

STATEMENT BEFORE
Special Committee on Aging
U.S. Senate
on
Medicare HMO
Payment Policy
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Mr. Chairman and members of the Aging Committee, I am pleased to be here today to discuss increasing choices and equity in the Medicare program. The Physician Payment Review Commission has substantial expertise in this area, beginning with our work on physician payment reform in the late 1980s and continuing into our more recent work concerning Medicare's managed-care program.

Throughout our work, we have looked for ways the program can benefit from the tremendous changes that are occurring in how Americans pay for and receive health care. The number of individuals covered by traditional indemnity insurance is shrinking. Managed-care plans are evolving toward more integrated systems and closer relationships with their provider networks, while physicians and hospitals are joining together in new types of organizations. In response to rising premiums, leading corporate purchasers of health care are changing the way they pay for health services, potentially affecting both the costs and quality of care.

Medicare can learn from these experiences. In fact, as commercial managed-care penetration grows and managed-care enrollees reach retirement age, it is inevitable that more and more beneficiaries will select this option within Medicare. Moreover, changes can be made in the traditional program that can help contain costs and improve quality. The challenge is to develop reforms that ensure both Medicare's financial solvency and beneficiary access to timely, appropriate health care services.

Expansion of managed care and introduction of new private health plan options for Medicare beneficiaries present both opportunities and challenges. It is important to keep in mind, however, that Medicare differs from other payers in several important ways. First, Medicare managed-care enrollment, while growing, still lags substantially behind commercial enrollment (Figure 1). Second, although managed-care growth in the private sector has been associated with reduced cost growth, under current policy, this is not the case for Medicare. In fact, research studies suggest that managed-care growth *increases* program outlays. Third, the private market encompasses a broader range of plan options than Medicare currently permits, but most individuals with employer-based insurance have only a limited number of plans from which to choose. Fourth, as a public program, Medicare may face certain obstacles in quickly adopting and implementing techniques for managing care that have been used by other payers.

In developing a work plan, conducting analyses, and discussing policy alternatives, the Commission has been working closely with congressional committees and staff to ensure that we can help inform your deliberations. My comments today begin with some brief background information about Medicare managed care and the issues that will arise as managed-care choices expand. Then I would like to highlight several topics that are most immediate on the congressional agenda:

improving payment policy under Medicare's managed-care program,

addressing the critical issue of risk adjustment, and

improving equity of payment policy under Medicare fee for service.

MEDICARE MANAGED CARE: PLAN PARTICIPATION AND BENEFICIARY ENROLLMENT

As you know, Medicare managed care is growing. By the end of 1996, about 13 percent of Medicare beneficiaries were enrolled in some form of managed care, compared to 5 percent in 1990. Participation by beneficiaries varies widely, with over 20 percent of urban beneficiaries enrolled in managed care, compared to about 1 percent of rural beneficiaries. Although predominantly an urban phenomenon, enrollment rates differ across urban areas. Over half of beneficiaries in Riverside, CA, are in risk plans, for example, while virtually none are enrolled in risk plans in Atlanta and Detroit (Figure 2).

Most plans participate in Medicare through the risk-contracting program. Under a risk contract, plans commit to providing Medicare-covered services to beneficiaries for a fixed monthly

payment from the program. There were 241 risk contracts in effect at the end of 1996; 35 more had been added as of April 1st (Figure 3).

Current policy allows only health maintenance organizations (HMOs) to be offered to Medicare beneficiaries (some of which offer point-of-service coverage). The Health Care Financing Administration's (HCFA) Medicare Choices demonstration, however, is testing the development of other types of managed-care products, such as preferred provider organizations and provider-sponsored organizations.

The availability of risk plans varies widely across the nation. In most urban areas, beneficiaries can choose among several plans, while 80 percent of rural beneficiaries have no plan available. Overall, about two-thirds of beneficiaries are served by at least one risk plan; 50 percent have access to more than one plan (Figure 4).

IMPROVING MEDICARE MANAGED-CARE PAYMENT POLICY

The debate on Medicare managed care always eventually turns to payment. Changes in payment policy could serve any of several goals: reducing program spending, encouraging managed-care enrollment by making the program more attractive to plans in certain markets, improving equity by reducing the variation in benefits offered by risk-plans in different areas of the country, or structuring payment policies so that the government remains neutral about the health plan choices beneficiaries make. The challenge facing policymakers is to develop an approach to paying plans that is fair, reduces cost growth, and ensures that beneficiaries have access to appropriate care at a cost they can afford.

As you have heard, there are a number of problems associated with Medicare's current payment methods. I will focus on the options for addressing these problems (including those included in the Balanced Budget Act passed in the last Congress and the President's February budget proposal) as well the Commission's recommendations concerning their implementation.

Current Policy Affecting Risk-Plan Payment, Benefits and Premiums

As a result of current policies and local competitive pressures, there is wide geographic variation in Medicare payments to risk-plans, in the benefits available to beneficiaries, and in the premiums that they pay. For example, there is a three-fold difference between the lowest and highest county payment rates (Figure 5). Over 50 percent of 1997 county rates, however, are between \$340 and \$440. Currently, more than three-quarters of risk plans offer additional eye and ear care, and over half provide prescription drug coverage (Figure 6). By the end of 1996, two-thirds of plans provided benefits beyond those covered by Medicare at no additional charge to enrollees (Figure 7).

Payments, benefits, and premiums are the result of two separate administrative processes, as well as of local competitive pressures. Payments are set to reflect local fee-for-service costs with some adjustment for differences in the demographic characteristics of local populations that affect their use of health services. This measure, known as the AAPCC, is the expected local cost of caring for a typical beneficiary. Each county's payment is set at 95 percent of the AAPCC. Plans are paid this rate with an adjustment for enrollee characteristics.

Benefits and premiums are set in a second process in which plans submit their estimated cost of providing Medicare-covered services to enrollees based on the costs of serving their commercial population. If these costs fall below the Medicare capitation payment, then the plan must return the difference to Medicare or to beneficiaries in the form of additional benefits. In practice, all plans opt to provide additional benefits to beneficiaries. In addition, to be competitive, plans may also offer even more benefits than those required under this process.

Concerns about Current Policy

The wide geographic variation and volatility in spending for traditional Medicare results in large differences in the AAPCC across counties. These differences may contribute to the uneven pattern of Medicare managed-care enrollment that I described earlier. And they account, at least in part, for the wide and seemingly arbitrary variation in additional benefits that Medicare beneficiaries receive from risk plans in different markets.

Several factors that could be addressed in legislation contribute to this geographic variation. The most important of these are:

Inadequacies of current demographic risk adjusters. Inadequate risk adjustment results in increased Medicare spending in two distinct ways. First, local rates may overstate the likely cost of a typical beneficiary because the AAPCC reflects only beneficiaries in fee-for-service. If these beneficiaries are less healthy than those in managed care and their poorer health is not captured by the current demographic adjusters, then expected fee-for-service payments are overstated. In fact, the Commission's analysis shows that new managed-care enrollees have significantly lower health care costs than those who remain in fee for service (Figure 8).

Second, in addition to the local rate being biased, inadequate risk adjustment results in overpayments to plans for their particular enrollees. Risk adjusters currently used in the Medicare program explain only a small portion of the variation in health costs among Medicare beneficiaries. More accurate risk adjustment would result in lower payments to plans reflecting their relatively healthier enrollment. Commission analyses of new enrollees suggest that currently available risk-adjustment methods would capture at least half of the true risk selection in Medicare managed-care plans.

As I will explain in a moment, the Commission made a series of recommendations concerning risk adjustment in its 1997 annual report to the Congress. Better risk adjusters would make the AAPCC a more accurate reflection of expected outlays for a typical beneficiary and would reduce some of the variation in payments.

Inclusion of earmarked funds. Medicare makes payments to hospitals for graduate medical education and for serving a disproportionate share (DSH) of low-income patients. Including these special funds in AAPCC-based rates contributes to geographic variation in managed-care payments. It also raises the question of whether these payments should be passed along to all risk-plans, since they are meant to compensate hospitals for special circumstances beyond the costs of caring for Medicare patients.

The Commission has recommended that these funds be removed from the AAPCC. A related issue is whether teaching and DSH hospitals should receive additional compensation for seeing managed-care enrollees or whether managed-care plans should be compensated an additional amount for teaching or serving low-income patients. The Commission recommends that mechanisms be developed to ensure that hospitals, plans, and other entities involved in training are paid fairly for these costs.

Geographic basis of rates. Use of counties, which are relatively small geographic units, in setting payments leads to more variation and volatility than may be appropriate. Variation and volatility reflect differences in practice patterns, differences in the health status of local populations, and, at least in some cases, small numbers of beneficiaries. Areas larger than counties would help address these problems and may be more consistent with the notion that managed-care plans serve markets, not counties. Using larger areas, however, obscures information about the variation in health status at the county level that contributes to the accuracy of payment. For this reason, any changes to geographic areas should be accompanied by implementation of better risk adjusters.

It is important to recognize that even if all of these technical issues were resolved, under current policy, savings from managed-care enrollment cannot exceed 5 percent. Because managed-care payments increase in lock-step with Medicare fee-for-service expenditures, cost increases in fee for service drive cost increases throughout the program. To expand managed-care without increasing outlays may require breaking the link between managed-care payments and fee-for-service expenditures.

Proposals for Change

Over the past two years, the Congress and the Administration have been considering how to set Medicare capitated rates that are fair to plans and allow the program to benefit from managed-care efficiencies. Proposals to improve risk-plan payment policies were included in the Balanced Budget Act passed during the 104th Congress. Proposals supported by the Administration last year and more recently put forward in the President's fiscal year 1998 budget proposal have many similarities. All of these proposals included provisions previously recommended by the Commission.

There are basically three different ways to reduce the variation in risk-plan payment rates. These approaches could be implemented to achieve budget savings, or could be budget-neutral, focused solely on reallocating payments across areas.

The first approach is to improve the AAPCC. Improving risk adjustment, removing earmarked funds, and changing the geographic basis of the local rate would all result in better estimates of patient care costs, which would differ less across areas. All of these modifications are among the changes the Commission recommended in this year's annual report. It also recommends that, once graduate medical education costs are removed from the AAPCC, separate mechanisms should be developed to ensure that

hospitals, managed-care organizations, and other training entities are paid fairly for those costs when they are involved in appropriate training activities. The General Accounting Office has recommended that the experience of managed-care enrollees be used in addition to those in fee for service in calculating county rates. This would result in county rates reflecting the costs of all Medicare beneficiaries.

A second approach is to unlink risk payments from local spending, using current rates as a starting point for new rates. A variety of strategies could be used to set rates which have less geographic variation than those now based on the AAPCC. These include blending current local rates with national rates, trimming rates through floors and ceilings, and setting new ways to update local rates. Since these approaches begin with the AAPCC, the Commission recommends that if they are adopted, that they be adopted in tandem with the improvements in the AAPCC that I just mentioned.

Finally, current policy could be discarded altogether in favor of market-driven competitive solutions. Local market characteristics could be used to set rates, either through some form of competitive bidding or a defined federal contribution for both fee-for-service and risk beneficiaries. This approach would work only in markets with sufficient local competition. It could be adapted to markets with little managed-care penetration if payments are based on the cost experience of both managed-care and fee-for-service beneficiaries. The Commission has recommended that HCFA continue to test such alternative methods for setting payments, including competitive bidding, partial capitation, and reinsurance.

THE IMPORTANCE OF RISK ADJUSTMENT

Regardless of how payment rates are set, as long as Medicare beneficiaries can choose among options, improved risk adjustment will be essential. Otherwise, plans will not be fairly paid for enrollees with better or worse-than-average health status (for example, those with chronic conditions or functional disabilities). Without improvements in risk adjustment, plans will continue to have an incentive to avoid enrolling patients who will be expensive to care for.

In addition, lack of risk adjustment translates into higher costs to Medicare. The Commission estimates that annual excess payments to health plans total \$2 billion. A recent study by the General Accounting Office similarly found that, in 1995, Medicare overpaid \$1 billion to plans in California. Improved risk adjustment would have reduced the excess by about \$276 million.

The Commission recommends that improved risk adjustment be implemented immediately. Although available approaches are not perfect, they would do a better job than the demographic factors currently used. As a first step, the Commission recommends that Medicare begin to phase-in risk-adjusted payment changes using administrative data. For example, our analyses and those of others would support an approach of paying less for new managed-care enrollees who have lower-than-average per capita costs. (New enrollees now account for 55 percent of Medicare managed-care enrollees, up from 43 percent in 1993.) Since risk adjustment methods typically underpredict the true variation in costs and selection, improvements such as paying less for new enrollees do not risk over adjusting (that is paying too little) for individuals with certain characteristics.

Because there are substantial differences among plans in the proportion of new enrollees, this approach would be preferable to an across-the-board cut which would particularly hurt those plans with a large proportion of long-time enrollees (Figure 9). The President's budget proposes such a cut, setting local rates at 90 percent of the AAPCC, instead of the 95 percent under current policy. Although this would mitigate the budget impact of risk selection against the fee for service program, it would not adjust for risk selection among managed-care plans and so would not reduce plans' incentives to avoid enrolling costly beneficiaries.

Steps could also be taken immediately to improve the availability of data useful for risk adjustment. For example, hospitals are now required to submit so-called no-pay bills to HCFA for hospitalized managed-care enrollees but many do not do so. The potential use of these data for risk adjustment increases the importance of enforcing this requirement.

Use of administrative data for risk adjustment is an important first step. Over the longer term, however, the data and infrastructure required to support risk adjustment should be developed and implemented. This includes obtaining data that more accurately capture risk (such as those obtained from surveys of beneficiaries or encounter data collected by plans and their contracting providers), further development of risk adjustment models, and implementation of adjusted payment rates.

EFFECTS OF CHANGES IN MANAGED-CARE PAYMENT POLICY

The effect of any payment changes on total Medicare payments, plans, and beneficiaries will ultimately depend upon how they are implemented, how much payment levels change, and how plans and beneficiaries respond. The effect of payment floors, blended rates, and other approaches to reducing inappropriate variation in risk plan payments will differ, depending upon the exact combination of policies and the sequence in which they are calculated.

The effects of changes on plan participation and beneficiary enrollment are also uncertain. If plans and beneficiaries are sensitive to payment rates, then rate changes could lead to participation increases in areas with increased rates and declines in those where rates drop. But if plans and beneficiaries are relatively insensitive to risk-plan payment rates, then we might not see such effects.

Unfortunately, there is little information that could guide us in predicting how plans and beneficiaries will react to payment changes. Researchers have been examining this question but their conclusions have been mixed. One recent analysis indicated that plan entry into the risk program is highly sensitive to the local payment rate. Another published study found that beneficiary enrollment rates are much more sensitive to factors such as local managed-care penetration in the commercial market than to local Medicare rates.

If risk payments differ from per capita fee-for-service outlays, then more detailed information about beneficiaries' enrollment behavior will be required in order to make accurate budget projections. In particular, it will be important to understand how beneficiaries of different risk categories select between managed care and fee for service. The Commission has concluded that any changes in payment policy should be designed and phased in so as to reduce disruptive effects on beneficiaries and plans.

Policymakers must also be mindful about the impact of changes in risk-plan payments on local markets where risk plans compete not only against each other but against Medicare fee for service. Efforts will also be needed to monitor the impact of any changes on beneficiaries' access to care.

Finally, it is critical to remember that expansion of Medicare managed care raises issues beyond setting payments to plans. The Commission this year is reiterating recommendations with regard to the process through which beneficiaries learn about their choices, enrollment and disenrollment policies, and enrollee grievance procedures. These recommendations were described more fully in its *Annual Report to Congress 1996*.

EQUITY IN MEDICARE FEE FOR SERVICE

Since the Commission began its work to reform Medicare's method for paying physicians, improving equity in payment has always been an important goal. My comments this afternoon focus primarily on physician payment because of the Commission's expertise in this area. While some of the same issues arise under other service sectors (for example, inpatient hospital, skilled nursing facilities, outpatient hospital), it is important to note that differences in current payment methodologies may dictate different types of policy solutions.

It is also important to keep in mind that managed-care payments are made for a bundle of services (reflecting both the price and volume of those services). Thus, variation in managed-care payments reflects variation in expenditures. Fee-for-service payments, in contrast, reflect only price. For the most part, there are deliberate policies designed to constrain geographic variation in price to an appropriate level.

With respect to physician payment, use of geographic adjustment factors serve the purpose of limiting variation in price to variations in the resource costs needed to provide particular services. Geographic adjustment factors were established for implementation of the Medicare Fee Schedule beginning in 1992. HFCA adopted a new method to define fee schedule payment areas last year. In addition, processes are in place to periodically modify both the geographic adjustment factors and payment area definitions, and the Commission has judged these to be generally successful in addressing outstanding problems. Committee staff have brought to our attention their concerns about the hospital wage index. Our sister commission, the Prospective Payment Assessment Commission, has identified issues in the calculation and application of the index and has recommended improvement. It should be a good resource to the Committee in developing options to promote equity in Medicare payments to hospitals.

Geographic variation also reflects differences in volume, which has been a challenge to control for both Medicare and private payers. This is because there are two sources of geographic variation in volume: discretionary sources (such as provider practice styles) and nondiscretionary ones (for example, health status). It is generally agreed that providers should not be held accountable for variation in service use due to factors like health status, but that reduction of differences in practice patterns is desirable. Policy tools that distinguish among the sources of variation are not well developed, although both profiling of providers and development and dissemination of practice guidelines have potential and should be encouraged.

After the Volume Performance Standard (VPS) system (under which growth in volume affects the price Medicians) was implemented in 1990, the Commission considered the feasibility of moving to a state or substate-level VPS system. Among other potential advantages, such a system could place greater pressure to control volume on physicians in areas with high rates of expenditures per beneficiary. Because of significant problems in establishing appropriate subnational spending targets and fee

updates, as well as the year-to-year volatility of expenditures at the subnational level, the Commission concluded that the limitations of this approach exceeded its benefits.

As Congress considers broadening the choices available to Medicare beneficiaries (and assuming that the traditional program remains a choice), it will be increasingly important to address how to constrain volume and reduce inequities across geographic areas. The Commission plans to continue working in this area and we will keep you and your staff informed of our progress.