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## PROPOSED MEDICARE MANAGED CARE INITIATIVE

HHS's approach to expanding and improving Medicare managed care options involves four elements that are interrelated:

- Expanding the types of managed care options available to Medicare beneficiaries and the types of organizations offering managed care products;
- Improving the Average Adjusted Per Capita Costs (AAPCC) payment methodology and developing alternatives;
- Fostering continuous improvement in health plan quality; and
- Making Medicare beneficiaries more informed about managed care.

Our strategy is aimed at improving current options and offering new options through high-quality, private managed care plans that meet beneficiaries' needs and which are paid fairly.

### EXPANDING OPTIONS AND EXPANDING TYPES OF CONTRACTING ORGANIZATIONS

Background - Currently, 74 percent of Medicare beneficiaries have access to a managed care plan and 9 percent of Medicare beneficiaries have chosen to enroll in a managed care option (entities with risk or cost contracts and Medicare SELECT plans). This 9 percent figure does not include beneficiaries who have supplemental coverage through a managed care plan as retirees.

1994 was a year of impressive growth in Medicare managed care with double digit increases both in plan enrollment and the number of plans participating in the program. Plan enrollment increased by 16 percent. We now have 11 counties where 40 percent or more of our beneficiaries are enrolled in managed care, an additional 30 counties with enrollment between 30 and 40 percent, and more than 44 counties with enrollment between 20 and 30 percent.

More important for future enrollment growth is the number of contracts with managed care plans. In 1994, the number of our Medicare managed care plans increased by 20 percent. Many of these new contracts are in regions beyond those that traditionally have had a strong Medicare managed care presence. In our Philadelphia region, the number of contracts increased from 6 to 16 and in the Boston region contracts increased from 4 to 9.

Although managed care in Medicare is strong and growing, we need to do more to expand options so that Medicare beneficiaries will have the same range of choices as are available to commercial enrollees.

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## Initiatives

- o Preferred Provider Organizations. Legislation will be proposed to allow Preferred Provider Organizations (PPOs) to contract with Medicare on a risk or a new partial risk basis (described below under Improved Payment Methodology). Examples of the types of entities that could contract under this new authority include commercial PPOs that:
  - Operate as indemnity insurers--that is, they do not assume full risk for the provision of services (they have premium margins to recover losses, or the premium is adjusted to recover the losses);
  - Share risk with an employer or other entity (other than its providers); and/or
  - Have a network of providers, but the full range of services are not available in plan, or, though there is a full range of services available through the network, enrollees do not necessarily obtain services "primarily" in plan.

Beneficiaries choosing to enroll with a PPO would automatically receive a self-referral option (SRO) under which any and all Medicare benefits could be obtained out-of-plan subject to standard Medicare cost-sharing. (See HCFA-96/71)

- o Self-Referral Option. HHS is currently developing guidelines, under existing statutory authority, for current risk contractor to offer SRO with implementation anticipated by 1996. The SRO would be similar to "point-of-service" plans that HMOs offer in the commercial marketplace. In contrast to the PPO option, the HMO-based SRO would be optional for both plans and enrollees. Plans would not have to offer such a benefit but if they did it would be as an optional benefit. Plans would have flexibility on the design of the SRO; however, all Medicare-covered services would have to continue to be available and accessible in-network for all enrollees.
- o Integrated Delivery Systems. HHS is also planning to use its demonstration authority to explore the possibilities of contracting on a risk or partial risk basis with integrated delivery systems (e.g., hospital-physician organizations) that are not already HMOs or that could not meet the PPO requirements. Preliminary discussions are already underway with a number of such systems.

## IMPROVED PAYMENT METHODOLOGY AND ALTERNATIVE METHODOLOGIES

Background - The current payment methodology for risk contractors, the adjusted average per capita cost (AAPCC) methodology, is often viewed as a flawed methodology. There is no adjustment for health status, and payments vary from area to area in ways that do not reflect variation in HMO costs across areas. The rates are derived through a complex computation method that has been controversial in and of itself, but the methodology is not necessarily inaccurate in what it is intended to accomplish (which is to predict fee-for-service costs on a county-by-county basis).

For Medicare to benefit from an expansion of managed care, significant improvements are needed in the way that Medicare pays plans. Managed care currently costs the Medicare program rather than achieving savings. HHS evaluations have suggested that Medicare pays 5.7 percent more for every enrollee in managed care than would have been paid if the beneficiary had stayed in fee-for-service. The reason for this is that plans attract the healthier members of the Medicare population whose health care costs are lower and a workable health status adjustor is currently not available.

### Initiatives

- o Risk Adjusters. For the past decade, HHS has been a leader in supporting research to develop health status adjusters for risk payments. Current research efforts should produce health status adjusters that can be used on a pilot or demonstration basis as early as 1996. HHS has also undertaken a demonstration project in which we are working collaboratively with participating HMOs in Seattle to develop a high-cost outlier pool risk-adjustment mechanism.
- o Competitive Pricing. As a potential alternative to the AAPCC, legislative authority will be sought to demonstrate using competitive pricing for rate-setting. In such a methodology, Medicare payments to plans would be based on a bidding process whereby competition among participating plans would determine payment levels (within certain limits). As part of the demonstration, beneficiaries would receive unbiased comparative information about plans. The demonstration payment methodology would be the only payment option available to Medicare managed care plans in the demonstration areas. (See HCFA-96/61)
- o Alternative Payment Demonstrations. HHS has entered into discussions with Kaiser to develop a demonstration of an alternative risk payment methodology based on rates established by competition in the commercial (non-Medicare) marketplace. Rates offered to commercial accounts would be

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adjusted for the Medicare benefit package and the higher risk of serving Medicare enrollees. In addition to this potential demonstration with Kaiser, HHS will soon issue a broad solicitation for demonstrations of alternative payment methodologies and risk sharing arrangements.

- o Partial Risk. Under another legislative proposal, the current archaic cost contracting options would be replaced with a partial risk methodology. Under this approach, plans would be paid on a fee for service basis minus a withhold for the provision of services to enrollees. Total payments at the end of the year would be compared with a target, initially set at 95 percent of the AAPCC.
  - + If total payments were less than the target, the plan would receive half of the difference.
  - + If total payments exceeded the target, the plan would receive half of that amount. However, Medicare payments could not exceed 100 percent of the AAPCC. (See HCFA-96/72)
- o AAPCC Technical Changes. Finally, HHS is working with the HMO industry to explore their technical concerns with the AAPCC methodology, e.g., MSA, rather than county-based, rates.

## FOSTERING CONTINUOUS IMPROVEMENT IN HEALTH PLAN QUALITY

Background - Monitoring quality of care for risk plans is especially important since capitation provides financial incentives to limit medical care. HHS monitors the quality of care provided by Medicare managed care plans through a variety of methods -- complaint monitoring, appeals monitoring, site visits, disenrollment data and external review by Peer Review Organizations (PROs).

PROs monitor quality by conducting medical record reviews for a sample of Medicare beneficiaries enrolled in the managed care plan. This approach can be confrontational and does not give plans insights into systemic problems in the delivery of care. It also does little to help guide them to make fundamental improvements in care.

### Initiatives

- o Cooperative Improvement Projects. HHS is moving away from medical record review and towards the development of performance indicators and cooperative improvement projects between the PROs and risk plans.
- o Performance Indicators. For example, HHS plans to pilot

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test a set of performance indicators developed by the Delmarva Foundation in several risk plans. Based on the performance indicators, the PRO and the risk plans will work cooperatively to develop an appropriate quality improvement plans. In a complimentary project, HHS also plans to begin collaborating with the National Committee on Quality Assurance (NCQA) to expand HEDIS to include performance indicators relevant to the Medicare population.

- o Encounter Data. Quality assurance systems utilizing performance indicators requires that managed care plans collect comparable, encounter data. However, due to the nature of capitation, most managed care plans do not collect this data. HHS plans to convene public and private purchasers of health care services and managed care plans to discuss issues regarding the collection of encounter data.

## INFORMATION\ENROLLMENT

Currently, Medicare beneficiaries do not have the information needed to make an informed choice about available managed care and Medigap options. Even if information were available, comparisons are complicated by varying benefit packages in managed care plans and the use of different premium rating methodologies by Medigap insurers. Limited open enrollment for Medigap further complicates choices.

While Medigap insurers are only required to offer a one-time open enrollment period, Medicare managed care plans are required to offer an annual open enrollment period of at least 30 days to all Medicare beneficiaries living in the service area. As a result, beneficiaries who enroll in managed care plans (and stay enrolled through their Medigap open enrollment period) lose their opportunity to purchase the Medigap plan of their choice.

## Initiatives

- o Consumer Information. As part of the competitive pricing demonstration described above HHS will be exploring how best to communicate to beneficiaries their available managed care and Medigap choices.
- o Level Playing Field. Under a legislative proposal, the current limited open enrollment for Medigap plans would be expanded to the requirement that currently applies to risk and cost contractors. Medigap plans would have to be open to all Medicare beneficiaries for a thirty day period every year. This provision should reduce the reluctance of Medicare beneficiaries to enroll in managed care options since they would not be giving up what is essentially a one-time option to select the Medigap plan of their choice. (See HCFA-96/70)

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HCFA-96/71

HEALTH CARE FINANCING ADMINISTRATION  
FISCAL YEAR 1996 LEGISLATIVE PROPOSAL

Medicare PPO Option

Expand the Types of Managed Care Entities That Can Contract to Enroll Medicare Beneficiaries to Include PPOs and Other Entities; Define Base Benefit Package to Include a Comprehensive Self-Referral Option

Current Law: Federally qualified HMOs and entities meeting the requirements to qualify as a competitive medical plan (CMP) can contract with Medicare on either a risk or cost basis to provide the Medicare benefit package to plan enrollees. They must provide all Medicare Part A and Part B services available in their geographic area.

In order for HMOs and CMPs to be eligible to contract with Medicare, they must either be a Federally Qualified HMO or meet certain criteria related to their commercial business. Among these criteria, the entity must:

- o provide physician services exclusively or primarily (defined as at least 51 percent) through physicians who are the plan's employees or partners, or who are under contract with the HMO, except for unusual and emergency services; and
- o assume full financial risk on a prospective basis for the provision of health care services.

Some preferred provider organizations (PPOs) and insurers cannot meet these requirements.

Contracting HMOs and CMPs can opt to be paid on either a full risk or cost basis. These two payment arrangements have specific implications for plan enrollees in regard to how they receive their care:

- o Cost plan enrollees are not locked in, i.e., if they choose to obtain out-of-plan services, Medicare pays its established payment and the cost plan enrollee is responsible for any Medicare cost sharing, e.g., 20 percent coinsurance for physician services.
- o Risk enrollees are locked in; if they choose to obtain out-of-plan services, they are responsible for payment of the full charges for those services.

Entities with risk contracts do have an option of providing an alternative to a strict lock-in through the use of a self-referral option (SRO). Under an SRO, an enrollee has the option of going out-of-plan for some subset of services and receiving

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partial payment from the HMO or CMP. Plans have flexibility in the design of SROs, but they can only be offered as an optional supplemental benefit.

Proposal: Allow (1) preferred provider organizations; (2) licensed insurance companies; and (3) prepaid hospital or medical service plans that meet the following criteria to contract with Medicare on a full or partial risk basis as "preferred provider organizations" or PPOs.

The contracting organization must:

- o be in the business of providing a plan of health insurance or health benefits, and be organized under the laws of any State.
- o provide physicians' services directly (1) through physicians who are either employees or partners of such an organization or (2) through contracts or agreements with individual physicians or one or more groups of physicians.
- o have made adequate provision, satisfactory to the Secretary, against the risk of insolvency (see §1876(b)(2)(E)).
- o have effective procedures, satisfactory to the Secretary, to monitor utilization and to control the cost of services.

In addition to the current requirement to offer all Medicare-covered benefits available in the geographic area, these PPOs would be required to provide Medicare enrollees a comprehensive self-referral (CSRO) benefit. Under the CSRO benefit, enrollees would have the option of obtaining any and all Medicare-covered benefits through a non-network provider. Cost sharing for non-network services could not exceed the Medicare deductibles and coinsurance amounts charged in traditional fee-for-service Medicare.

PPOs contracting on a full risk basis would include the cost of the comprehensive self-referral option (CSRO) with the cost of Medicare benefits when computing the adjusted community rate (ACR).

Requirements for an ongoing quality assurance program, availability and accessibility standards, enrollment standards, grievance and appeals requirements, review of marketing material, minimum commercial enrollee base, 50/50 enrollment requirement and intermediate sanctions and civil monetary penalties would be the same as those that apply to HMOs and CMPs.

Rationale: When the Medicare HMO/CMP provisions were enacted in 1982, only two options for health care coverage were available in the commercial sector: (1) fee-for-service plans or (2) lock-in (i.e., no coverage for any out-of-plan services) health maintenance organizations. Subsequently, hybrids of fee-for-

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service and lock-in HMOs were developed. They allow individuals and payers to obtain some of the cost and quality benefits of a managed care system, while also providing enrollees with the option of obtaining reimbursement for out-of-plan services. These hybrids go by several names, e.g., point of service options, preferred provider organizations, self-referral options, and out-of-network options.

Since they first became widely available, these options have become very popular with commercial enrollees, accounting for much of the dramatic growth in commercial managed care enrollment. This proposal would make such an option available to Medicare beneficiaries. Under this proposal, beneficiaries would be able to receive the benefits of managed care, but they would also have the option of receiving coverage if they go out-of-plan to receive services. It would also expand the number and types of managed care plans available to Medicare beneficiaries.

Effect on Beneficiaries: This proposal would make a comprehensive self-referral option available to Medicare beneficiaries, giving them more choices similar to those available in the commercial sector.

Cost: None.

Effective Date: January 1, 1997.

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HCFA-96/61

## HEALTH CARE FINANCING ADMINISTRATION FISCAL YEAR 1996 LEGISLATIVE PROPOSAL

### Medicare HMO Competitive Pricing Demonstration

#### Permit a Medicare HMO Competitive Rate Setting Demonstration

Current Law: Medicare pays health maintenance organizations (HMOs) and competitive medical plans (CMPs) with risk contracts 95 percent of the Adjusted Average Per Capita Cost (AAPCC). The AAPCC is Medicare's estimate, for each calendar year, of what the average cost per beneficiary would have been in the fee-for-service system in a specific county; this is the base rate. The base rate is then adjusted by demographic characteristics of Medicare beneficiaries; i.e., age, sex, institutional status, and Medicaid status. There is no adjustment for an individual's health status. HMOs may also enter into cost-reimbursement contracts with Medicare.

If a risk HMO's expected revenue from AAPCC payments exceeds the revenue needs of the HMO for providing Medicare covered services (including the same level of profit the HMO generates in the commercial market), the HMO must either accept a reduced government payment or return the "savings" to beneficiaries by reducing beneficiary charges or providing non-covered services.

Participation in demonstrations currently must be voluntary; entities cannot be required to participate in a demonstration.

Proposal: Permit the Secretary to conduct a demonstration under which rates paid to Medicare HMOs would be established using a competitive pricing methodology, including, but not limited to, a method that bases Medicare rates on the commercial, competitively determined rates of plans. Plans would compete in the context of coordinated open enrollment process and would bid using a standard basic benefit package. In its offering to beneficiaries, plans would be required to adhere to the premium structure included in their bid.

All HMOs in demonstration areas that want to continue to serve Medicare beneficiaries would either have to participate in the competitive pricing demonstration or receive payment under Medicare fee-for-service rules (including through Medicare SELECT, if available). There would be no cost option available to HMOs in such areas. Total payments across demonstration sites would be subject to a payment limit of 95 percent of the AAPCC, although payments to individual areas could exceed 95 percent of the AAPCC. The government contribution in an individual geographic area would be limited to 100 percent of the AAPCC. The Secretary would develop special transition rules in market areas where risk plan enrollees currently pay small or no premiums to prevent drastic increases in premiums as a result of

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the demonstration.

Other managed care options, such as preferred provider organizations and integrated delivery systems, might be eligible to participate in the competitive pricing process. Employer-based or union-based plans for retirees might also be included.

HCFA would develop details of the competitive pricing process, such as what type of health status adjuster to use; the minimum number of bidders; and the criteria for selecting geographic areas. It is anticipated that the geographic areas would include both relatively high and low payment areas and areas with both relatively high and low market penetration.

Rationale: Under the current payment methodology, the government determines rates on a yearly basis, and the HMOs decide, based on those rates, whether they wish to enter into contracts with Medicare. The established rates are based on historical fee-for-service costs in a given county, and the payment rates can vary significantly from year to year and from county to county. The AAPCC payments do not appear always to reflect the expected cost to a managed care organization of providing medically appropriate care to Medicare beneficiaries. For example, the 1995 monthly rates in counties in Miami are in the \$550 to \$600 range. Plans in Miami charge no premiums, and offer generous additional benefits at no cost. In contrast, the rates in counties in Minneapolis are in the \$360 to \$380 range; these plans must charge about \$150 a month to offer a benefit package comparable to what is available to beneficiaries in the Miami area.

This disparity in AAPCC rates has been a constant source of criticism, particularly from plans on the low end of the payment scale and beneficiaries who reside in their service areas, as well as from many observers who find such wide disparities disconcerting. (This disparity is addressed by creating ceilings and floors on Part B AAPCC rates, see HCFA-96/\_\_\_.) While the current methodology, which derives the base payment rate from Medicare's fee-for-service costs, is subject to criticism, there are very few options for changing it. One that has received a great deal of attention from the HMO industry, from academics, and from commercial payers is competitive pricing. A competitive pricing methodology should result in rates that more accurately reflect the true costs of doing business, and competitive pricing should promote efficiency through greater competition among health plans.

In a competitive pricing model, competition among health plans would establish the premiums in a given area (the premium being the government contribution, replacing the AAPCC, plus beneficiary liability amounts). Plans would "bid" on Medicare-covered services (i.e., offer to provide a defined set of services for a set premium), and the Medicare contribution would be set at the lowest bid or some higher level that takes advantage of bids offered by the most efficient HMO or HMOs.

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Alternatively, the plan premium could be based on the level of premiums the HMO charges in the commercial sector multiplied by a Medicare utilization factor.

There would not be a winner-take-all approach, in that high-bid HMOs would be allowed to participate and charge higher premiums to Medicare beneficiaries (based on their bid having exceeded the level of the government contribution). With plans offering a standard benefit package, competition among the plans for the Medicare population would be based on price and known or perceived quality (e.g., higher-cost plans might offer a greater range of providers or might include providers that are highly regarded in the community). There would also be a risk adjustment methodology to ensure that price differentials among HMOs do not reflect a healthier mix of enrollees in one or more HMOs.

The proposed demonstration would be mandatory because any change to the AAPCC methodology would create winners and losers relative to the status quo, and it would be difficult to develop consensus on changing the rate setting methodology. Since any HCFA demonstrations of competitive pricing would create winners and losers, voluntary demonstrations would not allow us to adequately demonstrate such a change because only plans that believe they would benefit (those in relatively low payment areas) would choose to participate. HCFA needs to require appropriate areas to participate in a demonstration if we are to adequately study whether this approach to ratesetting merits program-wide implementation.

Designing a demonstration of competitive pricing would require a significant investment of time because of the many complex, interrelated issues that would have to be addressed. It is not appropriate to invest the time needed to design such a demonstration unless plans in certain areas can be required to participate, and such a demonstration would not have merit if it did not involve all plans in a defined geographic area.

Effect on Beneficiaries: Beneficiaries in areas with high payments under the AAPCC method might have higher premium costs than they do now. Conversely, beneficiaries in lower payment areas might have lower individual premiums if Medicare's payments exceed 95 percent of the AAPCC. A more equitable payment system might ultimately encourage more plans to contract with Medicare, making the HMO option more widely available to our beneficiaries.

Cost: None.

Effective Date: January 1, 1997.

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HCFA-96/72

HEALTH CARE FINANCING ADMINISTRATION  
FISCAL YEAR 1996 LEGISLATIVE PROPOSAL

Partial Risk Payment Option

Create a Partial Risk Payment Methodology for Managed Care Entities

Current Law: Under Section 1876 of the Social Security Act, Federally qualified HMOs and entities meeting the requirements to qualify as a competitive medical plan (CMP) can contract with Medicare on either a risk or cost basis to provide the Medicare benefit package to plan enrollees. Under Section 1833(a)(1)(A), plans can enter into agreements with the Medicare program to provide or arrange for Part B medical and other health services on a prepayment basis. Two types of organizations enter such agreements: (1) commercial health maintenance organizations (HMOs) and (2) union- or employer-sponsored prepaid health plans. HCFA regulations refer to these organizations as "health care prepayment plans (HCPPs)."

Except for requirements about beneficiary cost-sharing liability, §1833(a)(1)(A) does not impose requirements for beneficiary or program safeguards on HCPPs. For example, there are no requirements that: prohibit health screening; require review of marketing material; provide assurances about the availability and accessibility of services within a defined service area; offer a process for enrollee grievances; or assure fiscal solvency. In addition, HCFA has almost no recourse if an HCPP performs poorly, whereas section 1876 contracts can be terminated or civil monetary penalties imposed if requirements are not met.

As a result of a provision in the Social Security Amendments of 1994, HCPPs will be treated as Medigap products as of January 1, 1996. Although employer- or union-sponsored plans are not affected by this requirement, other HCPPs would be unable to meet Medigap requirements such as the requirement for standard benefit packages.

HMOs and CMPs electing risk payment under section 1876 receive a predetermined monthly per capita payment based on 95 percent of Medicare's projected adjusted average per capita cost (AAPCC) for beneficiaries who are not enrolled in HMOs, i.e., they are in fee-for-service Medicare. Risk plans can obtain private reinsurance, but from the Medicare program's perspective, they are at full risk for the cost of services to enrollees. That is, they can keep any difference between their costs and their Medicare payments. Similarly, they are liable for any losses they sustain if Medicare payments do not cover their costs.

Except for the scope of benefits provided, payment to an entity electing a cost contract under section 1876 or an HCPP agreement under section 1833 is similar. Under both arrangements, the entity receives interim payments, subject to annual

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reconciliation of the cost report. Although in theory Medicare receives the full benefit from these managed care arrangements, plans have little incentive to be efficient because they are reimbursed for the costs that they document, subject to general provisions about reasonableness of costs. Sometimes they receive payments substantially in excess of 100 percent of the AAPCC, based on their reported costs.

Under current law, there is no partial risk payment methodology.

Proposal: Create a new partial risk payment option for managed care plans that contract with Medicare. Under this option, the entity would be paid for services provided to plan enrollees on a fee-for-service basis using Medicare payment rates, minus a five percent withhold. The entity would then pay providers and suppliers based on its negotiated rates.

At the end of the year, total Medicare payments plus the withhold would be compared to a target (initially established at 95 percent of the Adjusted Average Per Capita Cost (AAPCC)).

- o If this total were less than the target, the plan would receive the full withhold plus a bonus payment equal to 50 percent of the difference between the total Medicare payments (plus the withhold) and the target.
- o If the total were greater than the target, but less than 105 percent of the AAPCC, the plan would have to forfeit that portion of the withhold equal to 50 percent of the amount by which the target was exceeded.
- o If the total exceeded 105 percent of the AAPCC, the entity would forfeit that portion of the withhold, plus pay an additional penalty, if necessary, such that the total net payments to the entity would not exceed 100 percent of the AAPCC. If this happened in two consecutive years, the contract with the entity would be terminated.

Unlike the full risk methodology, entities would not be required to submit Adjusted Community Rates (ACRs) or provide any additional benefits beyond the base benefit package. This package, however, would include Medicare benefits, unlimited hospitalization, SNF services without a prior hospitalization requirement, and preventive services (for PPOs, the base package would also include a comprehensive self-referral option (CSRO), however, the CSRO would be limited to Medicare benefits (i.e., would not include unlimited hospitalization, etc.)).

As with the full risk option, the plan premium plus the actuarial value of cost-sharing for the base benefit package (excluding cost-sharing under the CSRO for PPOs) could not exceed the actuarial value of Medicare deductibles and coinsurance.

Requirements for an ongoing quality assurance program,

availability and accessibility standards, enrollment standards, grievance and appeals requirements, review of marketing material, 50/50 requirement, intermediate sanctions and CMPs would be the same as applies to risk contractors. Entities would be required to have 1,500 commercial enrollees in order to contract on a partial risk basis (5,000 enrollees are required for full risk). They would also have to demonstrate that they had adequate reinsurance to protect against the possibility of losses above 105 percent of the AAPCC.

For purposes of computing the AAPCC, enrollees in plans under the partial risk arrangement would be treated as fee-for-service beneficiaries.

The current HCPP option would be eliminated for managed care plans (entities that provide or arrange for inpatient hospital services in addition to Part B services, excluding union-sponsored plans), effective January 1, 1997. HCFA would provide oversight of the remaining HCPPs (with appropriate provisions of section 1876 being applied to these entities) and coverage of HCPPs under the Medigap definition would be repealed.

Except for HCPPs converting to section 1876 cost contracts, no new cost contracts would be entered into after January 1, 1996. The partial risk option would be available starting January 1, 1997. The cost option would be eliminated January 1, 2001.

Rationale: Some prepaid plans that contract with Medicare choose the cost contracting or HCPP options. However, Medicare costs for these entities often exceed 100 percent of the AAPCC, which means that Medicare pays more for these enrollees than it would have if they had stayed in fee-for-service Medicare. Further, preparation of cost reports and auditing of cost reports is a long and time-consuming process for both the plans and HCFA staff. In addition, since the early 1980s, partial risk payment arrangements in the commercial sector have become popular.

If cost plans are reluctant to assume full risk, a partial risk option should alleviate some of their concerns, while providing necessary incentives to manage care more effectively than they do currently. In addition, plans that have rejected both the cost and full risk options may choose to contract on a partial risk basis, particularly entities that conduct their commercial business on a partial risk basis.

The proposed partial risk payment methodology would provide HCFA with full utilization information and, to the extent that plans are successful in reducing unnecessary utilization, would have a restraining effect on the AAPCC in the area. Plans could use savings from discount arrangements and their share of the utilization savings to establish premiums substantially below those of traditional Medigap policies. Unlike the full risk methodology, plans would receive only half of any benefit resulting from favorable selection. It is assumed that the

partial risk option would normally lead to the assumption of full risk.

Effect on Beneficiaries: Assuming that more managed care entities would choose to contract with Medicare if a partial risk option were available, this proposal would make more managed care options available for beneficiaries.

Cost: None.

Effective Date: January 1, 1997.

## HEALTH CARE FINANCING ADMINISTRATION FISCAL YEAR 1996 LEGISLATIVE PROPOSAL

### Establish Annual 30-Day Open Enrollment for Medigap Policies

Current Law: Medigap insurers are required to have a six-month open enrollment period for Medicare beneficiaries that starts when they enroll in Part B and turn age 65. Outside of this one-time window, insurers may use health screening and medical underwriting to either exclude beneficiaries on the basis of health status or adjust premiums on the basis of past or potential use of services. During the open enrollment period, and at any other time, insurers can apply a six-month waiting period for benefits related to the treatment of a condition treated or diagnosed in the six months prior to the purchase of a policy.

Medicare SELECT policies are subject to the same enrollment provisions as are regular Medigap policies. However, SELECT insurers must make available, at the beneficiary's request and without further evidence of insurability, any non-SELECT policies that they otherwise offer that contain comparable or fewer benefits than the SELECT policy.

Managed care plans with risk or cost contracts with Medicare are required to have an annual thirty-day open enrollment period for all beneficiaries living in the service area. Plans are not permitted to health screen, impose pre-existing condition limitations or charge different premiums on the basis of health status.

Proposal: Require Medigap insurers to offer policies as guaranteed issue to all Medicare beneficiaries during an annual 30-day period, the timing of which is at the insurer's discretion.

Rationale: Health screening and medical underwriting can make it impossible for beneficiaries to obtain the Medigap policy of their choice after their one-time open enrollment period has ended. This discourages some beneficiaries from choosing to enroll in risk contracts or Medicare SELECT because they waive their open enrollment opportunity if they stay in the selected managed care option for longer than six months. In some cases, beneficiaries may purchase and carry an unnecessary Medigap policy as a safeguard in the event that they disenroll from managed care. Requiring Medigap insurers to offer an annual open enrollment period could eliminate these problems, which would increase the likelihood that beneficiaries would choose a managed care option. It would also benefit individuals who wish to change (e.g., upgrade) their level of coverage in a regular Medigap policy or switch from a policy that is attained-age rated or otherwise undesirable.

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Effect on Beneficiaries: An annual open enrollment period for Medigap policies would remove a barrier to participation in managed care and ensure the availability of choices for beneficiaries purchasing Medigap policies.

Cost: None.

Effective Date: January 1, 1996.

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HCFA-96/69

## HEALTH CARE FINANCING ADMINISTRATION FISCAL YEAR 1996 LEGISLATIVE PROPOSAL

### Permit Exceptions to Enrollment Requirement

Current Law: The combined enrollment of Medicare beneficiaries and Medicaid recipients may not exceed 50 percent of total enrollment for Medicare-contracting HMOs and CMPs (50/50 rule). Presently, waivers are permitted in two circumstances: (1) for contracting organizations in areas where the proportion of Medicare and/or Medicaid eligibles exceeds 50 percent of the area's population, and (2) for publicly owned or operated contracting organizations for a period of three years as long as the entity is making an effort to enroll commercial members.

Proposal: Permit waivers or modifications of the 50/50 rule for Medicare contracting HMOs/CMPs that (1) have a substantial Medicare enrollment in a State and wish to participate in the State's Medicaid managed care program or (2) would like to contract to serve a rural area. The Secretary would determine the factors and conditions that warrant a waiver, such as the level of managed care penetration and competition for commercial enrollment in an area, commercial enrollment trends, and demographics and other population characteristics. To qualify for the waiver, the following standards would be required. The HMO/CMP:

- a. has contracted with HCFA and continuously served Medicare enrollees in the State for at least the previous three years;
- b. has demonstrated, during the last three years, compliance with program requirements for quality, access, marketing, health services delivery, enrollment (including 50/50), and fiscal soundness;
- c. complies with additional quality monitoring and reporting requirements specified by HCFA, including collection and reporting of 100 percent encounter data;
- d. assures that appeal and grievance procedures meet Medicare and Medicaid requirements; and
- e. meets a minimum commercial enrollment requirement established by the Secretary and continues to make a reasonable effort to enroll commercial members.

Where the health plan is participating in a Medicaid managed care initiative, the HMO or CMP would be required to meet the 75/25 enrollment requirement set forth in §1903(m). If a health plan is participating in a Medicaid managed care program in a State with §1115 waiver authority and the State is exercising its option to waive the 75/25 requirement, then the HMO or CMP would

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be waived from meeting an enrollment requirement. In the latter case, HCFA could implement additional monitoring activities/requirements deemed necessary.

Rationale: A number of HCFA's contracting health plans committed to serving the senior population also wish to participate in State Medicaid managed care initiatives. However, participation in these State initiatives might jeopardize the plan's ability to enroll seniors, or continue to contract with HCFA, because of the 50/50 rule. For example, a Federally qualified HMO serving the greater Philadelphia area currently has over 10,000 Medicare enrollees in a risk contract and serves over 35,000 Medicaid enrollees under Pennsylvania's HealthPASS program; commercial enrollment is 50,000. The State is implementing a new program, HealthCHOICES, which will expand managed care from 250,000 to 650,000 Medicaid eligibles by mid-1995 in the greater Philadelphia area. Due to competition from five existing HMOs (including two very large, aggressive plans) in this urban area and six additional "newcomers" entering the market next year, this HMO does not anticipate commercial growth to keep pace with new Medicaid enrollment. Thus, in order to participate in the state's HealthCHOICES initiative, this HMO might be forced to drop its senior plan because of the 50/50 rule.

Additional Medicare contractors, depending on the §1115 and §1915(b) waiver authorities granted to the State, anticipate problems in the near future.

Further, several HMOs have exhibited an interest in serving rural areas and have listed the 50/50 rule among their concerns or barriers. Often, rural populations have high proportions of seniors, and younger residents are often uninsured, thus creating an imbalance in the population's characteristics for meeting this enrollment standard. One Catholic-owned health care chain, which has as part of its mission to enter rural areas and provide care to the underserved, has established an HMO to serve a rural county in Oregon with the cooperation of a local medical center and its managed care-experienced administrator. With active marketing, the health plan has been able to enroll 3,550 commercial members and 1,850 Medicare beneficiaries, but the plan anticipates more growth among seniors. The plan may be in violation of the 50/50 rule by the 1996 contract year and enforcement will require termination of this health plan which is otherwise in good standing. Such an action would deter this nonprofit corporation and other organizations from bringing low-cost, managed health care to other rural areas. The current Medicare enrollees would lose expanded benefits, including preventive services, coordination of care, and lower health expenditures.

Effect on Beneficiaries: This proposal would remove an artificial barrier to the availability of managed care and ensure Medicare beneficiaries, including those residing in rural areas, more choice in obtaining health care. In the absence of this

# DRAFT

change, it is likely that local managed health plans will close or not open enrollment to seniors.

Cost: To be determined.

Effective Date: Upon enactment.

# DRAFT

HCFA-96/67

## HEALTH CARE FINANCING ADMINISTRATION FISCAL YEAR 1996 LEGISLATIVE PROPOSAL

### Expand Authority to Terminate HCFA Contracts with Managed Care Plans

Current Law: Section 1876 provides that managed care plans may contract with HCFA provided they are Federally qualified health maintenance organizations (FQHMOs) as provided by Title XIII of the Public Health Service Act, or competitive medical plans (CMPs), according to §1876 requirements.

A FQHMO is eligible to contract under §1876 as long as it meets the requirements of §1302(c) of the Public Health Service Act. In order to termination a Medicare risk contract with a FQHMO, HCFA must first revoke the entity's Federal qualification status.

Proposal: Permit the termination process on a Medicare risk or cost contract with a FQHMO to begin when a finding of non-compliance is made in regard to the financial viability or provider network requirements for Federal qualification.

Rationale: Revocation of Federal qualification is a lengthy process, during which a Medicare contracting plan may continue to receive payments for and provide services to Medicare beneficiaries despite HCFA's finding of operational or access problems. This proposal would allow the Secretary to start the contract termination process approximately 60 days earlier.

Effect on Beneficiaries: This proposal would protect beneficiaries by reducing the length of time that they remain locked-in to a risk plan that is out of compliance with operational standards. Corresponding beneficiary access and quality problems would be reduced by accelerated termination.

Cost: Minor reduction in administrative costs.

Effective Date: Upon enactment.

# DRAFT

HCFA-96/73

## HEALTH CARE FINANCING ADMINISTRATION FISCAL YEAR 1996 LEGISLATIVE PROPOSAL

### Beneficiary Protections When Obtaining Out-of-Plan Services

#### Limit Amounts That Managed Care Enrollees Can Be Charged When Obtaining Out-of-Plan Services to Medicare Allowable Amounts

Current Law: Medicare risk plan enrollees receive coverage of services only when they use the physicians and other providers in their plan's network; this is referred to as the "lock-in." The effect of the lock-in is that, if risk enrollees choose to obtain out-of-plan services (other than emergency or urgently needed care), they are responsible for payment of the full charges for those services. Risk HMOs and CMPs may offer Medicare enrollees, as an optional supplemental benefit, a self-referral option (SRO). Under an SRO, the risk enrollee would have the option of going out-of-plan and receiving partial coverage of specified services from their HMO or CMP. For example, the enrollee might have to pay 30 percent coinsurance for a \$100 out-of-plan physician visit, instead of a \$10 copayment for receiving the same service in-plan. However, some risk plans do not offer an SRO benefit, and not all enrollees choose the SRO benefit even if one is offered by their plan.

When non-network hospitals, physicians, skilled nursing facilities, and dialysis facilities provide plan-covered services to risk enrollees, current law requires them to accept Medicare's payment level as payment in full from the risk plan. However, the same protection against charges in excess of Medicare allowable amounts has not been extended to risk plan enrollees who choose to obtain out-of-plan services.

Proposal: Extend the requirement for: (1) providers to accept Medicare payment as payment in full; (2) participating physicians to accept the fee schedule amount as payment in full; and (3) non-participating physicians to limit their submitted charges to the limiting charge for enrollees of managed care plans who receive services out-of-plan, whether or not they have an SRO benefit.

Rationale: Many commercial SROs provide that the enrollee pays for the out-of-plan service and then receives reimbursement from the HMO/CMP. Under current law, in SROs structured in this way, the beneficiary could be liable for substantial costs above Medicare's allowable amounts because the law does not protect them from being charged amounts that exceed Medicare's allowable amounts. Similarly, beneficiaries not covered by an SRO benefit are now liable for the full charges for any out-of-plan services they obtain, including charges in excess of Medicare allowable amounts.

# DRAFT

Improving the flexibility of managed care options by providing self-referral options to enrollees is expected to increase Medicare enrollment in managed care plans. It is not appropriate for physicians, providers, and suppliers to receive payments in excess of Medicare allowable amounts when they serve a beneficiary who is enrolled in a managed care plan simply because the beneficiary is using his or her SRO benefit. Further, this potential additional cost could discourage use of the SRO, hence diluting its value as an incentive for beneficiaries to enroll in a lock-in managed care plan.

In addition, beneficiaries who do not have an SRO benefit might occasionally desire out-of-plan services enough to pay the full charge for such services. Again, physicians and providers should not be permitted to charge a Medicare beneficiary amounts in excess of Medicare allowable amounts simply because the beneficiary is enrolled in a risk plan.

Effect on Beneficiaries: This proposal would affect beneficiaries who obtain out-of-plan services (whether or not they have an SRO benefit) by protecting them from charges in excess of Medicare allowable amounts.

Cost: None.

Effective Date: Upon enactment.

This is Legislative & Admin

**PROPOSED MEDICARE MANAGED CARE INITIATIVE**

*Last 2 pages*

HHS's approach to expanding and improving Medicare managed care options involves four elements that are interrelated:

*Summary of proposals.*

- Expanding the types of managed care options available to Medicare beneficiaries and the types of organizations offering managed care products;
- Improving the Average Adjusted Per Capita Costs (AAPCC) payment methodology and developing alternatives;
- Fostering continuous improvement in health plan quality; and
- Making Medicare beneficiaries more informed about managed care.

*I also have more detailed specs.*

Our strategy is aimed at improving current options and offering new options through high-quality, private managed care plans that meet beneficiaries' needs and which are paid fairly.

**EXPANDING OPTIONS AND EXPANDING TYPES OF CONTRACTING ORGANIZATIONS**

**Background** - Currently, 74 percent of Medicare beneficiaries have access to a managed care plan and 9 percent of Medicare beneficiaries have chosen to enroll in a managed care option (entities with risk or cost contracts and Medicare SELECT plans). This 9 percent figure does not include beneficiaries who have supplemental coverage through a managed care plan as retirees.

1994 was a year of impressive growth in Medicare managed care with double digit increases both in plan enrollment and the number of plans participating in the program. Plan enrollment increased by 18 percent. We now have 11 counties where 40 percent or more of our beneficiaries are enrolled in managed care, an additional 30 counties with enrollment between 30 and 40 percent, and more than 44 counties with enrollment between 20 and 30 percent.

More important for future enrollment growth is the number of contracts with managed care plans. In 1994, the number of our Medicare managed care plans increased by 20 percent. Many of these new contracts are in regions beyond those that traditionally have had a strong Medicare managed care presence. In our Philadelphia region, the number of contracts increased from 6 to 18 and in the Boston region contracts increased from 4 to 9.

Although managed care in Medicare is strong and growing, we need to do more to expand options so that Medicare beneficiaries will have the same range of choices as are available to commercial enrollees.

**Initiatives**

- o **Preferred Provider Organizations**. Legislation will be proposed to allow Preferred Provider Organizations (PPOs) to contract with Medicare on a risk or a new partial risk basis (described below under Improved Payment Methodology). Examples of the types of entities that could contract under

this new authority include commercial PPOs that:

- Operate as indemnity insurers--that is, they do not assume full risk for the provision of services (they have premium margins to recover losses, or the premium is adjusted to recover the losses);
- Share risk with an employer or other entity (other than its providers); and/or
- Have a network of providers, but the full range of services are not available in plan, or, though there is a full range of services available through the network, enrollees do not necessarily obtain services "primarily" in plan.

Beneficiaries choosing to enroll with a PPO would automatically receive a self-referral option (SRO) under which any and all Medicare benefits could be obtained out-of-plan subject to standard Medicare cost-sharing. (See HCFA-96/71)

- o Self-Referral Option. HHS is currently developing guidelines, under existing statutory authority, for current risk contractors to offer a SRO with implementation anticipated for the 1998 contract year. The SRO would be similar to "point-of-service" plans that HMOs offer in the commercial marketplace. In contrast to the PPO option, the HMO-based SRO would be optional for both plans and enrollees. Plans would not have to offer such a benefit but if they did it would be as an optional benefit. Plans would have flexibility on the design of the SRO; however, all Medicare-covered services would have to continue to be available and accessible in-network for all enrollees.
- o Integrated Delivery Systems. HHS is also planning to use its demonstration authority to explore the possibilities of contracting on a risk or partial risk basis with integrated delivery systems (e.g., hospital-physician organizations) that are not already HMOs or that could not meet the PPO requirements. Preliminary discussions are already underway with a number of such systems. These integrated delivery systems could play an important role in bringing managed care to rural areas.

#### IMPROVED PAYMENT METHODOLOGY AND ALTERNATIVE METHODOLOGIES

Background - The current payment methodology for risk contractors, the adjusted average per capita cost (AAPCC) methodology, is often viewed as a flawed methodology. There is no adjustment for health status, and payments vary from area to area in ways that do not reflect variation in HMO costs across areas. The rates are derived through a complex computation method that has been controversial in and of itself, but the methodology is not necessarily inaccurate in what it is intended to accomplish (which is to predict fee-for-service costs on a county-by-county basis).

For Medicare to benefit from an expansion of managed care, significant improvements are needed in the way that Medicare pays plans. Managed care

currently costs the Medicare program rather than achieving savings. HHS evaluations have suggested that Medicare pays 5.7 percent more for every enrollee in managed care than would have been paid if the beneficiary had stayed in fee-for-service. The reason for this is that plans attract the healthier members of the Medicare population whose health care costs are lower and a workable health status adjuster is currently not available.

### Initiatives

- o Risk Adjusters. For the past decade, HHS has been a leader in supporting research to develop health status adjusters for risk payments. Current research efforts should produce health status adjusters that can be used on a pilot or demonstration basis as early as 1996. HHS has also undertaken a demonstration project in which we are working collaboratively with participating HMOs in Seattle to develop a high-cost outlier pool risk-adjustment mechanism.
- o Competitive Pricing. As a potential alternative to the AAPCC, legislative authority will be sought to demonstrate competitive pricing as the basis for rate-setting. In such a methodology, Medicare payments to plans would be based on a bidding process whereby competition among participating plans would determine payment levels (within certain limits). As part of the demonstration, beneficiaries would receive...

# OFFICE OF LEGISLATIVE & INTER-GOVERNMENTAL AFFAIRS FAX COVER SHEET

# of Pages: Cover • \_\_\_\_\_

DATE: 8/29/95

TO:

*Chris Jennings*

Fax: \_\_\_\_\_

Phone: \_\_\_\_\_

FROM:

*Debbie Harvey*

Fax: (202) 690 - 8168

Phone: \_\_\_\_\_

REMARKS:

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**HEALTH CARE FINANCING ADMINISTRATION**

Washington, D.C.

This is Legislative & Admin

**PROPOSED MEDICARE MANAGED CARE INITIATIVE**

Last 2 pages is

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- o Competitive Pricing. As a potential alternative to the AAPCC, legislative authority will be sought to demonstrate competitive pricing as the basis for rate-setting. In such a methodology, Medicare payments to plans would be based on a bidding process whereby competition among participating plans would determine payment levels (within certain limits). As part of the demonstration, beneficiaries would receive unbiased comparative information about plans. The demonstration payment methodology would be the only payment option available to Medicare managed care plans in the demonstration areas. (See HCFA-96/81)
- o Alternative Payment Demonstrations. HHS has entered into discussions with Kaiser to develop a demonstration of an alternative risk payment methodology based on rates established by competition in the commercial (non-Medicare) marketplace. Rates offered to commercial accounts would be adjusted for the Medicare benefit package and the higher risk of serving Medicare enrollees. In addition to this potential demonstration with Kaiser, HHS will soon issue a broad solicitation for demonstrations of alternative payment methodologies and risk sharing arrangements.
- o Partial Risk. Under another legislative proposal, the current archaic cost contracting options would be replaced with a partial risk methodology. Under this approach, plans would be paid on a fee for service basis minus a withhold for the provision of services to enrollees. Total payments at the end of the year would be compared with a target, initially set at 95 percent of the AAPCC. Plans would share on a 50/50 basis in savings below 95 percent and costs between 95 and 105 percent. Plans would be responsible for all costs above 105 percent.
- o AAPCC Technical Changes. Finally, HHS is working with the HMO industry to explore their technical concerns with the AAPCC methodology, e.g., MSA, rather than county-based, rates.

### FOSTERING CONTINUOUS IMPROVEMENT IN HEALTH PLAN QUALITY

Background - Monitoring quality of care for risk plans is especially important

since capitation provides financial incentives to limit medical care. HHS monitors the quality of care provided by Medicare managed care plans through a variety of methods -- complaint monitoring, appeals monitoring, site visits, disenrollment data and external review by Peer Review Organizations (PROs).

PROs monitor quality by conducting medical record reviews for a sample of Medicare beneficiaries enrolled in the managed care plan. This approach can be confrontational and does not give plans insights into systemic problems in the delivery of care. It also does little to help guide them to make fundamental improvements in care.

#### Initiatives

- o Cooperative Improvement Projects. HHS is moving away from medical record review and towards the development of performance indicators and cooperative improvement projects between the PROs and risk plans.
- o Performance Indicators. For example, HHS plans to pilot test a set of performance indicators developed by the Delmarva Foundation in several risk plans. Based on the performance indicators, the PRO and the risk plans will work cooperatively to develop appropriate quality improvement plans. In a complementary project, HHS also plans to begin collaborating with the National Committee on Quality Assurance (NCQA) to expand the Health Plan Employer Data Information Set (HEDIS) to include performance indicators relevant to the Medicare population.
- o Encounter Data. Quality assurance systems utilizing performance indicators require that managed care plans collect encounter data that is comparable across plans. However, due to the nature of capitation, most managed care plans do not collect this data. HHS plans to convene public and private purchasers of health care services, consumer groups and managed care plans to discuss issues regarding the collection of encounter data.

#### INFORMATION\ENROLLMENT

Currently, Medicare beneficiaries do not have the information needed to make an informed choice about available managed care and Medigap options. Even if information were available, comparisons are complicated by varying benefit packages in managed care plans and the use of different premium rating methodologies by Medigap insurers. Limited open enrollment for Medigap further complicates choices.

While Medigap insurers are only required to offer a one-time open enrollment period, Medicare managed care plans are required to offer an annual open enrollment period of at least 30 days to all Medicare beneficiaries living in the service area. As a result, beneficiaries who enroll in managed care plans (and stay enrolled through their Medigap open enrollment period) lose their opportunity to purchase the Medigap plan of their choice.

#### Initiatives

- o **Consumer Information.** As part of the competitive pricing demonstration described above, HHS will be exploring how best to communicate comparative information to beneficiaries regarding their managed care and Medigap choices.
- o **Level Playing Field.** Under a legislative proposal, the current limited open enrollment for Medigap plans would be expanded to the requirement that currently applies to risk and cost contractors. Medigap plans would have to be open to all Medicare beneficiaries for a thirty day period every year. This provision should reduce the reluctance of Medicare beneficiaries to enroll in managed care options since they would not be giving up what is essentially a one-time option to select the Medigap plan of their choice. (See HCFA-96/70)
- o **50/50 Flexibility.** HHS would seek legislative authority to waive the 50/50 rule for plans responding to state initiatives to enroll Medicaid beneficiaries in managed care plans and for plans expanding into rural areas. (See HCFA-96/69)

**SUMMARY OF LEGISLATIVE PROPOSALS  
IN MEDICARE MANAGED CARE INITIATIVE**

**EXPANDING OPTIONS AND EXPANDING TYPES OF CONTRACTING ORGANIZATIONS**

- o **Preferred Provider Organizations (PPO) Option.** Allow Preferred Provider Organizations (PPOs) to contract with Medicare on a risk or a new partial risk basis (described below under Improved Payment Methodology). Examples of the types of entities that could contract under this new authority include commercial PPOs that:
  - Operate as indemnity insurers--that is, they do not assume full risk for the provision of services (they have premium margins to recover losses, or the premium is adjusted to recover the losses);
  - Share risk with an employer or other entity (other than its providers); and/or
  - Have a network of providers, but the full range of services are not available in plan, or, though there is a full range of services available through the network, enrollees do not necessarily obtain services "primarily" in plan.

Beneficiaries choosing to enroll with a PPO would automatically receive a self-referral option (SRO) under which any and all Medicare benefits could be obtained out-of-plan subject to standard Medicare cost-sharing. (See HCFA-96/71)

**IMPROVED PAYMENT METHODOLOGY AND ALTERNATIVE METHODOLOGIES**

- o **Competitive Pricing Demonstration.** Authorize a demonstration of competitive pricing as an alternative the basis for rate-setting to the current AAPCC. In such a methodology, Medicare payments to plans would be based on a bidding process whereby competition among participating plans would determine payment levels (within certain limits). As part of the demonstration, beneficiaries would receive unbiased comparative information about plans. The demonstration payment methodology would be the only payment option available to Medicare managed care plans in the demonstration areas. (See HCFA-96/61)
- o **Partial Risk Payment Option.** Replace the current archaic cost contracting payment options with a partial risk methodology. Under this approach, plans would be paid on a fee for service basis minus a withhold for the provision of services to enrollees. Total payments at the end of the year would be compared with a target, initially set at 95 percent of the AAPCC. Plans would share on a 50/50 basis in savings below 95 percent and costs between 95 and 105 percent. Plans would be

responsible for all costs above 105 percent.

INFORMATION ENROLLMENT

- o Annual Open Enrollment for Medigap. Expand the current limited open enrollment for Medigap plans to the current 30-day annual open enrollment requirement applicable to risk and cost contractors. Medigap plans would have to be open to all Medicare beneficiaries for a thirty day period every year. This provision should reduce the reluctance of Medicare beneficiaries to enroll in managed care options since they would not be giving up what is essentially a one-time option to select the Medigap plan of their choice. (See HCFA-96/70)
- o 50/50 Flexibility. Authorize waiving the 50/50 rule for plans responding to state initiatives to enroll Medicaid beneficiaries in managed care plans and for plans expanding into rural areas. (See HCFA-96/69)

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# of Pages: Cover + 3

DATE: 8/29/95

TO: Margaret Jefferson  
  
Fax: 410-786-0169  
Phone: 410-786-4482

FROM: Sue Clark  
HCFIA/OLIGA/DMA  
Rm. 341-H  
Humphrey Bldg  
Fax: (202) 690-8188  
Phone: 202-690-8226

REMARKS:  
Margaret Please give a copy of  
this material to Julie Walton,  
+ Julie Stanton  
Thank you

HEALTH CARE FINANCING ADMINISTRATION  
Washington, D.C.

April 27, 1995

NOTE TO: Bruce Vladeck

SUBJECT: HI Expenditure Reductions Required To Meet Certain Financing Goals

The attached tables show the estimated reductions in HI expenditures that would be required to meet certain trust fund financing goals. Under the first illustration, the goal would be to maintain a neutral cash flow between the HI trust fund and the general fund of the Treasury. Based on the intermediate assumptions from the 1995 Trustees Report, expenditures would have to be reduced by a total of \$196 billion through calendar year 2002 to match the level of non-interest income available under present law.

Under this scenario, HI assets would increase by about 8 percent a year as a result of interest earnings. Assets would also increase relative to annual expenditures because, after the reductions, expenditures would grow at slower rates than the assumed interest rates payable on fund assets. By the beginning of 2003, HI assets would increase to an estimated 144 percent of annual expenditures.

The second attachment shows the estimated expenditure reductions that would be required to place the HI trust fund in actuarial balance over the next 25 years. Under this scenario, income from all sources (including interest) would be sufficient to cover the reduced level of expenditures and to maintain the trust fund at a level of about 1 year's expenditures. The estimated expenditure reductions over selected periods are:

Period (calendar years)	Reduction in expenditures	
	Amount (in billions)	Percent of present-law expenditures
1995-2002	\$147	12%
1995-2004	252	15
1995-2019	2,709	30

Over long periods, the changing value of the dollar can make amounts such as those shown above difficult to interpret. As indicated, through 2019 the dollar amounts would be equivalent to reducing present-law expenditures by roughly 30 percent. Additional reductions in expenditures (or increases in income) would be required after the first 25 years to address the full effects of the baby boom's retirement.

If you have any questions about these figures, please don't hesitate to ask either of us or John Wandishin.

*Rick Foster*  
Rick Foster

*Sol Mussey*  
Sol Mussey

Attachments (2)

cc:  
Kathy Buto  
Debbie Chang

Table 1 -- HI expenditure reductions required to avoid negative cash flow

CY	Savings (\$ billions)	Trust Fund Ratio
1995	0	117%
1996	12	121%
1997	17	125%
1998	22	128%
1999	27	132%
2000	33	136%
2001	39	139%
2002	45	142%
2003	52	144%
2004	59	147%
2005	67	149%
2006	75	151%
2007	85	153%
2008	95	155%
2009	106	156%
2010	118	158%
2011	132	160%
2012	148	161%
2013	167	163%
2014	188	165%
2015	210	167%
2016	234	169%
2017	262	170%
2018	293	172%
2019	326	174%

Table 2 -- HI expenditure reductions required to keep in actuarial balance

CY	Savings Trust Fund	
	(\$ billions)	Ratio
1995	0	117%
1996	0	109%
1997	0	100%
1998	17	100%
1999	23	100%
2000	29	100%
2001	36	100%
2002	42	100%
2003	49	100%
2004	56	100%
2005	64	100%
2006	72	100%
2007	82	100%
2008	93	100%
2009	104	100%
2010	116	100%
2011	129	100%
2012	145	100%
2013	164	100%
2014	184	100%
2015	207	100%
2016	230	100%
2017	257	100%
2018	288	100%
2019	322	100%

April 27, 1995

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The attached tables show the estimated reductions in HI expenditures that would be required to meet certain trust fund financing goals. Under the first illustration, the goal would be to maintain a neutral cash flow between the HI trust fund and the general fund of the Treasury. Based on the intermediate assumptions from the 1995 Trustees Report, expenditures would have to be reduced by a total of \$196 billion through calendar year 2002 to match the level of non-interest income available under present law.

Under this scenario, HI assets would increase by about 8 percent a year as a result of interest earnings. Assets would also increase relative to annual expenditures because, after the reductions, expenditures would grow at slower rates than the assumed interest rates payable on fund assets. By the beginning of 2003, HI assets would increase to an estimated 144 percent of annual expenditures.

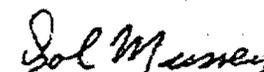
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Over long periods, the changing value of the dollar can make amounts such as those shown above difficult to interpret. As indicated, through 2019 the dollar amounts would be equivalent to reducing present-law expenditures by roughly 30 percent. Additional reductions in expenditures (or increases in income) would be required after the first 25 years to address the full effects of the baby boom's retirement.

If you have any questions about these figures, please don't hesitate to ask either of us or John Wandishin.

  
Rick Foster

  
Sol Mussey

Attachments (2)

cc:  
Kathy Buto  
Debbie Chang

Table 2 -- HI expenditure reductions required to keep in actuarial balance

	Savings Trust Fund	
CY	(\$ billions)	Ratio
1995	0	117%
1996	0	109%
1997	0	100%
1998	17	100%
1999	23	100%
2000	29	100%
2001	36	100%
2002	42	100%
2003	49	100%
2004	56	100%
2005	64	100%
2006	72	100%
2007	82	100%
2008	93	100%
2009	104	100%
2010	116	100%
2011	129	100%
2012	145	100%
2013	164	100%
2014	184	100%
2015	207	100%
2016	230	100%
2017	257	100%
2018	288	100%
2019	322	100%

**REPUBLICANS BREAK CONTRACT:  
MEDICARE CUTS FOR SENIORS AND TAX HIKES FOR WORKING FAMILIES  
TO PAY FOR TAX CUTS FOR THE WEALTHY**

Republicans have repeatedly promised that they could provide a huge tax cut targeted at the wealthy, balance the budget by 2002--and not hurt the elderly or raise taxes on working families. Their budgets show that these were false promises. Republicans have broken their contract with historically severe cuts in Medicare and tax hikes for working families in order to finance their tax break for the wealthy.

**REPUBLICANS ARE MAKING THE LARGEST MEDICARE CUT IN HISTORY TO PAY FOR THEIR TAX CUT AND CAMPAIGN PROMISES.** On April 28, Speaker Gingrich said that Medicare would not be a part of the Republican budget cuts. He could not have been more wrong. Medicare takes the largest single cut in the Republican budget. By their accounting, nearly 25 cents out of every dollar that Republicans cut is from Medicare. The cut is **three times larger** than the largest previous Medicare cut in history.

**THEIR MEDICARE CUT IS ABOUT PAYING FOR TAX CUTS AND HITTING ARBITRARY DEFICIT TARGETS--NOT ABOUT THE ECONOMY OR HEALTH CARE REFORM.** The proposed Medicare cuts of \$250 billion to \$300 billion are needed to make room for most--but not all--of a \$345 billion tax cut that provides a tax break of over \$20,000 for the wealthiest 1 percent. Speaker Gingrich and Majority Leader Dole have rejected the White House's call to renounce tax breaks for the wealthy; instead, Speaker Gingrich calls the Contract tax cuts his "crown jewel," while Senate Majority Leader Dole and Senator Gramm have insisted they will make room for the tax cut. However the tax cuts are officially paid for, the fact remains that the **entire Medicare cut would be totally unnecessary if Republicans did not need to pay for their tax cuts.**

**WHEN IT COMES TO HEALTH CARE, REPUBLICANS SINGLE OUT SENIORS FOR PAIN CUTTING GROWTH PER PERSON IN THEIR MEDICARE BELOW GROWTH IN PRIVATE HEALTH CARE.** Republicans claim that they are just slowing the "exploding" rate of growth in Medicare. In fact, the *cost per person* in Medicare is about the same as the private sector, even though Medicare deals with a population more prone to have health problems. The Republican approach ignores health care costs generally, and simply cuts the average growth rate for a Medicare recipient far below that for other Americans not on Medicare. *Medicare was designed to provide health insurance for senior citizens, not get turned into a second-class citizen program in order to meet arbitrary campaign promises.*

**BY 2002, REPUBLICAN CUTS WOULD INCREASE OUT-OF-POCKET COSTS BY ABOUT \$900 A YEAR AND DEVASTATE RURAL HOSPITALS.** If cuts are distributed evenly between providers and beneficiaries, they represent about a \$900 increase in out-of-pocket costs per beneficiary per year. That is equivalent to eliminating 40%-50% of the Social Security cost-of-living allowances for each Medicare beneficiary between now and 2002. As reimbursement rates decline, many rural hospitals that rely on Medicare would have to close down.

**REPUBLICAN MEDICAID CUTS WOULD DRASTICALLY RAISE LONG-TERM CARE COSTS FOR WORKING FAMILIES.** If the Republican cuts were divided evenly among eliminating eligibility for elderly and disabled beneficiaries, eliminating eligibility for children, cutting services, and cutting provider payments, **they would force states to cut off coverage for 5 to 7 million children and \$00,000 to 1 million elderly and disabled Americans.** The House and Senate budgets include a \$160 billion cut in Medicaid. They would limit growth to 4% per year--even though Medicaid's beneficiary growth alone is nearly that high. As a result, millions of Americans will be cut off while the costs of long-term care drastically increase. Two-thirds of Medicaid funds are spent on services for elderly and disabled Americans; without Medicaid, working families with a parent or spouse who needs long-term care would face nursing home bills averaging \$38,000 per year.

**REPUBLICAN MANAGED CARE PROPOSALS WILL NOT LEAD TO SIGNIFICANT SAVINGS UNLESS THEY CUT BENEFITS AND COERCE SENIORS.** There is no evidence that simply shifting to managed care can achieve significant savings among the populations that Medicare and Medicaid overwhelmingly serve--the elderly and disabled. Republican voucher proposals would overspend on younger, healthier seniors, while achieving limited savings only by dramatically raising costs, cutting benefits, and limiting choice for the seniors who need Medicare and Medicaid most.

**WHILE CUTTING TAXES FOR THE WEALTHY, REPUBLICANS ALSO RAISE TAXES FOR 12 MILLION LOW-INCOME WORKERS AND THEIR FAMILIES BY SLASHING THE EARNED INCOME TAX CREDIT.** The EITC helps families move from welfare to work and makes work pay for hard-working, lower-income Americans, providing a tax cut averaging nearly \$1,400 per year for over 21 million workers and their families earning up to \$28,500. Senate Republicans have proposed a major cut in the EITC that will raise taxes by an average of \$235 for 12 million of these workers and their families. Thus, 12 million low-income working families will pay \$235 more under the Republican budget, while the top 1% will pay \$20,000 less under the Contract's tax cuts.

The attached memorandum from the Office of the Actuary illustrates the effects on the Medicare Hospital Insurance (HI) Trust Fund of four different approaches for reducing Medicare HI spending. As part of the discussion on the budget, many in Congress have looked to Medicare as a major source of savings; some have also suggested that reductions in Medicare would improve the solvency of the Trust Fund. However, in considering reductions of the magnitude envisioned by the House and Senate Budget Committees, consideration should be given not only to effects on Medicare, but on the entire health care system.

The Actuary selected four different formulas for reducing spending and estimated their effects on both the short and long-term solvency of the Trust Fund. These illustrations are not estimates of the fiscal impact of specific policies. Rather, they are mathematical calculations that show, in the aggregate, the effects different formulas would have on HI spending and the Trust Fund. In practice, designing policies that would match precisely the savings illustrations in the Actuary's memo would be quite difficult. Implementation of these policies would not be painless. Beneficiaries, health care providers and institutions could suffer serious financial harm.

For example, if Congress capped annual spending growth at 5 percent, the trust fund would be solvent in the long term. But implementing this cap would not even allow Medicare spending to increase enough to account for growth in the number of beneficiaries and general inflation. Under one scenario, beneficiaries could be required to pay coinsurance for home health services and hospitals could suffer a real reduction -- not just a reduction in the rate of growth -- in payments.

Careful attention must also be paid to how these reductions would affect Medicare's long term viability. Very deep reductions would improve the solvency of the trust fund, but could seriously compromise Medicare's ability to deliver the same level of care to beneficiaries. The right balance must be struck between these goals. For example, the illustrations based on reductions or caps in the rate of growth result in relatively modest savings in the early years, but compound quickly in later years to produce much larger savings. The 5 percent cap on annual growth would reduce spending by only 4 percent in 1996, but the reduction would reach 25 percent in the year 2005 alone, and continue growing after that.

It's also important to bear in mind that any projections of future spending, particularly for a 75-year period, are uncertain. That's especially true for projections of health care spending because of the changes now occurring in our health care system. Growth in total health care spending has moderated substantially in the past two years after many years of rapid increases. Development of new technologies and changing delivery systems add to the uncertainty about the future and could significantly affect both private health spending and Medicare.

For example, the expansion of managed care in both in the private sector and Medicare is fueling changes in the delivery of health care. Managed care typically reduces inpatient hospital use and increases access to primary care.

Health care reform efforts could further affect the accuracy of long-range estimates. Reforms that increase coverage or spur more efficient delivery of services could lower spending overall and would change the distribution of costs among payers by reducing uncompensated care and cost-shifting. Medicare is an integral part of the health care system and would be significantly affected by broader system reforms. Similarly, Medicare changes, especially severe reductions in Medicare spending, would likewise affect the health care system overall.

The Actuary has provided these illustrations to facilitate an informed debate on measures to address the financial imbalance facing the HI Trust Fund. Use of these illustrations, however, should be tempered by a full understanding of their limitations and the implications of proposals to reduce spending.

April 27, 1995

NOTE TO: Bruce Vladeck

SUBJECT: HI Expenditure Reductions Required To Meet Certain Financing Goals

The attached tables show the estimated reductions in HI expenditures that would be required to meet certain trust fund financing goals. Under the first illustration, the goal would be to maintain a neutral cash flow between the HI trust fund and the general fund of the Treasury. Based on the intermediate assumptions from the 1995 Trustees Report, expenditures would have to be reduced by a total of \$196 billion through calendar year 2002 to match the level of non-interest income available under present law.

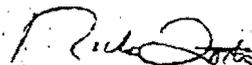
Under this scenario, HI assets would increase by about 8 percent a year as a result of interest earnings. Assets would also increase relative to annual expenditures because, after the reductions, expenditures would grow at slower rates than the assumed interest rates payable on fund assets. By the beginning of 2003, HI assets would increase to an estimated 144 percent of annual expenditures.

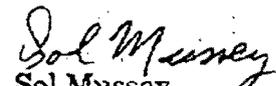
The second attachment shows the estimated expenditure reductions that would be required to place the HI trust fund in actuarial balance over the next 25 years. Under this scenario, income from all sources (including interest) would be sufficient to cover the reduced level of expenditures and to maintain the trust fund at a level of about 1 year's expenditures. The estimated expenditure reductions over selected periods are:

Period (calendar years)	Reduction in expenditures	
	Amount (in billions)	Percent of present-law expenditures
1995-2002	\$147	12%
1995-2004	252	15
1995-2019	2,709	30

Over long periods, the changing value of the dollar can make amounts such as those shown above difficult to interpret. As indicated, through 2019 the dollar amounts would be equivalent to reducing present-law expenditures by roughly 30 percent. Additional reductions in expenditures (or increases in income) would be required after the first 25 years to address the full effects of the baby boom's retirement.

If you have any questions about these figures, please don't hesitate to ask either of us or John Wandishin.

  
Rick Foster

  
Sol Mussey

Attachments (2)

cc:  
Kathy Buto  
Debbie Chang

Table 1 -- HI expenditure reductions required to avoid negative cash flow

CY	Savings (\$ billions)	Trust Fund Ratio
1995	0	117%
1996	12	121%
1997	17	125%
1998	22	128%
1999	27	132%
2000	33	136%
2001	39	139%
2002	45	142%
2003	52	144%
2004	59	147%
2005	67	149%
2006	75	151%
2007	85	153%
2008	95	155%
2009	106	156%
2010	118	158%
2011	132	160%
2012	148	161%
2013	167	163%
2014	188	165%
2015	210	167%
2016	234	169%
2017	262	170%
2018	293	172%
2019	326	174%

Table 2 -- HI expenditure reductions required to keep in actuarial balance

CY	Savings Trust Fund (\$ billions)	Ratio
1995	0	117%
1996	0	109%
1997	0	100%
1998	17	100%
1999	23	100%
2000	29	100%
2001	36	100%
2002	42	100%
2003	49	100%
2004	56	100%
2005	64	100%
2006	72	100%
2007	82	100%
2008	93	100%
2009	104	100%
2010	116	100%
2011	129	100%
2012	145	100%
2013	164	100%
2014	184	100%
2015	207	100%
2016	230	100%
2017	257	100%
2018	288	100%
2019	322	100%

# Medicare Managed Care File

## MEDICARE and MANAGED CARE

- **Current Base Proposal.** Our current base proposal includes a proposal to decrease Medicare reimbursement to managed care plans from its current 95 percent of fee-for-service rates to 90 percent. Since every independent study we have seen over the last three years suggests we are overpaying these plans by at least this much, this proposal is more than defensible. In fact, the actuaries at HCFA (and the estimators at CBO) now score Medicare costs for every beneficiary opting for Medicare managed care.
- **Benefit of the HMO Proposal.** The reduction in reimbursement to HMOs does not start until 2000, but still achieves about \$10 billion in savings over 5 years. (If we started the cuts earlier, HCFA tells me that our overall cuts in HMO payments -- we have other proposals too -- would be too deep.) This proposal has the added benefit that it allows us to reduce the overall hospital cut. It also contributes to our ability to pay for the Alzheimer's respite benefit to start in 1998, as well as some other modest beneficiary benefit improvements. If we go for this proposal, we will can say that we are giving the industry three years to prepare for it.
- **Potential Problem with this Proposal.** Clearly, however, as the Pear article from today illustrated, the managed care industry is ready to charge that such a reduction will force them to reduce the type of additional benefits (like prescription drug coverage, etc.) that they are now using to attract beneficiaries into managed care. They will undoubtedly cast our proposal as a benefit cut to millions of beneficiaries. The head of their industry trade group -- Karen Ignagni -- called me Friday evening to make clear this would be the case.
- **Department Response to HMO Criticism.** It is true that our overcompensation of managed care plans allows many plans to reinvest their overpayments in additional benefits. It is also true that it enables them to earn significant profits. The Department (Bruce Vladeck in particular) believes that the reduction we are proposing, which they say is on the modest end of what their studies now say is defensible (85-90%), will still be sufficient for most of these plans to continue to provide additional benefits. Having said this, they do recognize that this will be the HMO industry response to our proposal.
- **Question.** Do we need to raise this up to higher levels before we lock this proposal in? Some in the Administration, like Larry Summers, have suggested that we may want to consider being overly generous for the short-term to get beneficiaries into managed care. I personally have mixed feelings on this one, but I believe the delay in the implementation of the cut and our likely characterization of it as a transition policy to a better reimbursement system should be a sufficient defense. However, I strongly believe that the principals should be aware of where another attack is likely to come from.

Medicare Managed Care File

TO: Debbie

FR: Lucia

RE: **Payment to Managed Care Plans – Provisions and Rationale**

DT: March 15, 1996

Attached is a very brief summary of the payment provisions as well as the rationale for each of the provisions. Per your suggestion, I included examples of reductions that plans could expect if the GME/IME/DSH were not phased out and if the hold harmless provision was not included.

Also attached is a side-by-side of the payment provisions of Conference Agreement and Administration bill and the rationale for each provision.

Finally, the legislative language for the payment provisions is attached.

OPTIONAL FORM 90 (7-90)

**FAX TRANSMITTAL** # of pages

To: <i>Chris Jennings</i>	From: <i>Debbie Chery</i>
Dept./Agency	Phone #
Fax #	Fax #

NSN 7540-01-317-7386 5099-101 GENERAL SERVICES ADMINISTRATION

**CAPITATED PAYMENTS TO MANAGED CARE PLANS  
UNDER ADMINISTRATION'S BILL  
Provisions and Rationale**

**PROVISIONS**

- **Blended, minimum amount or minimum percent increase.** Under the Administration's bill, Medicare's payments to plans would equal the greater of three amounts -- (1) a blended rate of an area-specific rate and national rate, (2) a minimum payment amount; or (3) minimum percent increase.
  - ▶ **Blended Payment.** The blended payment would equal 90% national rate and 10% area-specific rate in 1997 and by 2002 would equal 70% national rate and 30% local rate. Blended payment rates would be adjusted to ensure that total blended rate payments would not be greater than what payments would have been if payments were based on 100% of the local rate (e.g., unblended).
  - ▶ **Minimum payment amount.** In 1997, the payment amount would equal \$3900 (\$325 per month). In subsequent years, this amount would be increased by the estimated growth rate in Medicare per capita spending.
  - ▶ **Minimum percent increase amount.** In 1997 and 1998, the minimum percent increase amount would equal the payment rate for 1996. In 1999 and subsequent years, amount would equal the previous year's rate increased by 2 percent.
- **Update factor.** Payment amounts (e.g., minimum payment amount, area-specific amount, national rate) would be increased based on projections of the Medicare per capita growth rate.
- **Phased-in removal of IME, GME, DSH.** Payments for IME, GME, and DSH would be removed from the area-specific rate over a two-year period. In 1997, 60 percent of the IME, GME and DSH payments would be removed from the area-specific rate and 100 percent in 1998.

**RATIONALE**

- **Blended rate, minimum payment amount – reduces geographic variation, increases managed care in rural areas.**
  - ▶ Currently there is wide variation in fee-for-service costs which is reflected in Medicare's capitation payments to plans. By basing plan payments on a blended rate and a minimum payment amount, geographic variation in payment would be reduced. Payments in lower payment areas would increase (e.g., rural areas) while payments in higher payment areas would receive smaller updates than under current law.

- ▶ Increasing capitation payments in rural areas, could encourage managed care plans to enter these markets.

#### ■ **Update Factor.**

- ▶ The updates to plan payments should be linked to the Medicare benefit package rather than to arbitrary budget targets as proposed in the Conference Agreement.
- ▶ Fixed updates established in statute could be inadequate and would not respond to changing circumstances in the health care market (e.g., higher than expected health care inflation). If Medicare's capitation payments to plans were insufficient to provide the Medicare benefit package, enrollees would receive fewer or no additional benefits and would eventually face stiff premiums for Medicare benefits as plans seek to replace lost revenues. Establishing update factors based on the projections of growth in Medicare per capita spending would address this problem.

#### ■ **Removal of IME, GME and DSH.**

- ▶ Payments for IME, GME and DSH were established to reimburse hospitals for the higher costs related to graduate medical education and for uncompensated care provided to low income patients. Since managed care plans generally do not incur the costs associated with medical training or uncompensated care, these amounts should be removed from plan payments and distributed to those teaching hospitals who admit managed care plan enrollees or to those specific managed care plans that do incur costs related to graduate medical education and uncompensated care.
- ▶ The removal of IME, GME and DSH over a two-year period and the minimum percent update provision would ensure that plans in payment areas with significant IME/GME/DSH payments (i.e., areas with larger numbers of teaching hospitals) would not experience sharp declines in capitation rates.

For example, if 100% of the IME, GME, and DSH payments were removed in 1997 and plans were not guaranteed at least the rate they received in 1996, the plans in Bronx County would experience 19% reduction in payments from the previous year, New York County a 17% reduction, San Francisco a 10% reduction and Philadelphia, PA a 13% reduction.

- ▶ Significant declines in capitation payments could result in declines in the additional benefits currently offered to beneficiaries by plans. Phasing in the removal of IME/GME/DSH from capitation payments would protect against sudden changes in the additional benefits currently offered to beneficiaries.

**DIFFERENCES BETWEEN ADMINISTRATION BILL AND CONFERENCE AGREEMENT**

<b>Provision</b>	<b>Conference Agreement (H.R. 2491)</b>	<b>Administration Proposal</b>	<b>Rationale for Difference</b>
<b>Blended rate, minimum amount, minimum percent increase</b>	Greater of blended rate, minimum payment amount or minimum percent increase.	Provisions similar to Conference Agreement.	Geographic variation in payment would be reduced.  Increasing capitation payments in rural areas, could encourage managed care plans to enter these markets.
<b>Update factor</b>	Updates to payments set in statute and based on budgetary goals.	Updates to payments based on estimates of growth in per capita Medicare spending.	The updates to plan payments should be linked to the Medicare benefit package rather than to arbitrary budget targets.  If Medicare's payments to plans were insufficient, enrollees would receive fewer or no additional benefits and would eventually face stiff premiums for Medicare benefits as plans seek to replace lost revenues.
<b>Removal of IME/GME/DSH phased in over 2 years</b>	No provision to remove IME, GME, DSH from plan payments.	Removes IME, GME and DSH from plan payments over a two year period.	Since managed care plans generally do not incur the costs associated with medical training or uncompensated care, these amounts should be removed from plan payments and distributed to those teaching hospitals and to managed care plans that do incur such costs.  This provision would ensure that plans in payment areas with significant IME/GME/DSH payments (i.e., areas with larger numbers of teaching hospitals) would not experience sharp declines in capitation rates.  Sharp declines in capitation payments could result in sudden changes in the additional benefits currently offered to beneficiaries.