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MEDICARE

Opportunities Are Available To Apply Managed Care Strategies

Statement of Janet L. Shikles,
Assistant Comptroller General
Health, Education, and Human Services Division

GAO/T-HEHS-95-81

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to participate in your discussion on expanding managed care under the Medicare program. For the past week you have been examining weaknesses in Medicare's predominantly fee-for-service program, which cost the government $162 billion in fiscal year 1994 and consumes an ever greater share of the federal budget each year. In testimony to the Subcommittee earlier this week, we reported that the magnitude of the Medicare program has overwhelmed the government's ability to police the hundreds of millions of claims submitted annually.[1] Today the Subcommittee is examining managed care options as alternatives to the current claim-by-claim management of program dollars. What we would like to contribute is our perspective on Medicare's HMO payment policy, efforts to enforce quality assurance standards, and the dissemination of consumer information. Our findings derive from numerous studies we have done on the Medicare program in recent years as well as ongoing studies. (See app. II for a list of the issued reports.)

In brief, the current Medicare HMO option, known as the risk contract program, has not grown much or achieved its cost containment potential. Comparisons with HMO trends in the private sector are instructive. Large employers use market power to negotiate with HMOs over price and increasingly over quality and the production of report-card-type information. Their efforts are directed at becoming more prudent and sophisticated purchasers of health care. Although the particulars of these efforts may not be directly transferrable to the federal government, their broad aims of finding incentive-based solutions to containing costs, assuring quality, and informing consumers are worthy of consideration and testing.

MANAGED CARE HAS POTENTIAL TO ADDRESS MEDICARE CLAIMS VULNERABILITY

Medicare's growing claims volume has placed substantial demands on Medicare's claims processing systems. In fiscal year 1994, Medicare processed nearly 700 million claims. In 1992 and again this month, we report that Medicare is one of several government programs highly vulnerable to waste, fraud, abuse, and mismanagement.[2] Since our first report, the Health Care Financing Administration (HCFA), the agency responsible for administering Medicare, has made various regulatory and administrative changes aimed at correcting flawed payment policies, weak billing controls,

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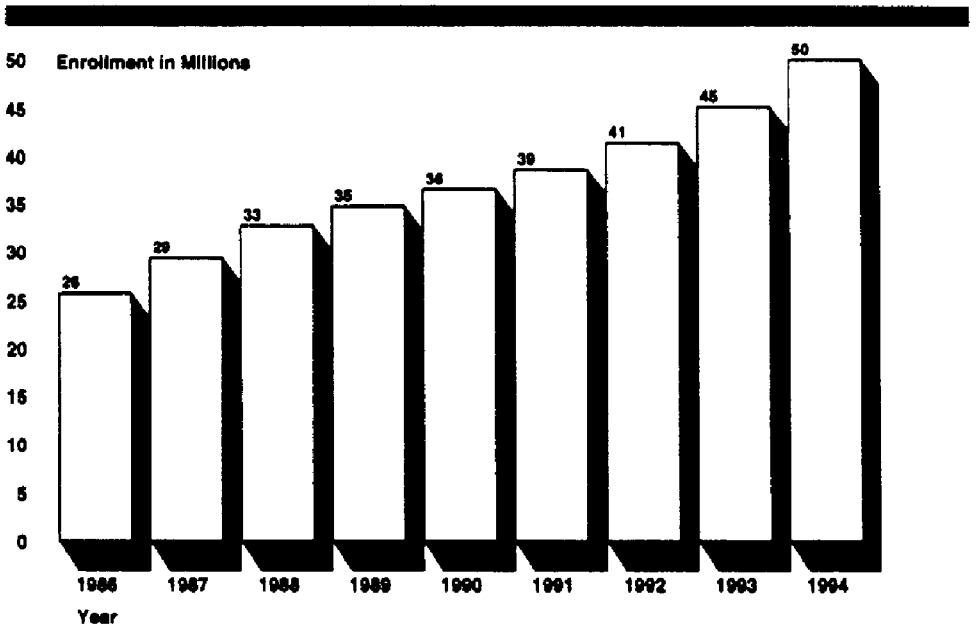
[1]Medicare: High Spending Growth Calls for Aggressive Action (GAO/HEHS-T-95-75, Feb. 6, 1995).

[2]Medicare Claims (GAO/HR-93-6, Dec. 1992) and forthcoming Medicare Claims (GAO/HR-95-7).

and deficient program management. However, these worthwhile improvements still are not sufficient to protect Medicare against continued program losses. The nation's health care delivery system is evolving with such changes as consolidations of various provider types and increasingly complex financial arrangements. In this environment, HCFA is seeking strategies to become less reliant on reviewing claims individually as a means of guarding against overpayment.

During the last decade, employers have increasingly turned to managed care to slow the rising cost of health benefits. As the Congressional Budget Office reported earlier this month, the most effective HMOs can reduce the use of services for the nonelderly population by 22 percent over typical indemnity plans.[3] Industry estimates show HMO enrollment nearly doubled since 1986 to 50 million people in 1994. (See fig. 1.) About 90 percent of the HMO enrollees are in commercial or employer-sponsored programs.

Figure 1: Growth in HMO Enrollment Between 1986 and 1994



Source:Group Health Association of America (GHAA), 1994

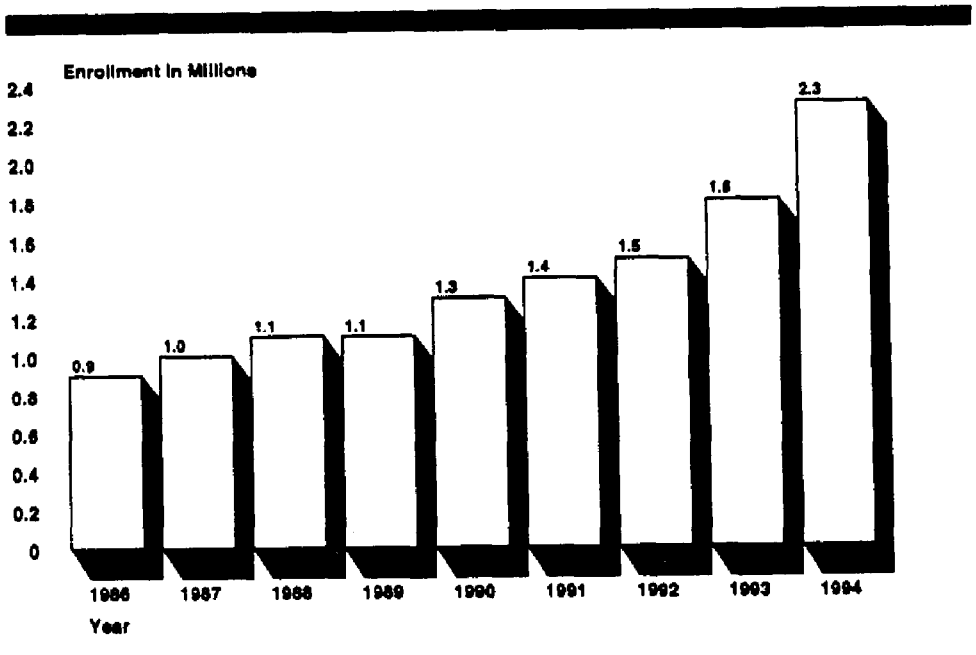
[3]The most effective plans were group and staff models HMOs. IPAs, another type of HMO, reduced utilization 2 to 4 percent on average. See CBO testimony on Federal Entitlement Spending, statement by Paul N. Van de Water, Congressional Budget Office, before the U.S. Senate, Committee on the Budget, Feb. 1, 1995.

States, too, are looking to managed care to help contain the costs of their Medicaid programs. These programs now enroll nearly 8 million people in managed care plans, about half of whom are in HMOs. Several states, such as Ohio, South Carolina, and Florida, plan to move large segments of their Medicaid population into HMO-type plans in the next few years.

Like states and employers, Medicare has also tried managed care as a way to contain the cost of providing care to over 35 million beneficiaries. Medicare offers its beneficiaries the option of obtaining managed care from prepaid plans or provider networks participating in a 15-state pilot program called Medicare Select. This program offers beneficiaries the incentive of savings on their supplementary insurance premiums if they obtain care from a designated network of providers.

HMOs are the most common form of Medicare managed care. Recently, Medicare HMO enrollment growth has accelerated. In the past 2 years, the number of Medicare HMO enrollees grew 50 percent, from about 1.5 million to about 2.3 million beneficiaries. (See fig. 2.) However, since this is only about 7 percent of the Medicare population, the growth is much lower than in the general population. Medicare HMO enrollment has been uneven, with high concentration in a few areas and no enrollment in others. (See app. I.)

Figure 2: Number of Medicare Beneficiaries Enrolled in HMOs with Medicare Risk Contracts Between 1986 and 1994



Source: Health Care Financing Administration

PAYMENT POLICIES NEEDED TO ACHIEVE MEDICARE SAVINGS

Medicare's risk contract program has been unable to harness the cost-saving potential of managed care. As we reported in 1994, Medicare's mechanism for setting HMO payment rates suffers from certain technical difficulties.[4] These may be best understood when contrasted with the private sector's rate-setting methods.

In the private sector, large employers and other purchasers can negotiate with managed care providers or shop among them for the best value. Meanwhile, with more HMOs entering various local markets, competition on price has become sharper. Some employers and other purchasers report obtaining reduced premiums compared to the prior year.

In contrast, HCFA does not shop or negotiate but sets its HMO rates, county by county, using a formula. That formula has two key flaws. First, it ties HMO payment rates to a county's fee-for-service costs. As a result, in some counties Medicare's HMO rates factor in excessive use of services and so are too high for Medicare to realize the potential savings from managed care. In other counties with lower service use, Medicare's rates are too low to encourage HMO participation in its risk contract program.[5] Second, Medicare's formula does not adequately adjust HMO rates for enrolled beneficiaries' risk of illness. This flaw in the program's "risk adjuster" results in significant losses to Medicare.

Remedies have been proposed to make Medicare managed care achieve its cost-saving goal. In particular, we have identified several promising health risk adjusters, including one shorter-term fix. Even with better risk adjusters, more fundamental changes may be required so that Medicare reduces its reliance on fee-for-service costs as a basis for HMO payment. For example, major proposed reforms include competitive bidding arrangements and negotiations between the government and HMOs.

We have also proposed administrative solutions to the inadequate risk adjustment in Medicare's payment formula.[6] For

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

[5]The rate differences can be substantial even in adjacent areas. For example, Medicare's unadjusted 1994 HMO payment rate is 28 percent lower in Montgomery County, Maryland, than in adjacent Prince George's County, Maryland.

[6]See Medicare: Further Changes Needed to Reduce Program and Beneficiary Costs (GAO/HRD-91-67, May 1991).

example, the required period of time that beneficiaries must stay with an HMO once enrolled could be lengthened from 30 days to 1 year. Because such restrictions "lock in" beneficiaries, additional measures would be needed to safeguard against substandard quality.

PRIVATE SECTOR LEADS IN EMPHASIZING QUALITY STANDARDS

The public and private sectors share a common interest in developing the means to ensure that HMOs provide quality as well as cost-effective care. HMOs' restrictions on individuals' choice of physicians, hospitals, and other sources of care create the need to provide payers and beneficiaries assurances that quality of care will be carefully monitored.

The federal government has had quality assurance standards for HMOs since the 1970s but has not enforced them aggressively. Medicare has a process to monitor HMOs' compliance with federal standards. It involves site visits to assess an HMO's financial solvency, quality assurance systems, and other features for ensuring the fair treatment of beneficiaries. In many instances, however, HCFA does not act on evidence of violations or make such evidence public.

For example, in the last 10 years, HCFA has repeatedly found quality assurance problems in certain Florida HMOs. The most recent quality violations included incorrect diagnoses, treatments delayed or withheld, and test results not acted on. One of the HMOs continued to enroll over 100,000 Medicare beneficiaries during a period of noncompliance without any HCFA intervention.

The private sector has taken a different approach in enforcing standards. Large employers have joined with a private accreditation agency in setting and enforcing HMO quality standards. This organization, the National Committee for Quality Assurance (NCQA), has developed standards and procedures for certifying HMOs that request accreditation.[7] NCQA certification is becoming increasingly important since large employers are beginning to require accreditation as a prerequisite to negotiating with HMOs.

PURCHASERS AND ENROLLEES NEED INFORMATION TO MAKE APPROPRIATE CHOICES

The private sector has also taken the lead in developing information that enable purchasers and consumers to compare

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[7]The Group Health Association of America in conjunction with the American Managed Care and Review Association, formed NCQA in 1979. NCQA became an independent agency in 1990.

different HMOs. To enable such assessment of health plans' cost effectiveness and performance, a group of large employers has led efforts in developing the Health Plan Employer Data and Information Set (HEDIS). These data constitute a set of performance measures to evaluate plans' quality of care, access to care, member satisfaction, utilization of services, and financial stability. Although HEDIS standards are still under development, some employers already require their plans to submit HEDIS-based information.

The private sector also disseminates quality-related information to purchasers and users. For example, NCQA publishes results of its medical quality assurance accreditation reviews nationwide. Of 15 Medicare HMOs reviewed in Florida, only 1 received full accreditation, 6 were denied accreditation, and 8 received less than full accreditation. With this knowledge, a consortium of employers has elected to exclude Florida's largest Medicare HMO from new business with their employer-sponsored health plans.

HCFA is beginning to define a similar set of quality measurements targeted to the senior population but expects collection and publication of these data to be several years away. HCFA has not spurred HMOs to provide the performance data beneficiaries need to make informed choices in selecting between managed care and fee-for-service options. Moreover, even where some data exist, such as HMO disenrollment rates or numbers of complaints, HCFA has not published these data which could help beneficiaries differentiate among HMOs.

The feasibility of producing and disseminating such information is apparent in a commercial document that compiles information on plans available to federal employees.[8] The publication rates the plans on customers' satisfaction with waiting times for physician office visits, access to specialty care, and making appointments. It also publishes HMO disenrollment rates.

CONCLUSIONS

The history of Medicare and private attempts to control health care costs is discouraging under fee-for-service. Medicare faces the overwhelming task of policing upward of 700 million claims each year. Private payers, seeking to control costs, have moved strongly toward managed care. Their experience suggests strategies for moving Medicare toward more of a managed care approach. As a prudent buyer, the private sector offers lessons in using market

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[8]Checkbook's Guide to 1995 Health Insurance Plans for Federal Employees, Walton Francis and Editors of Washington Consumers' Checkbook Magazine, Walter Francis and the Center for the Study of Services: Washington, D.C., 1994.

power to negotiate favorable payment rates; in being an advocate of value and quality assurance; and in educating consumers to make informed choices about health plan options.

HCFA can now move to test proposals drawing on private sector experience. It can (1) test the potential for such strategies as competitive bidding and negotiation to improve Medicare's HMO payment approach, (2) stop the enrollment of Medicare beneficiaries in HMOs that do not meet standards, and (3) use its data to publish disenrollment and certain beneficiary satisfaction data in annual reports comparing plans.

HCFA has shown a willingness to adopt these strategies by its proposals to test new reimbursement techniques, recent enforcement actions on quality, and a consumer information initiative. Because there may be policy and legislative impediments to moving aggressively in these areas, HCFA may have to ask the Congress for support.

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Mr. Chairman, this concludes my prepared statement. At this time, I will be happy to answer any questions you or other members of the Subcommittee may have.

For more information on this testimony, please call Edwin P. Stropko, Assistant Director, at (202) 512-7108. Other major contributors included Charles Walter, Lourdes Cho, Sarah Glavin, Julie Cantor-Weinberg, and Hannah Fein.

Table 1: Medicare HMO Enrollment by State as of January 1, 1995

State	Total Medicare Population[1]	Medicare Beneficiaries in HMOs	Enrollees as a Percentage of Total Beneficiaries	Enrollees as a Percentage of HMO Program
Alabama	619,000	1,944	0	0
Alaska	30,000	0	0	0
Arizona	561,000	**158,502**	28	7
Arkansas	410,000	0	0	0
California	3,499,000	**975,749**	28	**42**
Colorado	396,000	50,679	13	2
Connecticut	490,000	257	0	0
Delaware	96,000	109	0	0
Florida	2,519,000	**387,470**	15	**17**
Georgia	793,000	0	0	0
Hawaii	141,000	13,080	9	0
Idaho	143,000	0	0	0
Illinois	1,592,00	69,018	4	3
Indiana	802,000	2,684	0	0
Iowa	489,000	0	0	0
Kansas	379,000	0	0	0
Kentucky	565,000	2,724	0	0
Louisiana	562,000	6,636	1	0
Maine	194,000	0	0	0
Maryland	580,000	2,338	0	0
Massachusetts	911,000	41,369	5	2
Michigan	1,306,000	6,947	1	0
Minnesota	616,000	58,177	9	2.5
Mississippi	384,000	0	0	0
Missouri	815,000	16,226	2	1
Montana	125,000	0	0	0
Nebraska	245,000	3,271	1	0
Nevada	172,000	36,634	21	1.6
New Hampshire	149,000	53	0	0
New Jersey	1,142,000	5,364	0	0
New Mexico	199,000	28,147	14	1
New York	2,583,000	**104,731**	4	**4.5**
North Carolina	724,000	0	0	0
North Dakota	102,000	0	0	0
Ohio	1,626,000	20,816	1	1
Oklahoma	474,000	12,913	3	0.5
Oregon	454,000	**100,700**	22	**4**
Pennsylvania	2,041,000	60,055	3	3
Rhode Island	164,000	11,639	7	0
South Carolina	482,000	0	0	0
South Dakota	114,000	0	0	0
Tennessee	739,000	0	0	0
Texas	1,977,000	87,940	4	4
Utah	177,000	0	0	0
Vermont	79,000	0	0	0
Virginia	781,000	1,535	0	0
Washington	659,000	71,885	11	3
West Virginia	322,000	0	0	0
Wisconsin	745,000	0	0	0
Wyoming	57,000	0	0	0
Total	35,224,000	2,339,592	7	.....

[1]Total Medicare population as of July 1, 1993.

APPENDIX I

Related GAO Products

Health Care Reform: "Report Cards" Are Useful but Significant Issues Need to Be Addressed (GAO/HEHS-94-219, Sept. 29, 1994).

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).

Health Insurance: California Public Employees' Alliance Has Reduced Recent Premium Growth (GAO/HRD-94-40, Nov. 22, 1993).

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).

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