

# CBO TESTIMONY

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Statement of  
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on  
Medicare's Policies for  
Health Maintenance Organizations

before the  
Subcommittee on Health  
Committee on Ways and Means  
U.S. House of Representatives

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This statement is not available for public release until it is delivered at 9:00 a.m. (EST), Tuesday, February 25, 1997.



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Mr. Chairman and Members of the Committee, thank you for inviting me to discuss the role of health maintenance organizations (HMOs) in Medicare. Although the Congressional Budget Office (CBO) has recently reduced its projections of spending for Medicare, the program's costs are still growing at rates that contribute substantially to the deficit in the short term and are unsustainable in the long run. At the same time, CBO projects that enrollment in Medicare HMOs will continue to increase substantially. Those two projections naturally prompt the question: can risk-based health plans become the foundation for a sustainable Medicare program?

#### PROJECTIONS OF MEDICARE SPENDING

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CBO projects that spending for Medicare—primarily for medical benefits—will increase from \$194 billion in 1996 to \$317 billion in 2002 and \$469 billion by 2007, an average annual increase of more than 8 percent. Although growth in Medicare has slowed since the late 1980s and early 1990s, it will continue to outpace the growth in resources that finance the program (see Table 1). CBO projects that federal revenues will grow by only 5 percent a year—about the same rate as the economy.

TABLE 1. PROJECTIONS OF MEDICARE OUTLAYS (By fiscal year, in billions of dollars)

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Average Annual Rate of Growth, 1996-2007 (Percent)
Hospital Insurance <sup>a</sup>	125	137	149	161	176	184	202	218	235	259	275	290	7.9
Supplementary Medical Insurance <sup>a</sup>	<u>69</u>	<u>75</u>	<u>82</u>	<u>90</u>	<u>100</u>	<u>105</u>	<u>116</u>	<u>126</u>	<u>138</u>	<u>155</u>	<u>167</u>	<u>179</u>	9.1
Gross Medicare Outlays <sup>a</sup>	194	212	230	251	276	289	317	343	372	414	442	469	8.3
Premium Receipts	<u>-20</u>	<u>-20</u>	<u>-21</u>	<u>-22</u>	<u>-23</u>	<u>-24</u>	<u>-26</u>	<u>-27</u>	<u>-28</u>	<u>-29</u>	<u>-31</u>	<u>-32</u>	4.4
Net Medicare Outlays <sup>a</sup>	174	192	209	229	253	265	292	316	344	385	411	436	8.7

SOURCE: Congressional Budget Office.

NOTE: Numbers may not add to totals because of rounding.

a. Includes benefit payments and mandatory and discretionary administrative expenses.

Outlays for Hospital Insurance (HI) benefits will increase more rapidly than payroll tax revenues, depleting the HI trust fund by the end of 2001 (see Table 2). Moreover, because premiums for the Supplementary Medical Insurance (SMI) program may increase by no more than the Social Security cost-of-living adjustment after 1998, the share of costs covered by premiums will continue to shrink.

CBO's projections assume that the number of Medicare beneficiaries enrolled in HMOs will grow rapidly. Although most beneficiaries remain in the traditional fee-for-service plan, enrollment in risk-based HMOs jumped from 7 percent of the total in 1995 to 11 percent in early 1997. CBO projects that the fraction of beneficiaries in such plans will approach 25 percent by 2002 and 35 percent by 2007. With growth in overall enrollment in Medicare rising very slowly over that period, the number of beneficiaries in Medicare's fee-for-service sector will decline in absolute terms (see Figure 1).

Several factors drive the strong growth in enrollment in risk-based plans that CBO projects over the next decade. First, because of the rapid shift in enrollment from fee-for-service to managed care plans in the private sector, an increasing proportion of people becoming eligible for Medicare at age 65 will

TABLE 2. BASELINE PROJECTIONS OF THE MEDICARE HOSPITAL INSURANCE TRUST FUND  
(By fiscal year, in billions of dollars)

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Outgo	125	137	149	161	177	184	202	217	235	259	275	290
Income												
Payroll taxes <sup>a</sup>	111	118	122	129	135	142	148	156	163	171	180	189
Interest	<u>10</u>	<u>10</u>	<u>9</u>	<u>7</u>	<u>5</u>	<u>2</u>	<u>-1</u>	<u>-5</u>	<u>-9</u>	<u>-15</u>	<u>-21</u>	<u>-29</u>
Total	121	128	131	136	140	144	147	151	154	156	158	160
Deficit	-4	-10	-18	-25	-36	-41	-54	-67	-81	-103	-117	-130
Fund Balance <sup>b</sup>	125	116	98	73	36	-4	-59	-126	-207	-310	-426	-556

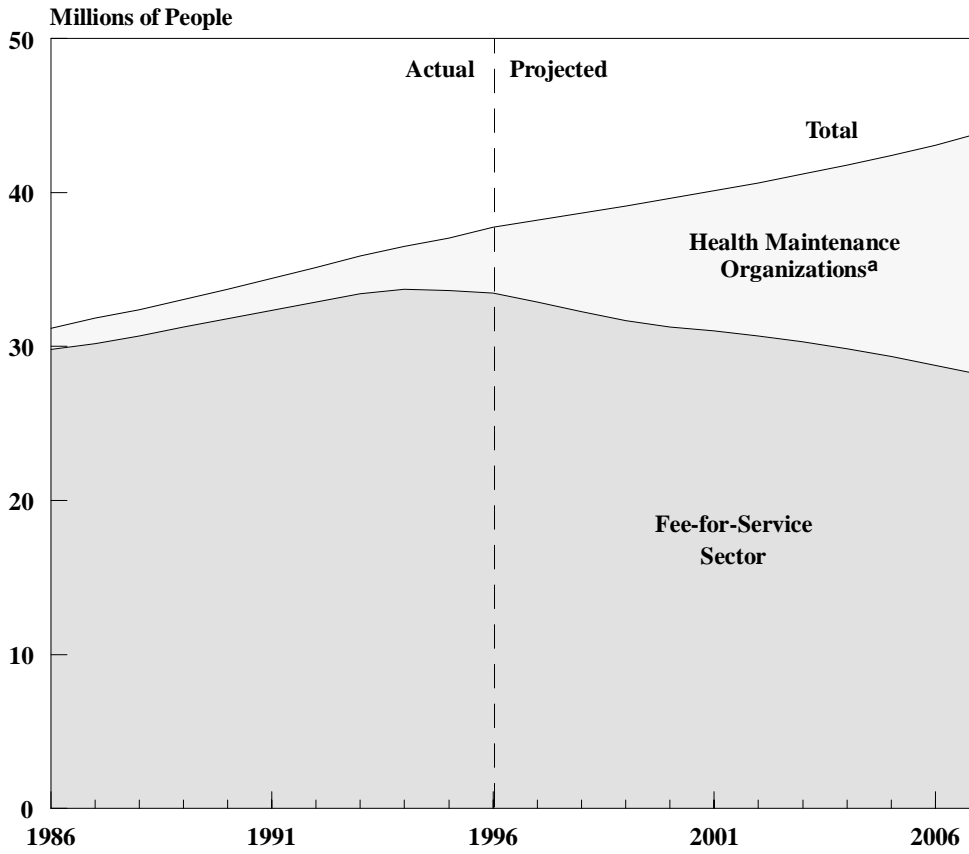
SOURCE: Congressional Budget Office.

NOTE: Numbers may not add to totals because of rounding.

a. Includes a small amount of premiums and other noninterest income.

b. At the end of the fiscal year.

FIGURE 1. MEDICARE ENROLLMENT (By calendar year)



SOURCE: Congressional Budget Office.

a. Includes risk-based plans, other health maintenance organizations, certain demonstrations, and health care prepayment plans.

already be HMO members. Second, rising premiums for Medigap coverage in the fee-for-service sector will make HMO enrollment relatively more attractive. Third, many employers are dropping or reducing the generosity of health insurance coverage for retirees.

#### MEDICARE'S PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS

As a result of the rapid increase in HMO enrollment, payments to managed care plans are the fastest growing element of Medicare spending. CBO projects that such payments will increase from \$18 billion in 1996 to \$73 billion in 2002—a 26 percent average annual rate of growth. In contrast to the private sector, however, where the increasing importance of HMOs and other health care plans has helped to slow the growth in health insurance premiums dramatically, under current Medicare payment policies the program incurs no financial benefit from higher HMO enrollment. In fact, the available evidence suggests that the growth in HMO enrollment actually works to Medicare's disadvantage.

## Current Medicare Payment Policies

Medicare's current payment system for risk-based managed care plans is, by design, unrelated to their cost of doing business. Medicare pays risk-based HMOs 95 percent of the adjusted average per capita cost (AAPCC) for each beneficiary. The AAPCC is an estimate of what a similar beneficiary in the fee-for-service sector in the same county would cost the program. That payment mechanism was intended to allow Medicare to claim some of the savings expected from the more efficient practices of HMOs, while permitting any additional savings to be shared between the HMO and its Medicare enrollees.

## Risk Selection

The calculation of the AAPCC takes into account a number of characteristics of beneficiaries that influence Medicare's costs: their age, sex, institutional status, Medicaid eligibility, disability status, and whether they have primary health insurance coverage through an employer. Those adjustments for health risk are crude, however, and result in overpayments.



Numerous studies suggest that Medicare's payment formula does not adequately adjust for differences in health status between HMO enrollees and fee-for-service beneficiaries. The Physician Payment Review Commission, for example, has estimated that new HMO enrollees incur below-average Medicare costs in the six months prior to their enrollment and that beneficiaries disenrolling from HMOs have above-average costs in their first six months back in the fee-for-service sector.

The consensus of the literature is that Medicare pays about 5 percent more on behalf of HMO enrollees than it would have paid if they had remained in the fee-for-service sector. One should note, however, that the available analyses are all based on a period when very few Medicare beneficiaries were enrolled in HMOs. The extent of Medicare's overpayment would decline in the future if HMO enrollment becomes more representative of the entire Medicare population.

## Regional Variations

Medicare's current payment system also results in large differences in payment rates among the nation's counties. The ratio of the highest AAPCC to the lowest is currently more than 3 to 1. Even adjusting for regional differences in input costs, that ratio is 1½ to 1.

The variation in price-adjusted payment rates stems from regional differences in patterns of medical practice in Medicare's fee-for-service sector, as well as from differences in the health status of fee-for-service beneficiaries. Regional variation in payment rates contributes to differences in the benefits that HMOs offer to Medicare beneficiaries. HMOs in counties with a high payment rate are able to offer more generous benefits to enrollees than HMOs in counties with a low payment rate. Regional differences in benefits in turn contribute to regional differences in rates of enrollment in HMOs.

## ACHIEVING SAVINGS FROM RISK-BASED PLANS

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How can Medicare's HMO program be changed to achieve budgetary savings in the short term and help assure Medicare's survival in the longer run? The shift in enrollment toward risk-based HMOs will not slow Medicare spending unless the program can retain some of the savings possible from managed care plans. In the short run, that result could be achieved in a couple of ways.

The simplest alternative would reduce Medicare's payment rate from 95 percent of fee-for-service costs to some lower percentage. That approach would save money for Medicare. However, it would also diminish the attractiveness of HMOs to beneficiaries, because HMOs would be less able to offer their current array of additional benefits. Yet in markets in which both the payment rate and enrollment in HMOs are high, those effects are likely to be small.

Another way of achieving savings is to break the link between payments to HMOs and costs in the fee-for-service sector. As fee-for-service enrollment shrinks, it makes less sense to base updates to HMO payments on fee-for-service spending in an area. One option is to set the rate of growth of

risk-based payments so that it equals an external factor, such as the rate of growth of the economy. Lower updates would achieve savings for Medicare, but they would also slow the growth in HMO enrollment.

In the longer run, a market-based strategy offers the most promising approach to slowing the growth of Medicare spending. Such a strategy would be based on a more competitive Medicare market and a defined contribution from the federal government. Although a complete restructuring of Medicare could require years to achieve, practical steps to begin that process could be adopted now. In particular, taking steps to make risk-based plans more widely available to beneficiaries would be conducive to long-term reform, even though those steps would not reduce Medicare spending in the short run.

One easy step would be to overhaul Medicare's enrollment procedures. Although beneficiaries are currently given a list of risk-based plans in their area, no single, reliable source of information compares the features of those plans. Moreover, most beneficiaries are automatically enrolled in fee-for-service Medicare on first gaining eligibility. Instead, Medicare could institute a coordinated open-enrollment process—similar to that of the Federal Employees Health Benefits Program—in which beneficiaries could select from

all health plans operating in their area. Beneficiaries would receive uniform information on all plans regarding benefits, costs, and access to providers.

Another possibility would be to reduce the wide disparities in Medicare payments among counties. That move would provide an incentive for risk-based plans to serve areas that now have low payment rates. At the same time, reducing payment rates in some high-cost areas could bring payments more into line with the costs that plans in those areas incur in covering Medicare services.

A third idea would be to expand the array of risk-based plans to include a larger range of managed care and private fee-for-service options. Beneficiaries would be better able to find plans that suited their needs if the range of options was expanded, although doing so would also increase the possibilities for favorable selection. Offering a wider variety of plans could also raise a number of regulatory issues, such as solvency requirements, standards for quality of care, and antitrust considerations.

## THE ADMINISTRATION'S PROPOSAL

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The Administration's proposal for Medicare managed care plans incorporates several of the foregoing ideas. The Administration would continue to update HMO rates based on changes in fee-for-service spending. However, it would change how those rates are calculated, and it would encourage additional HMO enrollment by expanding the type of plans eligible to participate and changing the regulations governing Medigap insurance.

### Payments to Health Maintenance Organizations

The Administration's proposal would modify payments to HMOs in a number of ways. Specifically, it would:

- o Reduce the percentage of the AAPCCs paid to plans from 95 percent to 90 percent starting in 2000.
  
- o Phase in a reduction in the AAPCCs to reflect payments for disproportionate share (DSH) hospitals and graduate medical education.

Removing those so-called special payments from the AAPCCs would reduce payment rates by about 5 percent. Those funds would be returned directly to teaching and DSH hospitals based on the number of HMO enrollees they served.

- o Narrow the gap between high- and low-AAPCC counties by phasing in a blend of 70 percent local and 30 percent national rates by 2002, and by setting a minimum AAPCC of \$350 per month.
- o Ensure that no county's AAPCC in 1998 and 1999 is reduced from its 1997 level. The proposal includes a computation for budget neutrality intended to ensure that this provision and the \$350 floor on the AAPCCs would not increase HMO payments overall.
- o Guarantee that the AAPCCs would be updated by a minimum 2 percent a year beginning in 2000.

## Measures to Encourage Enrollment in Health Maintenance Organizations

The Administration's proposal also contains several features intended to make HMO enrollment more attractive to beneficiaries. It would:

- o Allow contracting with additional types of plans, including preferred provider organizations and provider-sponsored networks.
- o Coordinate changes in HMO enrollment status through third-party brokers, provide beneficiaries with standardized comparative materials about eligible plans and Medigap policies, and establish an annual open-enrollment period.
- o Guarantee that Medigap coverage would be available at community rates for beneficiaries choosing to disenroll from a Medicare HMO.



## Impact of the Administration's Proposal

The Administration is still working out the details of some of its proposals, and CBO's analysis of the budget is not yet complete. However, we have reached some tentative conclusions about the effects of the Administration's plan.

CBO estimates that the Administration's proposal would not significantly increase or decrease enrollment in managed care plans. Reducing disparities between high- and low-cost areas, using a coordinated enrollment period, and contracting with additional types of plans would tend to expand the managed care program. But enhancing the benefits package in fee-for-service Medicare and reducing HMO payments relative to those in the fee-for-service sector would lead to lower enrollment in managed care plans.

The guarantee of Medigap coverage on disenrollment raises more complex issues. Such a guarantee could encourage HMO enrollment by easing beneficiaries' worries that they might be locked into a plan they did not like. But it would encourage the disenrollment of sicker beneficiaries from HMOs, compounding selection problems and causing Medigap premiums to increase.

CBO is currently estimating the effects of the Administration's proposals on Medicare spending. The estimate of managed care savings depends on both managed care and fee-for-service policies. We anticipate, however, that our estimate of savings in payments to managed care plans will fall short of the \$34 billion that the Administration projects.