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The Honorable William S. Cohen
Chairman, Special Committee on Aging
United States Senate

Dear Mr. Chairman:

In an attempt to control costs without diminishing access to quality services, public programs such as Medicare and Medicaid are relying more on managed care plans, including health maintenance organizations (HMO), to serve program beneficiaries. You asked us to identify (1) some of the tools managed care plans use to control costs and (2) recent state initiatives that address concerns associated with managed care.

In doing our work, we relied on previously reported information that describes some of the managed care cost-saving tools. We also obtained enacted and proposed laws from 15 states that have recently taken action related to managed care plans. (See enc. I for a further description of our scope and methodology.)

In summary, we found that managed care plans use a variety of tools to control costs, such as shifting some financial risk to providers and requiring plan permission to refer a patient to a specialist. Also, the provision of preventive care has been cited as one of managed care's cost-saving tools. (See enc. II for a description of some of the tools managed care plans use to control utilization and costs.) In response to concerns about patients' access to medical services and reported abuses that have occurred with a few managed care plans,[1] a number of states have supplemented their managed care regulatory programs by enacting laws and regulations governing the operation of managed care

[1]We have ongoing work, to be reported later this year, that addresses available Medicare HMO data that could be used more effectively to indicate the better and poorer performers in a market.

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plans.[2] Recently, for example, Maryland banned the practice of plans withholding a portion of doctors' fees, thereby eliminating the use of "withholds" as a financial incentive for providers to control services. Rhode Island passed a law requiring that only licensed physicians make the final decision to deny care to managed care enrollees. (See enc. III for additional information on state regulatory and legislative activities that address managed care concerns.)

COMMENTS AND OUR EVALUATION

In commenting on a draft of this letter, the American Association of Health Plans (AAHP) characterized the draft as biased against managed care strategies because it cited "concerns" about managed care and identified managed care techniques as being solely focused on controlling costs. We disagree with this characterization. To meet our objectives, our letter establishes a framework for categorizing various state legislative and regulatory actions concerning managed care providers. We did not (nor did we intend to) assess the merits of, or the rationale behind, these actions. Such state actions, however, are normally taken in response to public concerns.

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As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this letter until 30 days after its issue date. At that time, we will send copies to the Secretary of Health and Human Services and other interested parties.

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[2]Other groups have also identified state legislative initiatives. See, for example, Families USA Foundation, HMO Consumers at Risk: States to the Rescue (Washington, D.C.: July 1996).

If you have any questions about the matters discussed in this letter, please call me on (202) 512-7119. Major contributors include Ed Stropko, Associate Director; Barry Tice; Ron Viereck; Tim Bushfield; and Don Walthall.

Sincerely yours,

Sarah F. Jaggar
Director, Health Services Quality
and Public Health Issues

Enclosures - 3

SCOPE AND METHODOLOGY

To identify some of the tools managed care plans use to control costs, we reviewed past GAO reports analyzing managed care operations. We also obtained various studies assessing the use of these tools by managed care plans.

To obtain information on state initiatives addressing concerns associated with managed care, we collected information on state legislative activity in selected states and contacted legislative information offices and state health department officials. We selected states based on recent reports of legislative or regulatory initiatives proposed or taken. We collected examples of proposed and enacted legislation for the following states: Arizona, California, Connecticut, Georgia, Indiana, Louisiana, Maine, Maryland, Massachusetts, New York, North Carolina, Oregon, Rhode Island, Washington, and Wyoming. We also obtained revised Medicaid managed care contract requirements from state officials in Florida and Maryland. In addition, we obtained copies of ballot initiatives in California and Oregon. We did not assess the need for any of the proposed or enacted legislation in any of the states.

We performed our work between June 1995 and July 1996 in accordance with generally accepted government auditing standards.

COMMON COST CONTROL FEATURES OF MANAGED CARE PLANS

In 1995, about 70 percent of the U.S. workers insured through their employers were enrolled in managed care plans, up from 29 percent in 1988. A rapidly growing number of Medicaid beneficiaries are enrolling in managed care plans as states redesign their Medicaid programs. In addition, the enrollment of Medicare beneficiaries in managed care has grown recently in certain markets, and proposed federal legislation would encourage even greater numbers nationwide to join managed care plans serving Medicare beneficiaries.

The term "managed care," lacking a commonly accepted definition, has been used to characterize a wide range of health care plans. As managed care plans have developed, differences among types of plans have become blurred and it has become harder to categorize different plans. Despite the variety of managed care plans, most include the following common cost control features: (1) provider networks, with explicit criteria for selection; (2) alternative payment methods and rates that often shift some financial risk to providers; and (3) utilization controls over hospital and specialist physician services. The cost savings potential of managed care plans depends, in part, on the stringency of these features. Provision of preventive care and the incentive to detect illness early are also often cited as cost-saving factors of managed care.

By combining the financing of health care with its delivery and by changing the way health care providers are paid, managed care is transforming the nation's health care system. Managed care combines the roles of insuring against risk with the actual arranging and delivery of health care. For example, purchasers, such as employers and public programs, pay HMOs a fixed monthly fee for each enrollee regardless of the type or amount of services provided. In return, the HMOs agree to arrange for necessary health care services for the purchasers' enrollees.

Some managed care plans use fixed payments internally to shift some financial risk to providers, thereby giving the providers an incentive to avoid excessive services. These plans typically prepay primary care physicians a flat amount, usually on a monthly basis, for each enrollee. The physician generally receives the same per-enrollee (capitated) payment regardless of the number of services provided. This capped payment creates an incentive for the physician to avoid providing unnecessary services because doing

so can erode the provider's income.[1] Hospital and specialty care are often not covered in the capitation payment received by the primary care physician and, instead, are paid for on a fee-for-service basis. Some managed care plans use fee-for-service reimbursement for all providers but negotiate discounts or establish standardized fees. On the other hand, some plans use salaried physicians who do not increase their earnings by furnishing more services.

Another financial incentive some managed care plans use to control utilization of services involves withhold and bonus arrangements. Under these arrangements, the plan withholds a portion of the physicians' payments to establish a fund for rewarding physicians' performance. Often, the costs of referrals and diagnostic tests above preestablished levels are deducted from the fund, with any remaining funds distributed to the physicians. Other methods used to control costs and the use of services include requiring physicians to obtain the plan's preapproval when ordering expensive services, using primary care physicians to authorize expensive specialist and hospital services, reviewing cases after completion of treatment to identify inappropriate care, educating physicians about cost-effective treatment regimens, reprimanding and possibly terminating the contracts of physicians who exceed plan guidelines, and screening out physician applicants who do not seem to share the plan's goals.

Managed care plans contract with private employers and public payers, such as Medicare, Medicaid, the Civilian Health and Medical Program of the Uniformed Services, the Federal Employees Health Benefits Program, and state and local public employee health plans. Managed care plans are licensed and regulated by the states and must comply with additional federal requirements to participate in a federal health program or become federally qualified. Federal qualifications require HMOs to be fiscally sound and able to assume financial risk for providing care, be experienced in providing health care on a prepaid basis, provide a comprehensive set of health benefits, and operate an approved quality assurance program. Most states have similar requirements for HMOs operating within their boundaries.

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[1]According to AAHP, most capitated systems include mechanisms to shield providers from the financial impact of high-cost cases.

RECENT STATE REGULATORY AND LEGISLATIVE ACTIVITIES ADDRESSING MANAGED CARE CONCERNS

Some states have enacted, or proposed, legislation or regulations addressing concerns about the adequacy of medical care and reported abuses in managed care plans. The concerns generally fall into three categories: (1) the restriction of needed medical care stemming from physicians' financial incentives to control utilization; (2) the restriction of enrollees' choice of providers to only those participating in the plans' networks as well as the controls over referrals to hospitals and specialists; and (3) the loss of Medicaid funds to fraudulent or abusive marketing, enrollment, and patient selection schemes. States are taking a variety of actions that address these concerns, such as banning certain payment methods, requiring plans to give enrollees a greater choice of physicians and access to care, and prohibiting various marketing and enrollment practices.[1]

CONCERN THAT PHYSICIAN PAYMENT METHODS CREATE INCENTIVE TO UNDERSERVE PATIENTS

Physician financial incentive arrangements may be loosely defined as compensation arrangements between a managed care plan and its physicians that are intended to encourage physicians to control the services provided to plan enrollees. Such incentives can take many forms. For example, capitation payments, which shift financial risk to physicians, are sometimes used. Such risk-shifting capitation arrangements can be for primary care only or may also include referral services.

Managed care plans may also have an arrangement whereby physicians receive a bonus when the total cost of referral services (for example, to hospitals or specialists) is less than budgeted for an established period of time. Conversely, physicians may be required to absorb some referral costs that are higher than budgeted; sometimes, a portion of the physicians' compensation is withheld in case of high referral costs. Primary care physicians paid on a fee-for-service basis may also be required to absorb a portion of any deficit in the plan's primary care fund to discourage them from providing too many services.

Although physician financial incentive arrangements may be designed to improve the quality of care by reducing unnecessary or

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[1]Families USA reports that 33 states passed a variety of HMO legislation during the first 6 months of 1996.

inappropriate services, they can also have the potential to reduce quality by causing physicians to withhold from patients beneficial treatment. Like fee-for-service, these arrangements can create a potential conflict between providers' financial interests and patients' medical needs. While fee-for-service can lead to the overprovision of services, managed care physician incentive arrangements can lead physicians to limit services inappropriately. Concerns about tying treatment decisions to financial rewards have been expressed by members of the medical community, consumer advocacy groups, and others. We previously reported on issues surrounding physician financial incentives.[2]

In some states, laws have been enacted or proposed to prohibit or limit the use of physician financial incentive arrangements in managed care plans. The following are examples:

-- A 1995 Maryland law prohibits managed care plans from withholding a portion of a provider's salary or capitation payment.

-- A 1996 Rhode Island law prohibits health plans from making payments directly or indirectly to providers as an inducement to limit services or length of stays. In addition, a 1992 Rhode Island law prohibits plan representatives responsible for deciding appeals from patients who were denied services from receiving bonuses or other financial incentives for upholding denials.

-- A citizen ballot initiative in Oregon would restrict managed care plans' use of capitation payments and other financial incentives that might lead to limiting care.

-- Two ballot initiatives in California would prohibit managed care plans from offering or paying providers bonuses, incentives, or other compensation for denying, withholding, or delaying appropriate health care.

Other state laws have been enacted to help ensure that managed care enrollees are made aware of their physicians' financial incentive arrangements and that physicians are not prevented by plans from disclosing this information. For example, Arizona, Rhode Island, Washington, and Wyoming have laws requiring managed care plans to disclose and describe to enrollees certain incentives or penalties contained in provider payment arrangements that are based on a

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

provider's provision of care. Similar laws have been proposed in other states. In addition, Massachusetts passed a law prohibiting plans from terminating or not renewing a provider's contract because the provider disclosed financial arrangements to patients. Similar laws have been proposed in at least four other states.

CONCERN THAT PLANS RESTRICT CHOICE OF PROVIDERS AND ACCESS TO CARE

Managed care plans may also use methods other than physician financial incentives to control costs and the use of services. These methods include selecting providers to participate in the network who seem to share the plan's cost control goals, and requiring physicians to obtain the plan's preapproval when ordering expensive services such as hospital and specialty care.

Consumer advocates, the medical community, and others have expressed concerns about these controls. Concern has been expressed that a patient's choice of providers may be restricted because of a limited selection available in the number and types of providers participating in a managed care network. There is also concern that controls used by plans to limit the number of patient visits to hospitals and specialists may inappropriately restrict patient access to needed medical care. In addition, concerns have been raised that the threat of contract termination or nonrenewal can be used to influence and restrict physicians' health care decisions.

Some states have enacted a variety of laws to address such concerns. These laws are intended to help ensure that managed care patients receive access to appropriate medical care. For example, some of these laws provide managed care plan enrollees with a greater choice of and access to providers both within and outside plan networks, limit the influence that plans have over physicians' medical decisions, allow physicians to freely discuss all treatment options with their patients, and protect physicians from having their contracts inappropriately terminated or not renewed so they are not unduly influenced in their decisions about the need for medical care.

According to AAHP, as of April 1996, at least 24 states had laws requiring managed care plans to accept any provider willing to agree and abide by the terms of a plan's contract. Fourteen of these laws were enacted since 1992. The intent of these so-called any-willing-provider laws is to restrict plans from excluding providers from their networks and to provide enrollees with greater freedom of choice. Most laws apply only to certain types of providers--typically pharmacists--but several more recent laws

include physicians and other types of providers. At least 24 states were considering any-willing-provider bills in their 1996 legislative sessions, according to AAHP.

Other state laws have been enacted or proposed to ensure managed care plan enrollees have access to providers outside their plans' networks. For example, New York passed a law in 1995 requiring that plans allow certain enrollees to use nonplan providers, although the enrollees would have to pay higher deductibles and copayments. At least three other states have these so-called point-of-service laws.

Greater enrollee access to providers, including specialists, has been provided by a variety of other types of laws enacted and proposed in some states. California, Indiana, Louisiana, North Carolina, and Washington have laws to ensure that women cannot be denied care by an obstetrician or gynecologist. North Carolina's law allows a woman to see an obstetrician or gynecologist without receiving a referral, and a woman enrolled in a managed care plan in California must be allowed to select an obstetrician or gynecologist as her primary care provider. A statewide citizen initiative in Oregon on the November 1996 ballot would require managed care plans to contract with all types of medical service providers licensed by the state. A more limited Washington bill would require managed care plans to employ and contract with chiropractors and naturopathic physicians.

Some states have also enacted or proposed laws to help ensure that enrollees are not denied necessary medical care because of decisions by plan representatives who are not licensed physicians. For example, Oregon passed a law in 1995 mandating that all managed care plan contracts with providers require licensed doctors to be responsible for all decisions about coverage of medical and mental health services. Rhode Island passed a similar law in 1992. That law requires that only a licensed physician or dentist in the appropriate specialty for the medical condition or treatment under consideration can decide to deny care. Proposed laws and regulations requiring that only qualified medical personnel make decisions to deny care have also been introduced in at least six other states.

Indiana, Rhode Island, and Washington have enacted laws prohibiting managed care plans from including provisions in their physician contracts that prevent the physicians from discussing treatment options with their patients. Similar laws have been proposed in Connecticut, Maine, and New York.

Indiana, Maryland, Massachusetts, Oregon, Rhode Island, and Washington recently enacted laws to protect physicians from losing their managed care contracts or being penalized for communicating fully about patient treatment options or advocating care for their patients. Maryland's law prohibits a plan from terminating or penalizing providers for advocating the interests of their patients in seeking medical care or for filing appeals with a plan on behalf of their patients.

MEDICAID MARKETING AND ENROLLMENT ABUSES HAVE LED TO INCREASED REGULATION

In their Medicaid programs, most states contract with managed care plans to provide health care to at least some of the eligible Medicaid beneficiaries. The capitation payments paid by the states can provide an incentive for plans to enroll Medicaid beneficiaries, and state Medicaid programs have been vulnerable to a variety of fraudulent and abusive marketing and enrollment schemes.

Some plans have illegally collected state Medicaid payments after enrolling people who were ineligible or did not know they had been enrolled. Other types of abuses have included managed care plans or their representatives misrepresenting benefit packages to entice potential enrollees and using high-pressure sales tactics to enroll Medicaid recipients. Some abuses have been more subtle, such as making it difficult for dissatisfied enrollees to disenroll from a plan. The following cases illustrate some of the marketing and enrollment schemes that have been detected:

-- Tennessee's Medicaid managed care program recovered $134,213 in capitation payments from a managed care plan that had enrolled 277 ineligible people. Two plan employees were found guilty of fraud. In addition, Tennessee recovered another $1.8 million from the plan pending an investigation of 4,502 questionable enrollments.

-- In Maryland, marketing representatives for several Medicaid managed care plans bribed state workers to provide them with confidential information so they could identify potential enrollees. The marketing agents used the information to visit the individuals and subject them to aggressive and false marketing tactics. In some instances, marketing agents were unable to enroll the individuals, so they forged their signatures on enrollment applications, submitted the applications to the state, and enrolled the people without their knowledge.

-- Investigations are ongoing in Florida concerning the allegedly fraudulent enrollment of more than 1,200 individuals in a plan that participates in the state's Medicaid managed care program. A marketing company the plan contracted with to enroll Medicaid recipients allegedly obtained the names and addresses of eligible Medicaid beneficiaries in a fraudulent manner and then used the information to forge enrollment applications. The applications were given to the plan, which then submitted them to the state. The state became aware of the problem after receiving numerous complaints from Medicaid beneficiaries that they had been enrolled in the health plan without their knowledge. The state has recouped over $469,000 from the plan, whose contract with the state has been terminated.

-- In California, a Medicaid managed care plan agreed to pay a $535,000 settlement as a result of an investigation into allegations that the plan deliberately misled Medicaid beneficiaries in order to enroll them. Allegedly, the plan also inappropriately delayed the disenrollment of many of those who had been enrolled.

-- A survey of Maryland Medicaid beneficiaries enrolled in managed care plans uncovered evidence that health plans were illegally attempting to exclude unhealthy individuals from enrolling in their plans. The plans asked the potential enrollees about their medical conditions and use of prescription medications. Another investigation of Maryland Medicaid managed care plans found that a managed care organization issued a written warning to a marketing agent for his failure to comply with the company's policy to "probe for preexisting health problems" in potential enrollees.

Some states have tightened their regulations governing Medicaid managed care plans to prevent such marketing and enrollment abuses from occurring. In Tennessee, for example, the state now contracts with a private vendor to verify each Medicaid managed care enrollment application for eligibility before an individual is enrolled. Florida issued new Medicaid marketing and enrollment requirements in response to a variety of abuses that involved several managed care plans. The requirements mandate that managed care plan marketing agents be salaried employees of the plans, place a cap on the marketing agents' commissions, prohibit marketing at county welfare offices, require enrollments to be independently verified by the plans before the applications are submitted to the state, prohibit paying marketing agents commissions when enrollees disenroll within 3 months or are enrolled by error, and require capitation payments to be refunded

to the state when beneficiaries voluntarily disenroll during the first 3 months of enrollment without receiving services.

Maryland now requires marketing agents to pass a state examination, prohibits plans from marketing at welfare offices, and prohibits marketers from obtaining medical information about beneficiaries during the enrollment process. Maryland recently announced that it was also eliminating direct marketing by managed care plans. Managed care plans can be fined up to $5,000 for each violation of marketing and enrollment requirements and up to $10,000 for each Medicaid beneficiary found to be fraudulently enrolled.

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