at least 5000 members and a 3-year history of successful operation.

HMOs did not regard this risk contract option favorably, apparently because of the limits placed on their profit potential and the fact that profits had to be shared with Medicare while their losses had to be fully absorbed. In addition, the 25,000-member enrollment requirement made many of them ineligible to participate in the risk program. Consequently, between 1972 and the 1982 enactment of TEFRA, only one HMO elected to contract with Medicare on a continuing basis under the risk contract option.

PROVISIONS LIBERALIZED UNDER TEFRA

TEFRA encouraged more HMO risk contracts. Section 114 of TEFRA changed the Medicare law, amending section 1876 of the Social Security Act to (1) liberalize the beneficiary enrollment standards of the section and (2) adopt reimbursement provisions similar to those first proposed in 1971. The 25,000-enrollee standard was reduced to 5,000 enrollees, no more than 50 percent of whom could be Medicare and Medicaid enrollees. This allowed more HMOs to qualify for Medicare contracts than under the previous law.

TEFRA also increased financial incentives for HMOs to participate in Medicare. Section 114 gave HMOs an opportunity to profit on Medicare as much as on their other lines of business. HMOs were paid on the basis of fixed per-enrollee rates of 95

percent of Medicare's estimate of the average cost it would have incurred for HMO enrollees had they remained in the fee-for-service sector (the AAPCC). This payment method provides a 5 percent savings for the Medicare program, assuming the AAPCC is set accurately. Instead of sharing any additional savings with Medicare, HMOs could retain all profits up to the level of profits earned on their non-Medicare enrollment. Also, HMOs had to use any savings above this amount to give Medicare enrollees additional health benefits or reduced liability for deductibles and co-payments, or to reduce the Medicare payment rates.

In enacting TEFRA, the Congress continued to be concerned, as it was in 1972, that the AAPCC methodology for computing HMO payment rates would not accurately reflect the differing health care needs of Medicare beneficiaries who enroll in HMOs as compared to beneficiaries in the fee-for-service system. Without adequate adjustments to Medicare average costs, payment rates would either be too high or too low depending on whether HMOs attracted beneficiaries with lesser or greater health care needs. Therefore, the Congress established the effective date of the TEFRA HMO amendments as the later of (1) October 1, 1983, or (2) when the Secretary of HHS notified the cognizant congressional committees that HHS was "reasonably certain" that an appropriate methodology had been developed for computing the AAPCC to assure actuarial equivalence of HMO and non-HMO Medicare beneficiaries.

The Secretary made the required notification to the congressional committees on January 7, 1985, and section 114 of TEFRA became effective February 1 of that year.

IS THE AAPCC SET CORRECTLY?

The success of the TEFRA risk contract program--both from the government and the HMO perspective--depends in large part on how accurately the AAPCC estimates what Medicare would have paid for HMO enrollees had they remained in the fee-for-service sector. HCFA estimates this amount based on projected program costs for beneficiaries with similar characteristics who remain in the fee-for-service sector. HCFA computes AAPCC rates for aged and disabled beneficiaries for each county in the United States. It then adjusts these rates for a set of risk factors defined by age, sex, institutional status, and welfare status.

The HMO rate-setting process contains two potential sources of error. First, there could be problems with the data or the methodology used to project the AAPCC, causing the estimate to be too high or too low. Second, the risk factors used to adjust the AAPCC may not be adequate to account for factors affecting health costs of beneficiaries within each AAPCC category. If this were the case and, for example, the HMO enrolls beneficiaries who are healthier on average than those in their corresponding AAPCC category, the HMO will be paid too much. If enrolled

beneficiaries are less healthy than average, the HMO will be paid too little. This problem is usually called "biased selection".

The results of recent studies[2] suggest that reimbursement rates for TEFRA risk contracts may be too high due to biased selection. For example, as part of a HCFA-funded study, Mathematica Policy Research reviewed the health care status and treatment costs of Medicare beneficiaries enrolled between 1982 and January 1985 in HMOs with Medicare risk contracts. In a January 1989 report,[3] Mathematica concluded that, because of biased selection, Medicare HMO enrollees in the study group had lower expected costs than comparable non-HMO beneficiaries. Mathematica estimated that because the AAPCC risk adjustment factors do not fully account for these differences, HCFA paid between 15 and 33 percent more during the study period for beneficiaries in these risk contracts than it would have if these individuals had been treated in the fee-for-service sector. If problems related to the data and methodology used in projecting

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[2]For example, see P.W. Eggers and R. Prihoda, "Pre-Enrollment Reimbursement Patterns of Medicare Beneficiaries Enrolled in `At Risk' HMOs," Health Care Financing Review, Vol. 4, No. 1, September 1982, pp. 55-73; F. J. Hellinger, "Selection Bias in Health Maintenance Organizations: Analysis of Recent Evidence," Health Care Financing Review, Vol. 9, No. 2, Winter 1987, pp. 55-63; R.P. Ellis and T. McGuire, "Setting Capitation Payments in Markets for Health Services," Health Care Financing Review, Vol. 8, No. 4, Summer 1987, pp. 55-64.

[3]Lyle Nelson and Randall Brown, The Impact of the Medicare Competition Demonstrations on the Use and Cost of Services: Final Report. Report Submitted to HCFA by Mathematica Policy Research under Contract No. 500-83-0047, January 31, 1989.

the AAPCC were considered, the study estimated that Medicare's overpayments would have been even higher.

The results of the Mathematica study are consistent with those of an earlier GAO study. In 1986 we reported[4] that the mortality rate for Medicare enrollees in 27 HMOs with Medicare risk contracts was lower than that projected for this group. This suggests that Medicare HMO enrollees were healthier than non-HMO enrollees. We estimated that to realize the savings envisaged by TEFRA, the HMO payment rate would have to be lowered by an additional 5 percent of the AAPCC in order to adjust for mortality differences alone.

The Mathematica and GAO studies were based on analysis of risk contracts awarded to HMOs as part of a demonstration project that preceded the implementation of the TEFRA HMO risk contract provisions in 1985. However, the demonstration contracts were similar to the TEFRA risk contracts, and the method used to calculate the AAPCC was almost identical. Because of the identified shortcomings in the AAPCC methodology, these studies raise serious questions about the accuracy of HMO payments.

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[4]MEDICARE: Issues Raised by Florida Health Maintenance Organization Demonstrations. GAO/HRD-86-97, July, 1986.

PAYMENT SAFEGUARD NOT EFFECTIVE

Medicare law provides a payment safeguard to help ensure that Medicare and its beneficiaries, rather than HMOs, benefit from any inaccuracies in the AAPCC process. HMOs are required to compute an adjusted community rate (ACR), which is an estimate of the premium the HMO would have charged Medicare enrollees for the Medicare benefit package based on its premium-setting policies for the non-Medicare portion of its business. HMOs must apply any excess of their AAPCC payments over their ACRs to additional benefits for Medicare enrollees or accept reduced Medicare payments.

As discussed in our March 1989 report,[5] our review of the ACR process indicated that it was not effective. HCFA's process for reviewing, validating, and approving ACR submissions did not assure that the ACR process was meeting its payment safeguard objective. Judging from GAO's case studies of ACRs submitted by 4 HMOs and the reviews of a random sample of ACRs submitted by 15 other HMOs, the process was susceptible to HMO manipulation and error. This was because HCFA did not always enforce its requirements that an HMO (1) use its own historic cost and utilization data as a basis for calculating its ACR, (2) follow the prescribed computational methods to account for differences between Medicare and commercial

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[5]Medicare: Reasonableness of Health Maintenance Organization Payments Not Assured. GAO/HRD-89-41, March 1989.

members' volume and cost of services, and (3) document the calculations.

In commenting on that report, HHS stated that it had begun to make improvements to the ACR process and planned to take further action as a result of our recommendations. Although we have not reviewed the ACR process since that time, unless HCFA has implemented major improvements in the last year we doubt the ACR can be relied upon to meet its safeguard objectives.

CONCLUSIONS

Based on our review of the history of HMO Medicare reimbursement, we believe that raising the payment rate from 95 to 100 percent of the AAPCC would be contrary to what the Congress envisioned when authorizing TEFRA risk contracts. The Congress expected that paying HMOs 95 percent of the AAPCC would save the Medicare program 5 percent of what it would have cost had enrollees remained in the fee-for-service sector. Thus, increasing the payment rate to 100 percent of the AAPCC would eliminate any potential for such savings.

In addition, there was congressional concern that inaccuracies in the AAPCC methodology could lead to excessive payments to HMOs. This concern seems well founded in light of recent studies. These studies have concluded that Medicare

beneficiaries enrolled in HMOs are healthier and tend to use fewer health care services--and are thus on average less costly to treat--than non-HMO beneficiaries. The studies also found that the methodology used to calculate the AAPCC does not accurately reflect these cost differences. Thus, rather than paying less, Medicare may have paid more for HMO enrollees than had they remained in the fee-for-service sector. If, as the studies indicate, payment rates are too high, increasing the HMO payment rate to 100 percent would exacerbate the problem.