

GAO

Testimony

Before the Subcommittee on Health and Environment,
Committee on Commerce, House of Representatives

For Release on Delivery
Expected at 10:00 a.m.
Wednesday, July 12, 1995

MEDICARE MANAGED
CARE

Enrollment Growth
Underscores Need to Revamp
HMO Payment Methods

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



064062/154680

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 have stated in previous reports, Medicare's current HMO option, known to providers as the risk contract program, has not harnessed the cost-saving potential of managed care.¹ 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 previous reports on this subject. (See app. I for a list of related GAO products.)

In brief, we found that recent enrollment growth in Medicare HMOs has been rapid and accelerating, which adds to 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 capture from HMOs. Alternative methods of determining HMO rates have been suggested, but little experience exists on how well these methods would work under Medicare. 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.

¹See, for example, Medicare: Opportunities Are Available to Apply Managed Care Strategies (GAO/T-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 at least several 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 in which it determines:

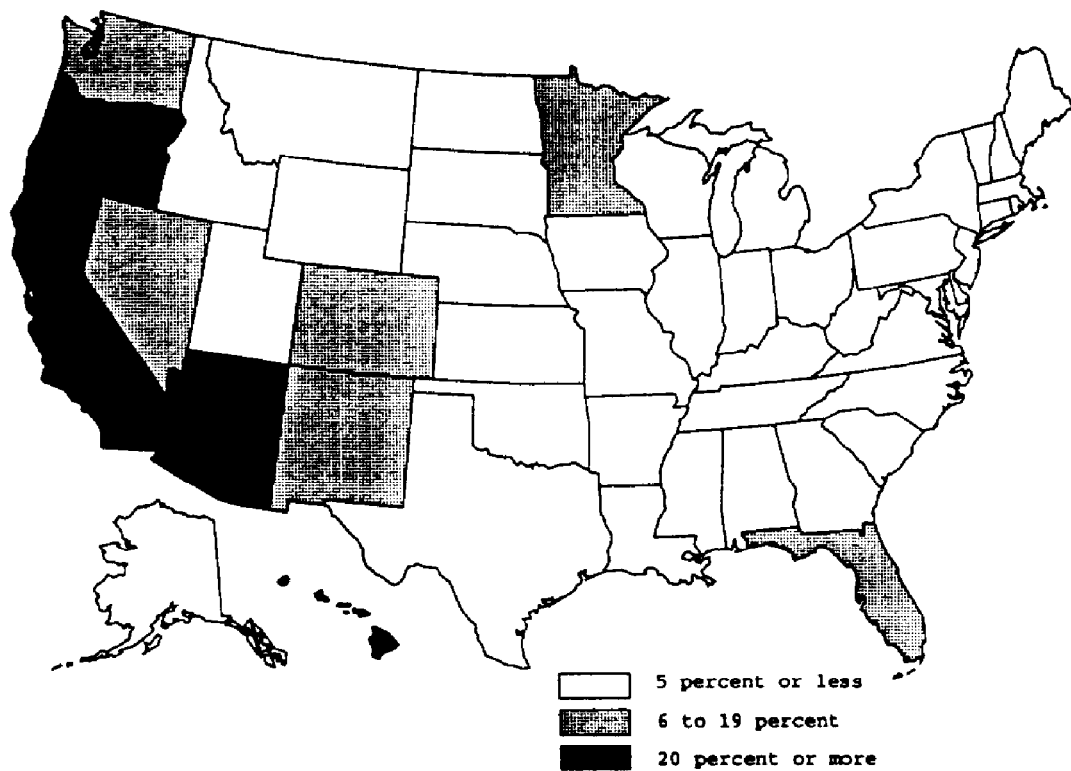
- The base rate. HCFA calculates the projected Medicare expenses nationwide for the average beneficiary in the next year.
- The adjusted average per capita cost (AAPCC). HCFA adjusts the base rate for differences in medical costs among the counties and multiplies the result by 0.95.
- The capitation 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.

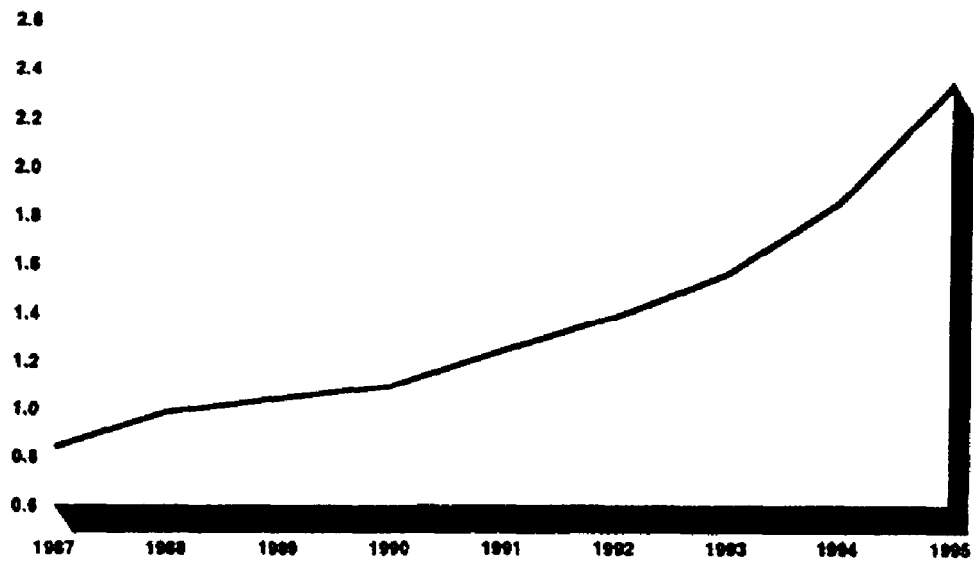
Note: Data used to construct figure 1 are presented in appendix II.

As of May 1995, about 2.6 million beneficiaries were enrolled in the risk contract program--about 7 percent of the total Medicare population.² Figure 1 shows that the percentage of Medicare beneficiaries enrolled is significantly higher than the national average in only a few states. HMO enrollment is further concentrated in urban areas. The 5 metropolitan statistical areas (MSA) with the largest risk contract enrollments accounted for 34 percent of the nationwide risk program enrollment in 1995, and the top 10 MSAs accounted for 51 percent of nationwide risk program enrollment. Enrollment data for the top 100 MSAs appear in appendix III.

Although the HMO share nationwide is small, 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.

²Another 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, cost contract HMOs are not relevant to proposals that would expand Medicare's use of capitated health plans.

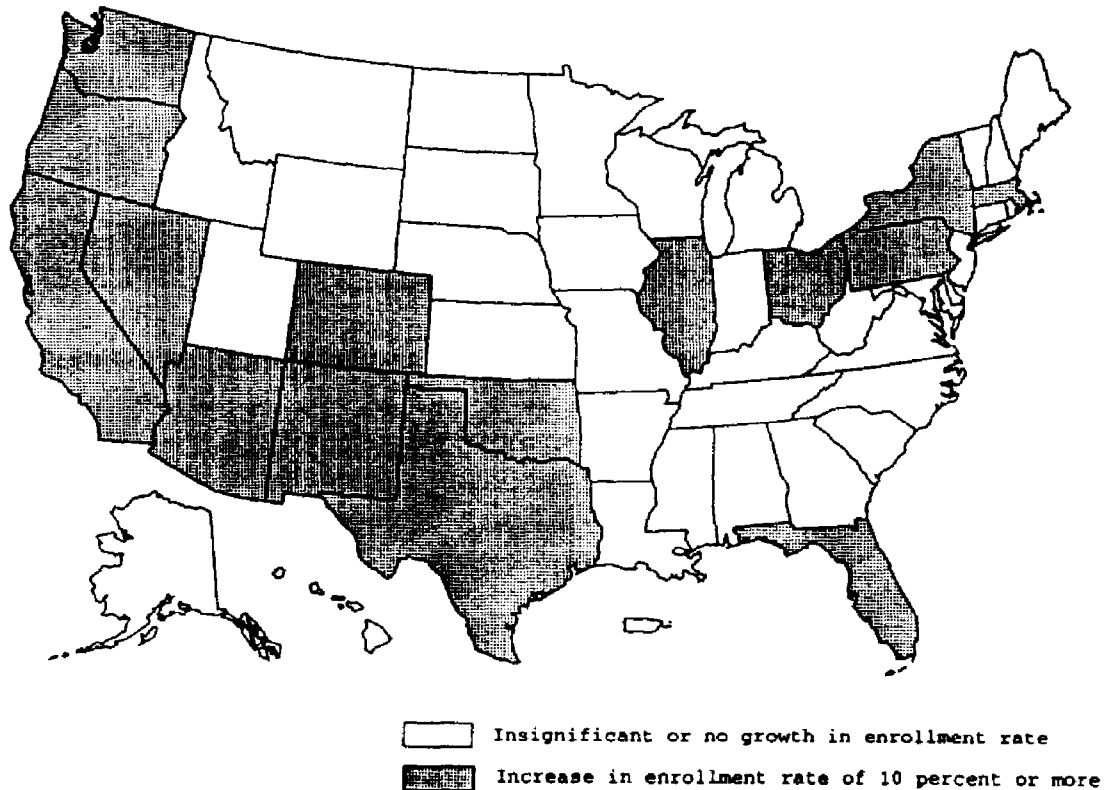
Figure 2: Number of Beneficiaries Enrolled in HMOs With Risk Contracts (in millions), 1987-1995



Source: HCFA, Office of Managed Care

In 1994, the HMO enrollment rate in California and 14 other states--whose enrollees account for 55 percent of all Medicare beneficiaries--experienced double-digit increases. The other states showed no growth in their enrollment rates. For the most part, these states have had extremely low HMO market penetration.

Figure 3: Fifteen States Had Double-Digit Increases in their Rates of Medicare 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. Data used to construct figure 3 appear in appendix II.

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.³

The recent surge in HMO participation indicates that many organizations now view Medicare risk contracts as potentially

³HMOs 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.

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.⁴ 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.⁵

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.^{6,7} Estimates of the excess payments range

⁴Randall S. Brown and others, "Do Health Maintenance Organizations Work for Medicare?" Health Care Financing Review, Vol. 15, Number 1 (1993), p. 14.

⁵HCFA 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.

⁶Medicare: Changes to HMO Rate Setting Method Are Needed to Reduce Program Costs. (GAO/HEHS-94-119, Sept. 2, 1994), pp. 21-23.

⁷Favorable selection--combined with Medicare's linkage of HMO rates to average Medicare costs in the fee-for-service sector--can increase Medicare outlays in two related ways. First, because Medicare HMO beneficiaries are healthier on average, their treatment costs the HMOs less, on average, than the

from almost 6 percent to 28 percent. However, these estimates have been criticized as too high for various technical reasons, such as the data analyzed (from 1991) no longer reflects current conditions.⁸ Nonetheless, our review suggests that favorable selection 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.⁹ The inconsistency of payment rates across county lines leads some HMOs to enroll beneficiaries from a limited portion of the HMO's service area.

capitation rate Medicare pays HMOs--even after that base rate is risk-adjusted by HCFA for demographic factors. (In other words, Medicare pays more for HMO enrollees than if they had remained in fee-for-service.) Second, favorable selection causes the average fee-for-service costs to increase as healthier (than average) beneficiaries leave fee-for-service to join the HMOs. Because the average fee-for-service costs are now higher, the HMO base payment rate increases.

⁸For example, Laurance Baker, Can Managed Care Control Health Care Costs: Evidence From the Medicare Experience, (The National Institute for Health Care Management, June, 1995) suggests that Medicare HMOs drive down Medicare costs in the fee-for-service sector thereby offsetting the effects of favorable selection. Other research finds that the proportions of chronically ill individuals in HMOs and in the fee-for-service sector are roughly comparable (see HMOs and Medicare: Myths and Realities, Group Health Association of American, June 1995).

⁹Capitation payments are based upon beneficiary residence, not where medical care is received.

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 future capitation rate, while an especially "healthy" year will have the opposite effect. HMO 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 locations likely to attract many bidders--typically 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.¹⁰ 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 1993-94 to 5.2 percent in 1995-96.¹¹

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.

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.¹² 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

¹⁰Managed Medicaid Cost Savings: The Arizona Experience, Laguna Research Associates (San Francisco: 1994).

¹¹Health Insurance: California Public Employee's Alliance Has Reduced Recent Premium Growth (GAO/HRD-94-40, Nov. 1993) and Responsible Choices for Achieving Reform of the American Health System, eds. Paul Ellwood and Alain Enthoven, Jackson Hole Group (March 1995).

¹²Our 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.

these schemes would increase beneficiaries' price sensitivity and help control Medicare costs is unknown. As with competitive bidding, a wide variety of approaches may be used to implement these Medicare reforms. However, a fuller discussion is outside of the scope of this statement.¹³

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 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 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.¹⁴ 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

¹³For 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.

¹⁴Medicare: Changes to HMO Rate Setting Method Are Needed to Reduce Program Costs (GAO/HEHS-94-119, Sept. 2, 1994).

has a specific condition but also on the severity of the illness.¹⁵ 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. Recent evidence suggests that HMOs find participation in the risk contract program to be lucrative under current payment rates. Specifically, the number of HMOs obtaining risk contracts has increased from 109 to 164 in less than a year and a half, and the percentage of risk contract HMOs charging Medicare beneficiaries a zero premium increased from 28 (23 plans) in 1993 to 49 (77 plans) in 1995.¹⁶ 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 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.

¹⁵The two risk adjustment measures are Ambulatory Care Groups (ACGs) and Diagnostic Cost Groups (DCGs).

¹⁶The weighted (by number of beneficiaries) average monthly premium charged to Medicare enrollees by participating HMOs was about \$26 in 1993 and fell 32 percent to about \$18 by 1995. In 1993, nearly 726,000 beneficiaries paid no premium for HMO risk contract services; in 1995, more than 1.4 million paid no premium. An HMO may lower the premium it charges to comply with statutory requirements to return to Medicare or its Medicare enrollees any profits from its risk contract business that exceed its profit rate on its non-Medicare enrollment. Compared to giving the excess profits to the U.S. Treasury, reducing beneficiary premiums has obvious advantages for the HMO.

These changes would also tend to reduce the volatility of the AAPCC over time and consequently increase HMO participation in the risk contract program.¹⁷

HCFA PLANS TESTS OF
HMO PAYMENT REFORMS

HCFA is planning to conduct demonstration projects to examine several proposals for modifying or replacing the current method of determining payment rates to HMOs. Early results from some demonstrations could emerge during fiscal year 1996, but we believe that a thorough assessment of the demonstrations is, at best, several years away. The projects are at various stages, from solicitation of proposals from private contractors to implementation of the demonstration. Table 1 summarizes information about the demonstration projects.

¹⁷Annual Report to Congress 1995, Physician Payment Review Commission (Washington, D.C.: 1995).

Table 1: Ongoing and Planned HCFA Demonstration Projects Under the Risk Contract Program

Project	Objective	Status
Amend current prospective risk adjustment methodology by introducing outlier pools. (This retrospective approach entails giving HMOs additional payments for very high cost beneficiaries or "outliers.")	Supplement current risk adjustment of rates to further reduce incentive of plans to avoid high-cost beneficiaries.	Demonstration about to enter implementation phase.
Medicare Choices project: offers flexibility in contracting requirements and payment methods for health plans and other organized delivery systems seeking to participate in the Medicare program.	Test receptivity of beneficiaries and evaluate suitability for Medicare of delivery system innovations such as preferred provider organizations, open-ended HMOs, point-of-service plans, integrated delivery systems, and primary care case management systems.	Solicitations of proposals planned for summer 1995.
Use competitive bidding as a means to set rates, combined with a coordinated open enrollment process. (Beneficiaries select an HMO or fee-for-service option during a single open season, perhaps once a year, rather than throughout the year.)	Introduce competitive market forces into HMO rate setting and examine the advantages of coordinating the enrollment process.	Proposals now being solicited; demonstration likely in 1996.
Research on the risk adjustment potential of two health status measures (versions of ACGs and DCGs).	Reduce potential for favorable or adverse selection of beneficiaries.	Demonstration anticipated to begin in 1996.

While hopeful that these demonstrations will provide valuable information on alternative payment approaches, HCFA officials believe that the design and results for some projects could be improved if the legislative authority to conduct demonstrations were clearer. Specifically, HCFA's current authority was created in 1967 and modified in 1972. However, even as modified, the authority does not explicitly discuss Medicare managed care options. As a result, the authority lacks sufficient clarity concerning HCFA's ability to, for example, mandate that HMOs remaining in the Medicare program participate in a demonstration. If the authority is not clear, then the project can be subject to litigation, which can delay or terminate a project, or interfere with achieving quality results. Even the prospect of litigation can inspire compromises in project design that reduce the scope or quality of project results. Because the lack of clear legislative authority to conduct such projects could limit or otherwise affect demonstration project results, HCFA's research efforts would clearly benefit from a clarification of its legislative authority.

In our view, these demonstration projects are steps in the right direction. 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--HCFA could immediately take other steps 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,
- 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 be to 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 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 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.

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, Mar. 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, Mar. 8, 1985).

Enrollment in Medicare Risk Contract HMOs by State

State	Number of Medicare beneficiaries enrolled in a risk HMO, Dec., 1994	Percent of Medicare beneficiaries enrolled in a risk HMO, Dec., 1994	Percent growth in risk HMO enrollment rate (Dec., 1993 - Dec., 1994)
California	929,849	26.30	27.87
Florida	366,003	14.30	13.38
Arizona	151,162	26.00	15.50
New York	103,427	4.00	27.99
Oregon	93,248	20.40	10.32
Texas	82,103	4.10	51.13
Washington	80,669	12.10	14.21
Illinois	66,449	4.20	11.25
Minnesota	60,770	9.90	-1.68
Pennsylvania	55,455	2.70	77.13
Colorado	49,175	12.00	17.90
Massachusetts	42,019	4.60	31.26
Hawaii	40,886	28.20	6.03
Nevada	35,514	19.40	23.24
New Mexico	27,569	13.50	48.49
Ohio	19,790	1.20	12.72
Oklahoma	12,663	2.70	26.08
Missouri	11,606	1.40	4.27
Rhode Island	8,328	5.10	-16.37
Michigan	7,335	0.60	-0.03
New Jersey	6,785	0.60	224.84
Kansas	6,526	1.70	4.64
Indiana	3,568	0.40	8.65
Nebraska	2,980	1.20	-2.04
Kentucky	2,466	0.40	2.94
Louisiana	2,416	0.40	1,419.38
Virginia	1,938	0.20	215.17

APPENDIX II

APPENDIX II

Alabama	1,838	0.30	675.15
Maryland	1,592	0.30	61.59
Wisconsin	664	0.10	0.38
Connecticut	640	0.10	35.96
Georgia	618	0.10	-3.26
Iowa	546	0.10	8.61
North Carolina	471	0.00	13.21
South Carolina	412	0.10	21.70
Utah	327	0.20	6.37
Tennessee	301	0.00	4.22
Arkansas	296	0.10	10.95
Idaho	258	0.20	4.18
New Hampshire	248	0.20	12.75
Montana	174	0.10	-5.44
Dist. of Columbia	148	0.20	543.76
Maine	147	0.10	11.41
Delaware	137	0.10	166.54
Mississippi	113	0.00	-17.87
Wyoming	112	0.20	6.60
West Virginia	83	0.00	1.04
North Dakota	78	0.10	18.74
South Dakota	68	0.10	-6.82
Alaska	62	0.20	17.49
Vermont	62	0.10	8.09
U.S. Totals	2,280,403	6.3	22.8

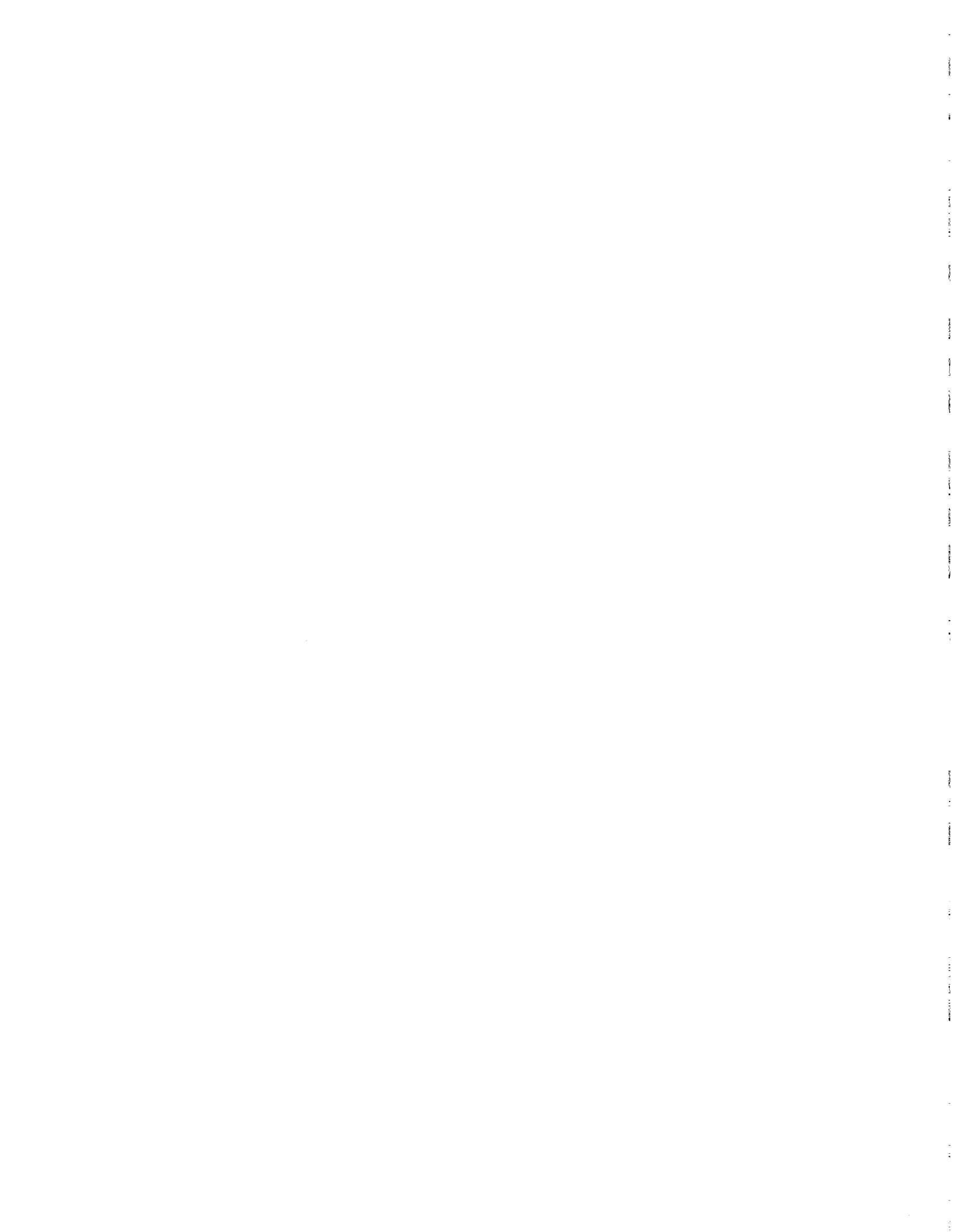
Enrollment in Medicare Risk Contract HMOs by SMSA (Top 100 SMSAs ranked by
number of Medicare Enrollees)

SMSA	Number of beneficiaries enrolled in a risk HMO, Dec., 1994	Percent of beneficiaries enrolled in a risk HMO, Dec., 1994	Percent growth in risk HMO enrollment rate (Dec., 1993- Dec., 1994)
Los Angeles-Long-Beach, Cal.	299,784	32.59	11.11
Riverside-San Bernadino, Cal.	154,510	47.50	8.54
San Diego, Cal.	125,901	41.50	12.04
Phoenix-Mesa, Ariz.	104,440	30.89	12.97
Orange County, Cal.	93,312	37.31	11.40
Fort Lauderdale, Fla.	85,216	33.86	8.05
Miami, Fla.	83,622	29.69	9.95
Portland-Vancouver, Ore.-Wash.	83,161	40.08	6.86
Tampa-St. Petersburg- Clearwater, Fla.	68,221	15.10	12.57
Chicago, Ill.	66,105	7.17	11.18
Minneapolis-St. Paul, Minn.- Wis.	60,049	20.70	-2.30
New York-Newark, N.Y.-N.J.-Pa.	59,517	5.23	34.91
West Palm Beach-Boca Raton, Fla.	54,344	24.53	10.61
Seattle-Bellevue-Everett, Wash.	52,984	21.39	10.01
Philadelphia, Pa.-N.J.	49,986	6.86	69.48
San Francisco, Cal.	49,651	21.39	64.94
Denver, Colo.	43,647	23.40	32.69
Boston-Brockton-Nashua, Mass.- N.H.	41,851	5.04	30.95
Tucson, Ariz.	41,123	37.32	14.46
San Antonio, Tex.	37,672	22.75	17.30
Oakland, Cal.	37,523	14.79	219.94
Las Vegas, Nev.-Ariz.	35,622	24.13	21.89
Sacramento, Cal.	32,004	17.90	290.91
Daytona Beach, Fla.	31,018	29.89	6.16
Honolulu, Hawaii	29,096	27.42	3.98

Nassau-Suffolk, N.Y.	28,900	7.51	25.36
San Jose, Cal.	27,383	18.48	157.95
Orlando, Fla.	25,970	13.64	14.87
Houston, Tex.	25,312	8.80	210.96
Albuquerque, N.M.	24,950	31.82	39.43
Ventura, Cal.	23,906	32.63	20.03
Bakersfield, Cal.	20,690	30.77	19.90
Cleveland-Lorain-Flyria, Ohio	16,527	4.71	10.30
Kansas City, Mo.-Kans.	13,759	6.54	1.74
Santa Barbara-Santa Maria-Lompo, Cal.	13,083	26.03	48.42
Modesto, Cal.	11,354	23.18	575.25
Santa Rosa, Cal.	9,427	15.99	405.91
Jacksonville, Fla.	8,898	7.39	1,523.71
Providence-Warwick, R.I.	8,328	5.05	-16.45
Salem, Ore.	8,310	17.53	10.54
Rochester, N.Y.	8,134	5.27	6.83
Tulsa, Okla.	7,823	8.09	24.95
San Luis Obispo-Atascadero-Paso, Cal.	7,816	22.26	420.68
Buffalo-Niagara Falls, N.Y.	6,020	2.96	12.81
Fresno, Cal.	5,935	6.08	696.43
Dallas, Tex.	5,756	2.20	42.84
Corpus Christi, Tex.	4,672	10.75	-9.91
Oklahoma City, Okla.	4,544	3.74	26.33
Vallejo-Fairfield-Napa, Cal.	4,080	7.69	899.13
Lansing-East Lansing, Mich.	3,623	7.65	-2.88
Tacoma, Wash.	3,582	4.95	12.11
Boulder-Longmont, Colo.	3,556	15.53	10.54
Fort Worth-Arlington, Tex.	3,421	2.38	37.26
Omaha, Nebr.-Ia.	3,229	4.05	-2.29
Olympia, Wash.	3,176	13.67	6.37
Chico-Paradise, Cal.	3,033	8.62	58.48

Detroit, Mich.	2,997	0.51	3.66
Eugene-Springfield, Ore.	2,682	6.00	392.17
Louisville, Ky.-Ind.	2,669	1.86	1.92
Austin-San Marcos, Tex.	2,517	3.06	127.07
Pittsburgh, Pa.	2,405	0.54	111.32
Scranton-Wilkes-Barre-Hazleton, Pa.	2,302	1.74	5,637.94
Stockton-Lodi, Cal.	2,261	3.66	496.32
Indianapolis, Ind.	2,221	1.20	7.39
Medford-Ashland, Ore.	2,126	7.42	1,861.33
Wichita, Kans.	2,096	3.16	-11.12
Akron, Ohio	1,841	1.88	7.53
St. Louis, Mo.-Ill.	1,831	0.50	56.05
Ocala, Fla.	1,652	2.89	707.63
Birmingham, Ala.	1,607	1.25	4,168.92
Bremerton, Wash.	1,599	6.88	11.10
New Orleans, La.	1,593	0.95	2,643.68
Santa Fe, N.M.	1,591	11.19	745.50
Yolo, Cal.	1,438	9.16	249.76
Norfolk-Virginia Beach-Newport, Va.	1,353	0.86	231.25
Gainesville, Fla.	1,221	5.39	592.90
Allentown-Bethlehem-Easton, Pa.	1,149	1.10	45.20
Santa Cruz-Watsonville, Cal.	1,095	3.93	948.90
Baltimore, Md.	1,076	0.34	28.71
Washington, D.C., Md., Va., W.Va.	1,057	0.26	370.33
Bergen-Passaic, N.J.	1,015	0.51	161.03
Monmouth-Ocean, N.J.	1,008	0.54	80.84
Galveston-Texas City, Tex.	989	3.59	201.80
Spokane, Wash.	972	1.75	316.86
Sarasota-Bradenton, Fla.	958	0.63	230.39
Colorado Springs, Colo.	915	2.13	-60.03
Salinas, Cal.	717	1.84	619.39

Yuba City, Cal.	666	3.88	119.57
Baton Rouge, La.	619	1.07	5,394.31
Bellingham, Wash.	589	3.20	20.45
Toledo, Ohio	544	0.63	260.46
Newark, N.J.	527	0.20	142.64
Fort Pierce-Port St. Lucie, Fla.	492	0.75	6.95
Merced, Cal.	460	2.48	340.32
Atlantic-Cape May, N.J.	432	0.76	408.50
Gary, Ind.	406	0.48	72.34
Middlesex-Somerset-Hunterdon, N.J.	392	0.30	67.33
Trenton, N.J.	375	0.75	931.23
Cincinnati, Ohio-Ky.-Ind.	347	0.16	160.14
Lakeland-Winter Haven, Fla.	344	0.42	13.04
Top 100 SMSAs	2,222,702	12.0	22.7
U.S. Totals	2,280,403	6.3	22.8



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