



CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
WASHINGTON, D.C. 20515

June E. O'Neill
Director

MEMORANDUM

April 26, 1995

TO: Health Staff
FROM: Sandra Christensen
SUBJECT: Managed Care and the Medicare Program

In the past few years, premiums charged by employment-based insurance plans have increased more slowly than Medicare's per enrollee costs. Many people attribute the slowdown in the rate of growth in private health plan costs to the now widespread adoption of managed care techniques and believe that growth in Medicare's costs might also be slowed by expanding enrollees' options for managed care.

This memorandum addresses a number of questions that arise about managed care in the Medicare program. It also compares the extent and nature of managed care arrangements in Medicare and in the private sector.

What is managed care?

The term "managed care" has come to encompass almost any intervention in health care delivery intended to reduce unnecessary and inappropriate care or to reduce costs. It is useful, however, to distinguish between managed care plans and certain managed care techniques, some of which are now used by most health insurance plans.

The health maintenance organization (HMO) is the prototype of a managed care plan because of its integrated financing and delivery systems. In return for a fixed payment per enrollee per period (the capitation rate), an HMO agrees to provide plan enrollees with any medical services they may require during the period. An HMO, like any insurer, is at risk for whatever the costs of care for its enrollees may be. However, an HMO generally differs from an indemnity insurer in the fee-for-service sector in

that it shares insurance risk with the providers who treat the HMO's enrollees. HMOs share risk either by paying physicians on a capitated basis for the patients they treat, or by using a system of withholds and bonuses to reward salaried or fee-for-service physicians based on their adherence to cost-effective treatment patterns.

There are two main types of HMOs--the group/staff model, in which the plan either contracts with or employs a group of physicians who serve only the HMO's enrollees; and the Independent Practice Association (IPA), in which the plan contracts with a number of separate practices whose physicians treat other patients along with the IPA's enrollees.

When providers share insurance risk as they do in an HMO, they have financial incentives to avoid providing unnecessary services. By contrast, in a traditional indemnity plan with fee-for-service reimbursement, providers do not share insurance risk and they have a financial incentive to provide more services than may be necessary. To counteract this incentive, most indemnity insurers have adopted some managed care techniques in an attempt to control enrollees' use of services. Most indemnity plans now have utilization review programs through which they may limit access to certain services or providers. In addition, some plans have established networks of "preferred" providers that enrollees are encouraged to use because these providers accept the plan's cost control measures. These latter plans are called preferred provider organizations (PPOs).

How do Group/Staff HMOs Differ from IPAs?

In a group or staff model, the plan either contracts with or employs a group of physicians who serve only the HMO's enrollees. In an IPA, the plan contracts with a number of separate practices whose physicians treat other patients along with the IPA's enrollees. Because of its exclusive contract with plan providers, the group/staff model tends to be more effective than the IPA model at controlling use of services.

Most HMOs of both types require prior authorization for nonemergency inpatient care and concurrent review during an inpatient stay. Most group/staff HMOs permit access to specialists only after referral by the patient's primary care physician, who serves as a gatekeeper. IPAs are more likely to permit patients to self-refer to in-plan specialists. In recent years, HMOs (especially IPAs) have also begun to offer an open-ended or "point-of-service" option, which permits members to use out-of-plan providers but subjects them to greater cost-sharing when this option is used.

What techniques to control costs does a Preferred Provider Organization (PPO) Use?

PPOs provide coverage on a fee-for-service basis, but they encourage patients to use their network of "preferred" providers by reducing cost-sharing requirements when they do so. Patients are generally free to see out-of-plan providers as well. The preferred providers agree to accept the PPO's utilization management techniques and typically treat the PPO's patients at discounted prices. The evidence to date indicates that most savings achieved by PPOs are the result of the discounted prices they negotiate. It appears that PPOs' interventions to change use of services are barely enough to offset the increased demand for services by patients that results in response to PPOs' low in-plan cost-sharing requirements.¹

What does utilization review mean?

Today, most indemnity plans have utilization review programs in place. Utilization review may include prior authorization for certain services (especially for nonemergency hospital admissions), gatekeepers (primary care physicians who must be seen first to obtain referrals to specialists), concurrent review of hospital use (to ensure the patient's discharge to a less intensive setting as soon as medically indicated), and profiling of physician practices to identify those with inappropriate treatment patterns. There is evidence that the most effective forms of utilization review focus on hospital inpatient stays, through preadmission certification and concurrent review for hospital stays²

How much do these different managed care arrangements reduce use of health care services and health care costs?

Evidence from privately insured people indicates that most managed care techniques currently reduce patients' use of services somewhat compared with unmanaged care, although the extent of this effect varies significantly by technique and even among plans using the same techniques (see table below). In general, managed care arrangements become more effective as they mature. With longer experience, it is possible that the relatively poor average performance of IPAs and PPOs (most of which were only recently formed) would improve.

¹See "Effects of Managed Care: An Update," CBO Memorandum (March 1994).

²Ibid.

Average Reduction in Use of Services by Type of Managed Care Arrangement³

Managed Care Plans	
Group/Staff HMOs	22 percent
Independent Practice Associations (IPAs)	4 percent
Fee-for-Service Plans	
With Utilization Review Programs	2-4 percent
With Preferred Provider Organizations (PPOs)	0-2 percent.

Some of the savings from a reduction in use of services are used up in the process of achieving that reduction because monitoring providers and utilization of services raises a plan's administrative costs. But, in addition to savings from a reduction in use of services, large network plans (IPAs and PPOs) are often able to negotiate price discounts with their providers, who agree to accept lower payment rates in return for a larger number of patients. Whether the overall savings to the plans are passed on to consumers through lower premiums depends on whether the plans are in a competitive market.

What is Medicare's experience with alternative cost control techniques, including managed care?

Medicare implemented both price controls and utilization review during the 1970s, in response to rapid growth in Medicare's costs. These early attempts at control were not notably effective, though, and dissatisfaction with them led to three innovations enacted during the 1980s. First, legislation to facilitate Medicare enrollment in HMOs was passed in 1982 and implemented in 1985. Second, Medicare's retrospective cost-based reimbursement system for hospital services in the fee-for-service sector was replaced by the prospective payment system (PPS), which was enacted in 1983 and implemented in 1984. Third, Medicare's charge-based reimbursement system for physicians' services in the fee-for-service sector was replaced by the Medicare fee schedule (MFS), enacted in 1989 and implemented in 1992.

Currently, about 7 percent of Medicare enrollees are in managed care plans--capitated risk-based HMOs. Another 2 percent are enrolled in HMOs that have opted to participate in Medicare on a cost basis; these enrollees may receive services either

³From "The Effects of Managed Care and Managed Competition," CBO Memorandum (February 1995).

through the HMO (which is reimbursed by Medicare on the basis of a cost report) or in the fee-for-service sector. The remaining 91 percent of Medicare enrollees are in Medicare's fee-for-service sector, where a number of managed care techniques are in place.

By contrast, about 20 percent of privately insured people are enrolled in risk-based HMOs. Of the 80 percent in the fee-for-service sector, about half are in plans with effective utilization review and the rest are in plans with relatively ineffective utilization controls.

What techniques are used to control costs in Medicare's fee-for-service sector?

Medicare exercises control over use of hospital services in two ways. First, Medicare's Peer Review Organizations monitor the necessity for hospital admissions and the appropriateness of the care provided in hospital. Second, through its prospective payment system, Medicare has given hospitals strong incentives to minimize enrollees' length of stay, making explicit controls through concurrent review less important. Medicare also monitors physicians' treatment practices in an attempt to identify those with inappropriate patterns of care, although these controls are relatively weak.

In addition, Medicare pays substantially discounted prices for both hospital and physician services--about 60 percent of charges and 70 percent of the average amount paid by private insurers for a given set of services. All Medicare-certified hospitals and 83 percent of physicians who treat Medicare patients accept Medicare's payment rates, meaning that they may collect nothing from patients beyond the cost-sharing requirements imposed by Medicare. In particular, these "participating" providers may not bill the patient for the difference between their charges and Medicare's rates, a practice known as balance-billing. For the minority of physicians who do balance bill, the amount is limited by law to no more than 15 percent of Medicare's payment rate, which is set at 95 percent of the Medicare fee schedule amount for these nonparticipating physicians.

What about the Medicare Select Program? Doesn't it add some elements of managed care to Medicare's fee-for-service sector?

Medicare Select is a demonstration program featuring a medigap PPO that has been available since 1992 in 14 states but would be available nationwide if H.R. 483 is enacted. (Medigap is private insurance that covers some or all of enrollees' cost-sharing liabilities under Medicare.) Enrollees who purchase medigap plans through the Medicare Select program get full coverage for their Medicare cost-sharing

liabilities when they are treated by providers in the PPO's network, but they are fully liable for cost sharing when treated by out-of-plan providers. Select enrollees pay medigap premiums that are typically lower than premiums charged by other medigap plans in the same area. So far, however, these savings have come almost entirely from persuading hospitals to waive Medicare's inpatient deductible amount. There is no evidence that the Medicare Select program has increased the number of networks with cost-effective providers. In fact, most of the enrollment in Select plans currently has come from reclassification of existing medigap enrollment in Blue Cross/Blue Shield network plans in the states selected for the demonstration, a reclassification the plans believed was required under the legislation authorizing the Medicare Select demonstration. An unintended consequence of the demonstration program was that medigap plans with restrictive networks had to be discontinued in the states not participating in the demonstration.⁴

Why is Medicare's HMO participation rate lower than the private sector's?

While about 20 percent of privately insured people are in HMOs, only 9 percent of Medicare enrollees are--7 percent on a risk basis and 2 percent on a cost basis. Initially, Medicare's exclusive reliance on a fee-for-service payment system made it difficult for HMOs to serve Medicare enrollees on a risk basis. It was not until 1982 that legislation was passed to facilitate Medicare enrollment in HMOs on a prepaid risk basis, and regulations to implement the legislation were not final until 1985. Since then, growth in risk-based enrollment has been steady, while cost-based enrollment has grown little (see table).

Growth in Medicare HMO Enrollment (in thousands)

	<u>1985</u>	<u>1990</u>	<u>1995</u>
Cost-Based Enrollment	731	732	758
Risk-Based Enrollment	441	1264	2340

Since 1989, the rate of growth in HMO enrollment for the Medicare population has exceeded the growth rate for HMO enrollment in the non-Medicare population. In 1994, HMO risk-based enrollment increased by 25 percent, while HMO enrollment for the non-Medicare population grew by 11 percent.

Currently, about 75 percent of Medicare enrollees have access to either a risk- or a cost-based HMO. One reason that Medicare enrollees are less likely to enroll in

⁴See "Medicare Select," Congressional Research Service, Report 94-962 EPW (December 2, 1994).

HMOs than does the working-age population is that, unlike those with employment-based health plans, Medicare enrollees have no ready source of information about the HMO options available to them. Another reason is that most Medicare enrollees who were not already in an HMO offered through an employment-based plan prior to retirement will have established ties to fee-for-service providers that they may be reluctant to leave.

Medicare's HMO enrollment rates are highly correlated with, but generally lower than private sector HMO penetration in each area. About 70 percent of HMOs offer a Medicare product--either a risk-based, cost-based, or Select plan. HMO participation on a risk basis in Medicare may be impeded by the volatility of Medicare's payment rates, which are set each year separately by county based on Medicare's costs in the fee-for-service sector.⁵ Other reasons are that the medical needs of the Medicare population differ significantly from the needs of the younger groups that have been the primary market for HMOs, and that HMOs' marketing and administrative costs tend to be higher for Medicare enrollees. One impediment that sometimes prevents Medicare enrollees from continuing with an employment-based HMO on a risk basis after retirement is the requirement that Medicare HMOs be open to anyone in the area, while some employment-based plans are limited to current and former employees.

Why Do Some HMOs participate on a Cost Basis?

Participation on a cost basis was the only way Medicare enrollees could be served by HMOs prior to 1985, at which time Medicare established a risk-based capitated payment system for HMOs while retaining the option of cost-based participation as well. Plans commit to either a risk or cost basis for only a year at a time. Plans may choose the cost basis for a number of reasons, some related to Medicare's payment rates and others related to Medicare's administrative requirements for HMOs.

Plans that expect to incur costs for Medicare enrollees in excess of Medicare's payment rate for them--whether because of poor management, high provider costs, or adverse selection--will opt to participate on a cost basis to avoid losses. Even some well-managed plans may choose to participate on a cost basis in preference to the uncertainty and volatility of Medicare's risk-based payment rates.

In addition, Medicare imposes a number of administrative requirements--intended to protect enrollees--on risk-based HMOs that may cause some of them to prefer participation on a cost basis. For example, the minimum benefit package required for

⁵Physician Payment Review Commission. *Annual Report to Congress, 1995*, Chapter 5.

Medicare enrollees includes some services, such as skilled nursing, that HMOs often do not provide their non-Medicare enrollees, and which they may have to purchase from nonplan providers. Further, risk-based HMOs are responsible for maintaining a number of information, enrollment, and grievance procedures for Medicare enrollees that may not be required for their non-Medicare enrollees. Finally, risk-based HMOs are not permitted to restrict enrollment to certain groups in the area; because some employment-based plans restrict HMO enrollment to current and former employees, Medicare retirees can continue in those HMOs only on a cost basis.

Medicare's costs for those enrolled in cost-based HMOs are probably higher than they would have been in the fee-for-service sector. One reason for this is that cost-based HMOs are generally free to pay providers at rates higher than Medicare's rates in the fee-for-service sector. Another reason is that enrollees are free to use both HMO and fee-for-service providers, so that neither system can exert significant control over use of services.

Do risk-based HMOs save as much for Medicare as they do in the private sector?

Our best guess is that HMOs achieve about the same average percentage reduction in use of services among Medicare enrollees as they do for non-Medicare enrollees. However, under Medicare's payment system these savings benefit enrollees or the HMOs rather than reducing Medicare's costs.

CBO's analysis of the 1992 National Health Interview Survey data indicates that HMOs reduce use of services by about 8 percent for privately insured people and by about 7 percent for Medicare enrollees, on average, when compared with similar people in the fee-for-service sector. For both Medicare and non-Medicare groups, this overall HMO effect is the average of a relatively large effect for group/staff HMOs and a much smaller effect for IPAs.

However, HMOs' effects on use of services do not necessarily lead to savings for payers. In the private sector, savings will typically result when there is sufficient competition among health insurers to induce them to reduce premiums (and profits) in order to maintain or build enrollment. But under Medicare's current payment system for HMOs, it is believed that Medicare spends more for HMO enrollees than it would have spent on them had they remained in the fee-for-service sector. Thus, in the absence of a major increase in enrollment that would alter the current extent of favorable selection among Medicare HMO enrollees, Medicare's costs are likely to increase for each fee-for-service enrollee who switches to an HMO even though use of services by those enrollees might fall.

A recently completed study of Medicare's risk-based HMOs estimated that Medicare

pays 5.7 percent more, on average, for risk-based HMO enrollees than it would have paid had those people stayed in the fee-for-service sector.⁶ This occurs because Medicare's capitation payment to HMOs does not adequately reflect the favorable selection that most HMOs experience with the Medicare population. Medicare's payment for each enrollee is equal to 95 percent of the AAPCC (adjusted average per capita cost). The AAPCC is an estimate of Medicare's cost per enrollee in the fee-for-service sector in the same county, adjusted to reflect the enrollee's age, sex, disability, institutional status, and Medicaid eligibility. If Medicare's payments to risk-based HMOs are 5.7 percent higher than they would have been for the same enrollees in the fee-for-service sector, this means that the AAPCC--which is supposed to represent the expected cost in the fee-for-service sector for enrollees of a given type--is about 11 percent higher than that expected cost.⁷ This 11 percent excess is a measure of the extent of favorable selection experienced by Medicare's risk-based HMOs that is not accounted for in the AAPCC. The experience of individual HMOs doubtless varies around this average, however.

Why is there favorable selection in Medicare's Risk-Based HMOs?

There would tend to be favorable selection among new enrollees for any plan with a restricted panel of providers. This effect is more pronounced among older sicker groups, such as the Medicare population, because most of them have established ties to providers that they may be reluctant to sever. But Medicare's provisions that permit beneficiaries to enroll or disenroll from HMOs on a monthly basis, together with provisions that permit HMOs to switch between cost-based and risk-based reimbursement each year, further contribute to favorable selection for risk-based HMOs.⁸

Isn't there some mechanism to ensure that Medicare doesn't pay HMOs too much for the Medicare people they enroll?

⁶R.S. Brown et al., "The Medicare Risk Program for HMOs--Final Summary Report on Findings from the Evaluation," Mathematica Policy Research, Inc., Princeton, N.J. (February 1993).

⁷If $.95 * AAPCC = 1.057 * FFS$ costs, then the $AAPCC = (1.057 / 0.95) FFS$ costs, or the $AAPCC = 1.11 * FFS$ costs.

⁸F.W. Porell et al., "Factors Association with Disenrollment from Medicare HMOs: Findings from a Survey of Disenrollees," Report to the Health Care Financing Administration, Cooperative Agreement No. 99-C99256/11-06 (July 1992).

Under current law, if a risk-based HMO's profit rate on Medicare enrollees exceeds its profit rate on other enrollees, it is required to return the excess either to the Medicare program or to enrollees. All HMOs in this situation choose to return the excess to enrollees through waived premiums for benefits beyond the basic Medicare package, such as eliminating Medicare's cost-sharing requirements and providing coverage for prescription drugs. The value of additional benefits that the HMO must provide at no additional premium cost is set by the difference between Medicare's average capitation payment to the HMO and the HMO's adjusted community rate (ACR), which is the HMO's estimate of the premium it would charge its Medicare enrollees for the basic Medicare package in the absence of Medicare's capitation payment. HMOs submit an ACR proposal to the Health Care Financing Administration each year.

Estimates for 1991 show that HMOs returned about 9 percent of Medicare's capitation payments to enrollees through additional benefits. This implies that HMOs were able to provide Medicare's basic benefit package for about 86 percent of the AAPCC, on average.⁹ If, because of favorable selection, the AAPCC was 11 percent higher than HMO enrollees' expected costs in the fee-for-service sector, this means that HMOs covered Medicare's basic benefit package for about 96 percent of what those enrollees would have cost in the fee-for-service sector.¹⁰

What changes in Medicare's payment system would generate savings from HMO enrollment in Medicare?

One way to generate savings from HMO enrollment in Medicare might be to add a health status measure to the other factors used to calculate the AAPCC, which is the capitation rate Medicare pays HMOs for each enrollee. According to one study, if a health status indicator for whether the enrollee had a history of cancer, heart disease, or stroke was added to the AAPCC, then Medicare's current payments to HMOs (capitation rates set at 95 percent of the AAPCC) would be about 1 percent lower than Medicare would have paid for those same enrollees in the fee-for-service

⁹Medicare's payments equal $.95 * \text{AAPCC}$, and HMOs returned 9 percent of those payments to enrollees in extra benefits. Hence, HMOs provided the basic Medicare benefit package for $.91 * .95 * \text{AAPCC}$, or for $.86 * \text{AAPCC}$. Again, this no doubt varies by HMO.

¹⁰Because $0.86 * 1.11 = 0.96$. Thus, if Medicare had claimed all of the excess payments identified through the ACR mechanism in 1991, it would have saved 4 percent of its costs for every enrollee who moved from the fee-for-service sector to an HMO, and 9 percent for every enrollee already in a risk-based HMO.

sector.¹¹ The same study indicates that Medicare currently pays 5.7 percent more for HMO enrollees than they would have cost in the fee-for-service sector. This means that adding health status to the AAPCC would reduce Medicare's costs for current or currently projected HMO enrollees by more than 6 percent. In fiscal year 1995, this would have reduced Medicare spending by about \$900 million.

Another way to generate savings (without changing the AAPCC) would be to claim more of the excess payments identified through the ACR mechanism for Medicare, instead of permitting HMOs to return all of the excess to enrollees through additional benefits. If, for example, Medicare required that half the excess be returned to Medicare, and if the excess remained at its 1991 level of 9 percent, then Medicare's HMO costs would be lower by 4.5 percent. In fiscal year 1995, this would have reduced Medicare spending by \$640 million.

Alternatively, as the Physician Payment Review Commission has suggested, Medicare's capitated payments to HMOs could be set by competitive bidding in areas with adequate competition among plans.¹² The ACR mechanism now in place is already an implicit bidding system whose benefits accrue to enrollees. An explicit bidding system in competitive areas could lead to more aggressive bidding among plans, perhaps inducing plans to reduce their profit rates on Medicare enrollees below current levels.

Relative to current law, however, each of these options for generating savings from HMO enrollment in Medicare would reduce enrollees' incentives to choose an HMO over the fee-for-service sector, because it would either reduce the supplemental benefits HMOs provide or increase the supplemental premiums HMOs charge. In many areas, though, enrollees would still be able to get comprehensive coverage through an HMO for less than they would pay for medigap coverage in the fee-for-service sector. Stronger incentives to choose lower-cost alternatives could be created by charging supplemental premiums to enrollees who remain in Medicare's fee-for-service when lower-cost alternatives are available in the area.

¹¹R.S. Brown et al, "The Medicare Risk Program for HMOs--Final Summary Report on Findings from the Evaluation," Mathematica Policy Research, Inc., Princeton, N.J. (February 1993).

¹²See PPRC's *Annual Report to Congress, 1995*, Chapter 5.