



Testimony

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MEDICARE HMOs

HCFA Could Promptly Reduce Excess Payments by Improving Accuracy of County Payment Rates

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Medicare HMOs: HCFA Could Promptly Reduce Excess Payments by Improving Accuracy of County Payment Rates

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the rates Medicare pays health maintenance organizations (HMO) in its risk contract program, Medicare's principal managed care option.¹ As you know, Medicare's method for paying risk contract HMOs was designed to save the program 5 percent of the costs for beneficiaries who enroll in HMOs. However, 10 years of research on Medicare's costs under HMOs has found that the program's rate-setting method results in excess payments to HMOs because HMO enrollees would have cost Medicare less if they had stayed in the fee-for-service sector.² Recently, the Physician Payment Review Commission (PPRC) estimated that annual excess payments to HMOs nationwide could total \$2 billion.³

A number of proposals have been made recently to help alleviate Medicare's HMO payment problems. For example, the proposed Balanced Budget Act of 1995 called for, among other things, mechanisms to lessen rate disparities across geographic areas and to decouple annual HMO rate increases from annual fee-for-service spending increases. The administration's current budget proposal adopts several provisions from the proposed Balanced Budget Act but also adds new twists—such as an across-the-board reduction in Medicare's HMO payments that would lower the payments from 95 percent to 90 percent of estimated fee-for-service costs. Under the auspices of the Health Care Financing Administration (HCFA), which administers the Medicare program, several demonstration projects are planned or under way, including efforts to improve risk adjustment and using a process of competitive bidding to set rates.

At the request of the Chairman, Subcommittee on Health, House Committee on Ways and Means, we reviewed HCFA's method for setting HMO rates to identify feasible options for promptly reducing the amount of excess payments. A comprehensive discussion of our work is included in a forthcoming report. In conducting our study, we reviewed previous research on Medicare's HMO rate-setting method; analyzed available HCFA data; and had our findings reviewed by experts on HMO payment issues, including staff at PPRC and HCFA.

¹Other Medicare managed care plans include cost contract HMOs and health care prepayment plans, which together enroll fewer than 2 percent of the total Medicare population. Because Medicare pays these plans using methods other than capitation rates, they are not the subject of this statement.

²See the attached list of related GAO products.

³This estimate was contained in material presented to the Commissioners for their December 12-13, 1996, meeting.

Today, I would like to focus my comments on our proposed modification to HCFA's HMO rate-setting method. We believe this modification could help reduce excess HMO payments under Medicare's current payment method, the administration's method, or other methods that rely on fee-for-service costs to set initial HMO rates or update those rates. Central to the current method and proposals for setting HMO rates is an estimate of the average cost of serving Medicare beneficiaries under fee-for-service in defined geographic areas (currently, counties). The actual rates paid HMOs for an enrollee are set by adjusting these averages up or down on the basis of the enrollee's "risk" of incurring higher or lower costs. Considerable attention has focused on the failure of current risk adjustment methodology to adequately account for favorable selection, the term used to describe the tendency of HMOs to attract a population of Medicare seniors whose health costs are generally lower than those of the average beneficiary. Our work centers on the estimate of average cost of serving a county's beneficiaries: the county rate.

In summary, we found that HCFA's current method of determining the county rate produces excess payments. Because HCFA's method excludes HMO enrollees' costs from estimates of the per-beneficiary average cost, it bases county payment rates on the average per-beneficiary cost of only those beneficiaries that remain in the fee-for-service sector and ignores the costs HMO enrollees would have incurred if they had remained in fee-for-service. Research has shown the costs of those remaining in fee-for-service to be higher on average than the likely costs of HMO enrollees. A difficulty in correcting the problem is that HCFA cannot directly observe the costs HMO enrollees would have incurred if they had remained in the fee-for-service sector. Our proposed modification is designed to fix that problem. We developed a way to estimate HMO enrollees' expected fee-for-service costs using information available to HCFA. Our approach produces a county rate that represents the costs of all Medicare beneficiaries and could result in hundreds of millions of dollars in savings to Medicare.

How Medicare Determines an HMO's Payment Rate

Essentially, HCFA's calculation of its per-enrollee (capitation) rate can be expressed as follows:

**Capitation rate = average per-beneficiary cost x .95 x
risk adjustment factor**

Medicare pays risk HMOs a fixed amount per enrollee—a capitation rate—regardless of what each enrollee’s care actually costs. Medicare law stipulates that the capitation rate be set at 95 percent of the costs Medicare would have incurred for HMO enrollees if they had remained in fee-for-service.⁴ In implementing the law’s rate-setting provisions, HCFA estimates a county’s average per-beneficiary cost and multiplies the result by 0.95.⁵ The product is the county adjusted average per capita cost rate.⁶

HCFA then applies a risk-adjustment factor to the county rate. Under HCFA’s risk-adjustment system, beneficiaries are sorted into groups according to their demographic traits (age; sex; and Medicaid, institutional, and working status). HCFA calculates a risk factor for each group—the group’s average cost in relation to the cost of all beneficiaries nationwide. For example, in 1995 the risk factor for younger seniors (65- to 70-year-old males) was .85, whereas for older seniors (85-year-old or older males) it was 1.3. HCFA uses the risk factor to adjust the county rate, thereby raising or lowering Medicare’s per capita payment for each HMO enrollee, depending on the individual’s demographic characteristics.

Medicare’s HMO Rate-Setting Method Has Led to Excess Payments

One reason the HMO rate-setting method overstates the expected fee-for-service costs of HMO enrollees is that it uses only the cost experience of fee-for-service beneficiaries. If the health status of the mix of beneficiaries enrolled by HMOs were the same as the health status of those in fee-for-service, using fee-for-service beneficiaries to estimate the expected fee-for-service costs of HMO enrollees would be an appropriate method. However, because research has shown that HMOs have in general attracted healthier-than-average beneficiaries, the beneficiaries remaining in fee-for-service represent a sicker-than-average population.⁷ This, in turn, means that using data on fee-for-service beneficiaries exclusively produces HMO payment rates higher than envisioned when the current rate setting provisions were enacted.

⁴Section 1876(a)(4) of the Social Security Act (42 U.S.C. 1395mm(a)(4) (1994)).

⁵A 5-percent discount is taken on the premise that, compared with fee-for-service care, managed care plans achieve certain efficiencies. For example, HMOs can negotiate with hospitals, physicians, and other providers to obtain discounts on services and supplies.

⁶Medicare determines four capitation rates for each county, one each for part A aged, part B aged, part A disabled, and part B disabled.

⁷HCFA’s Health Care Financing Review, a 1996 study using postdisenrollment data, estimated that HMO enrollees’ costs were 12 percent lower than average, while a 1996 PPRC study using preenrollment data estimated that enrollees’ costs were 37 percent lower than for comparable fee-for-service beneficiaries.

Medicare's risk adjustors explain about 3 percent of the variation in individual-level health care costs and are thus not adequate to account for the cost differences among beneficiaries. The difficulty is that, within the same demographic group, HMO enrollees are healthier than fee-for-service beneficiaries; for example, 70-year-old males in HMOs are, on average, healthier than 70-year-old males in fee-for-service. Medicare's risk adjustor is said to be inadequate because, while it makes broad distinctions among beneficiaries of different age, sex, and other demographic characteristics, it does not account for the significant health differences among demographically identical beneficiaries. The cost implications of health status differences can be dramatic—for two demographically alike beneficiaries, one may experience occasional minor ailments while the other may suffer from a serious chronic condition.

Including HMO Enrollees' Costs in County Average Improves Accuracy of County Rates

Independent of improved risk adjustment, modifying the method for calculating the county rate would help reduce Medicare's excess HMO payments. In setting county rates, HCFA currently estimates the average Medicare costs of a county's beneficiaries using the costs of only those beneficiaries in Medicare's fee-for-service sector. This method would be appropriate if the average health cost of fee-for-service beneficiaries were the same as that of demographically comparable HMO enrollees. However, in counties where there are cost disparities between Medicare's fee-for-service and HMO enrollee populations, this method can either overstate the average costs of all Medicare beneficiaries and lead to overpayment or understate average costs and lead to underpayment. Correcting this problem is difficult because it is impossible to observe the costs HMO enrollees would have incurred had they remained in the fee-for-service sector. Therefore, we developed a method to estimate HMO enrollees' expected fee-for-service costs using information available to HCFA. Our method consists of two main steps:

- First, we compute the average cost of demographically similar new HMO enrollees during the year before they enrolled—that is, while they were still in fee-for-service Medicare. These fee-for-service costs are available through HCFA's claims data.
- Next, we adjust this amount to reflect the expectation that a new enrollee's use of health services will, over time, rise.⁸

⁸Our analysis adjusts for (1) the tendency for enrollees' costs to become more like—or “regress” toward—the fee-for-service cost mean after joining an HMO and (2) the costs incurred by HMO enrollees who die while enrolled. How our method accounts for these costs is discussed more thoroughly in our report.

Having completed these steps, we combine the result with an estimate of the average cost of fee-for-service beneficiaries. This new average produces a county rate that reflects the costs of all Medicare beneficiaries.

**Selected 1995 County
Rates Produced
Substantial Excess
Payments**

To illustrate the effect of our approach, we analyzed data for counties with different shares of beneficiaries enrolled in HMOs. We chose counties within a single state to eliminate variations attributable to state differences. We selected California because it covers 36 percent of all Medicare HMO enrollees and includes counties that in 1995 had the nation's highest HMO penetration rates. We found that our method could have reduced excess payments by more than 25 percent. Although better risk adjustors could further reduce the large remainder of excess payments, improvements to risk adjustment require developing direct measures of health status, which is a complex effort that may take years.

The following key points also emerged from our analysis:

- First, for the counties that we analyzed, we estimate that total excess payments in 1995 amounted to about \$1 billion (of about \$6 billion in total Medicare payments to risk HMOs in the state). Applying our method for setting county rates would have reduced the excess by about \$276 million.
- Second, the excess payments attributable to inflated county rates were concentrated in 12 counties with large HMO enrollment and ranged from less than 1 percent to 6.6 percent of the counties' total HMO payments, representing between \$200,000 and \$135.3 million.⁹ Despite the size of these amounts, the application of our method would have produced relatively small changes in the monthly, per-beneficiary capitation payments, ranging from \$3 to \$38.
- Third, our analysis did not support the hypothesis, put forward by the HMO industry and others, that the excess payment problem will be mitigated as more beneficiaries enroll in Medicare managed care and HMOs progressively enroll a more expensive mix of beneficiaries. Our data—which include counties with up to a 39-percent HMO penetration—indicated that the disparity between Medicare rates and our rates is larger in counties with higher Medicare penetration. For example, the four counties with the highest rates of excess payment in 1995, ranging from 5.1 to 6.6 percent, were also among the counties with the highest enrollment rates.

⁹For the state's remaining 46 counties, excess payments attributable to inflated county rates amounted to less than 3 percent of the 58-county total.

Data Are Available to Enable HCFA to Promptly Adjust County Rates

Because the data we used to estimate HMO enrollees' costs come from data that HCFA compiles to update HMO rates each year, our method has two important advantages. First, HCFA's implementation of our proposal could be achieved in a relatively short time. The time element is important, because the prompt implementation of our method would avoid locking in a current methodological flaw that would persist in any adopted changes to Medicare's HMO payment method that continued to use current county rates as a baseline or fee-for-service costs to set future rates. Second, the availability of the data would also make our proposal economical: we believe that the savings to be achieved from reducing county-rate excess payments would be much greater than the administrative costs of implementing the process.

Conclusions

Medicare's HMO rate-setting problems have prevented it from realizing the savings that were anticipated from enrolling beneficiaries in capitated managed care plans. In fact, enrolling more beneficiaries in managed care could increase rather than lower Medicare spending—unless Medicare's method of setting HMO rates is revised. Our method of calculating the county rate would have the effect of reducing payments more for HMOs in counties with higher excess payments and less for HMOs in counties with lower excess payments. In this way, our method represents a targeted approach to reducing excess payments and could lower Medicare expenditures by at least several hundred million dollars each year.

Furthermore, our approach is useful under several possible scenarios, including whether (1) the Congress adopts any proposal that uses current county rates as a baseline, (2) HCFA develops and adopts improved risk adjusters, or (3) the Congress and HCFA take no action, thus preserving Medicare's current rate-setting process.

Mr. Chairman, this concludes my prepared statement. I would be pleased to answer any questions.

Contributors

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Related GAO Products

Medicare HMOs: Rapid Enrollment Growth Concentrated in Selected States
(GAO/HEHS-96-63, Jan. 18, 1996).

Medicare Managed Care: Growing Enrollment Adds Urgency to Fixing HMO
Payment Problem (GAO/HEHS-96-21, Nov. 8, 1995).

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

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