



JUL 27 1998

Memorandum

Date: *Michael Mangano*
for June Gibbs Brown
From: Inspector General

Subject: Administrative Costs Submitted by Risk-Based Health Maintenance Organizations on the Adjusted Community Rate Proposals Are Highly Inflated (A- 14-97-00202)

To: Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

Attached are two copies of our final report which provides you with the results of our review of the administrative costs submitted by risk-based health maintenance organizations (HMO) on their adjusted community rate (ACR) proposals. The objective of our review was to determine if the amounts submitted for administration by HMOs on their ACR proposals were reasonable.

The present methodology used in the HMO reimbursement process results in an unreasonable amount of Medicare funds being allocated to the HMOs for their planned administrative costs and has resulted in Medicare paying a disproportionate share of most HMOs' administrative costs. We estimated that about \$1 billion per year could be saved if the allocation of the category within the ACR termed "administration" was determined in accordance with the Medicare program's longstanding principle that Medicare only pay its applicable or fair share of needed health care costs.

The Medicare ACR process is designed for HMOs to present to the Health Care Financing Administration (HCFA) their estimate of the funds needed to cover the costs of providing the Medicare package of covered services to any enrolled Medicare beneficiary. The HMO's anticipated or budgeted funds are calculated to cover medical and administrative costs of the plan for the upcoming year and must be supported by the individual HMO's operating experiences relating to **utilization** and expenses.

We found that the ACR process enables plans to exploit the use of medical utilization factors when computing their anticipated administrative costs to deliver services to Medicare beneficiaries. As a result, the HMOs overestimated their anticipated needs for administrative costs in the 1994, 1995, and 1996 contract years by as much as \$ billion, \$1.3 billion, and \$1.9 billion, respectively. We believe that HMOs are using these funds to finance a portion of the additional benefits offered to Medicare beneficiaries.

We recommended that HCFA amend its criteria to require HMOs to allocate their planned administrative costs on their ACR proposals using a more realistic allocation method. One such method would be to use the ratio of Medicare enrollees in the HMO to the total HMO

enrollment. This approach would result in an allowance for administrative costs that would better approximate Medicare's fair share to administratively operate the HMO.

We also recommended that HCFA introduce legislation to capture the savings that would be achieved by this amended administrative costs allowability criteria. Capturing these savings will require that an adjustment be made in the present calculation of additional benefits provided by an HMO to a beneficiary when the HMO's estimated cost of providing the Medicare package is less than the Medicare monthly capitation payment. This is because, under the current reimbursement formula, HMOs use the savings to fund additional benefits offered to the Medicare enrolled beneficiaries. In order for these savings to be returned to the Medicare trust funds instead of being used to fund an even greater array of additional benefits (presently quite an extensive list of traditionally Medicare non-covered services/benefits are being offered by HMOs), a cap or limit to the amount of these additional benefits would have to be enacted. Depending upon the methodology adopted to cap these additional benefits, we estimated the Medicare program could realize savings of up to 5 percent of the Medicare payments made under Medicare risk HMO contracts--presently about \$1 billion annually.

In response to our draft report, HCFA agreed that the criteria governing the computation of administrative costs in the ACR proposals almost certainly resulted in overstated administrative costs. According to HCFA, the new format for the ACR proposals that will be used as part of the Medicare+Choice program will more accurately reflect administrative costs for Medicare beneficiaries and should result in a lesser amount of costs being allocated to Medicare enrollees. The HCFA also noted that changes brought about by the Balanced Budget Act (BBA) of 1997 will reduce Medicare capitation payments in geographic areas with higher payment levels and require audits of the computation of the ACRs.

However, HCFA does not concur with our second recommendation to introduce legislation to recover the excessive amount presently being paid for administration. The HCFA believes that the congressional intent with the changes brought about by the BBA of 1997 was that all savings should be passed on to the beneficiaries. In addition, HCFA stated that some HMOs are reducing the amount of benefits because of reduced Medicare capitation payments. The HCFA believed that it may be appropriate to reassess our recommendation in the future once they have an opportunity to fully assess the impact of the BBA of 1997 mandated payment changes and ACR audits. The HCFA also believed that the savings estimated in this report were overstated due to technical problems with our formulae. The full text of HCFA's comments is included as Appendix G to the report.

We believe that HCFA's changes to the methodology HMOs use to compute administrative costs in the ACR proposals should help ensure that non-Medicare costs are not borne by Medicare. While HCFA did not concur with our second recommendation, we are encouraged with HCFA's willingness to reassess our recommendation to recapture excessive administrative amounts after assessing the impact of BBA-mandated payment changes and ACR audits. However, we believe that before this recommendation is implemented, some plans will continue to profit excessively as a result of the Medicare payment system. Given

the amounts that this excess has been during the period of our audit and the tentative situation of the Medicare trust funds, the Congress may want to reassess this situation.

We are also concerned that any delay in implementing a legislative change to recover excess payment amounts will be problematic for processing future Government recoveries if audits/investigations disclose that HMOs are not providing its enrollees with the additional benefits as indicated in their ACR proposals. The HCFA encountered this situation recently as part of their evaluations of HMOs. It would be easier for the Government to ask for a recovery of these types of funds than to retroactively offer the denied benefits after the close of the contract year.

We considered HCFA's comments and revised our computations for these cost items for which data was available. The report contains the revised calculations for your staffs review and consideration. Our estimate of the excessive payments for administration presently being paid by Medicare as a portion of the monthly capitation payments, however, still exceeds \$1 billion annually. We will continue to work with your staff to both evaluate the planned review of the ACRs as part of Medicare+Choice program and to reevaluate the potential savings to the Medicare program if only reasonable administrative costs were allowed for HMOs as part of the monthly capitation payments.

We would appreciate your views and the status of any action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please contact me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-14-97-00202 in all correspondence relating to this report.

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**ADMINISTRATIVE COSTS
SUBMITTED BY RISK-BASED
HEALTH MAINTENANCE
ORGANIZATIONS ON THE
ADJUSTED COMMUNITY RATE
PROPOSALS ARE HIGHLY INFLATED**



**JUNE GIBBS BROWN
Inspector General**

**JULY 1998
A-14-97-00202**

SUMMARY

The present methodology used in the health maintenance organizations (HMO) reimbursement process results in an unreasonable amount of Medicare funds being allocated to the HMO for their planned administrative costs. The present adjusted community rate (ACR) formula has resulted in Medicare paying a disproportionate share of most HMOs' administrative costs. We estimated that about \$1 billion per year could be saved if the allocation of the category within the ACR termed 'administration' was determined in accordance with the Medicare program's longstanding principle that Medicare only pay its applicable or fair share of needed health care costs.

The Medicare ACR process is designed for HMOs to present to the Health Care Financing Administration (HCFA) their estimate of the funds needed to cover the costs of providing the Medicare package of covered services to any enrolled Medicare beneficiary. The HMO's anticipated or budgeted funds are calculated to cover medical and administrative costs of the plan for the upcoming year and must be supported by the individual HMO's operating experiences relating to utilization and expenses.

The objective of our review was to determine if the amounts submitted by risk-based HMOs on their ACR proposals for administrative costs were reasonable. We found that for the 1994, 1995, and 1996 contract years, the presently used methodology allowed HMOs to overestimate their anticipated needs for administrative costs by as much as \$1 billion, \$1.3 billion, and \$1.9 billion, respectively. This is a result of the ACR process which enables plans to exploit the use of medical utilization factors when computing their anticipated administrative costs to deliver services to Medicare beneficiaries.

We recommended that HCFA amend its criteria to require HMOs to allocate their planned administrative costs on their ACR proposals using a more realistic allocation method. One such method would be to use the ratio of Medicare enrollees in the HMO to the total HMO enrollment. This approach would result in an allowance for administrative costs that would better approximate Medicare's fair share to administratively operate the HMO.

We also recommended that HCFA introduce legislation to capture the savings that would be achieved by this amended administrative costs allowability criteria. Capturing these savings will require that an adjustment be made in the present calculation of additional benefits provided by an HMO to a beneficiary when the HMO's estimated cost of providing the Medicare package is less than the Medicare monthly capitation payment. This is because, under the current reimbursement formula, HMOs use the savings to fund additional benefits offered to the Medicare enrolled beneficiaries. In order for these savings to be returned to the trust funds instead of being used to fund an even greater array of additional benefits (presently quite an extensive list of traditionally Medicare non-covered services/benefits are being offered by HMOs), a cap or limit to the amount of these additional benefits would have to be enacted. Depending upon the methodology adopted to cap these additional benefits, we estimated the

Medicare program could realize savings of up to 5 percent of the Medicare payments made under Medicare risk HMO contracts--presently about \$1 billion annually.

In response to our draft report, HCFA agreed that the criteria governing the computation of administrative costs in the ACR proposals almost certainly resulted in overstated administrative costs. According to HCFA, the new format for the ACR proposals will more accurately reflect administrative costs for Medicare beneficiaries and should result in a lesser amount of costs being allocated to Medicare enrollees. The HCFA also noted that changes brought about by the Balanced Budget Act (BBA) of 1997 will reduce Medicare capitation payments in geographic areas with higher payment levels and require audits of the computation of the ACRs.

However, HCFA does not concur with our second recommendation to introduce legislation to recover the excessive amount presently being paid for administration. The HCFA believes that the congressional intent through BBA of 1997 changes was that all savings should be passed on to the beneficiaries. In addition, HCFA stated that some HMOs are reducing the amount of benefits because of reduced Medicare capitation payments. The HCFA believed that it may be appropriate to reassess our recommendation in the future once they have an opportunity to fully assess the impact of the BBA of 1997 mandated payment changes and ACR audits. Finally, HCFA believed that the savings estimated in this report were overstated due to technical problems with our formula. The full text of HCFA's comments are included in Appendix G.

We believe that HCFA's changes to the methodology HMOs use to compute administrative costs in the ACR proposals should help ensure that non-Medicare costs are not borne by Medicare. While HCFA did not concur with our second recommendation, we are encouraged with HCFA's willingness to reassess our recommendation to recapture excessive administrative amounts after assessing the impact of BBA-mandated payment changes and ACR audits. However, until this recommendation is implemented, some plans will continue to profit excessively as a result of the Medicare payment system. Given the amounts that this excess has been during the period of our audit and the tentative situation of the Medicare trust funds, the Congress may want to reassess this situation.

We are also concerned that any delay in implementing a legislative fix to recover excess payment amounts will be problematic for processing future Government recoveries if audits/investigations disclose that HMOs are not providing its enrollees with the additional benefits as indicated in their ACR proposals. It would be easier for the Government to ask for a recovery of these types of funds than for HMOs to retroactively offer the denied benefits after the close of the contract year.

We considered HCFA's comments and revised our computations for those cost items for which data was available. The report contains the revised calculations for your staffs review and consideration. Our estimate of the excessive payments for administration presently being paid by Medicare as a portion of the monthly capitation payments, however, still exceeds \$1 billion

annually. We will continue to work with HCFA to both evaluate the planned review of the ACRs as part of Medicare+Choice program and to reevaluate the potential savings to the Medicare program if only reasonable administrative costs were allowed for HMOs as part of the monthly capitation payments.

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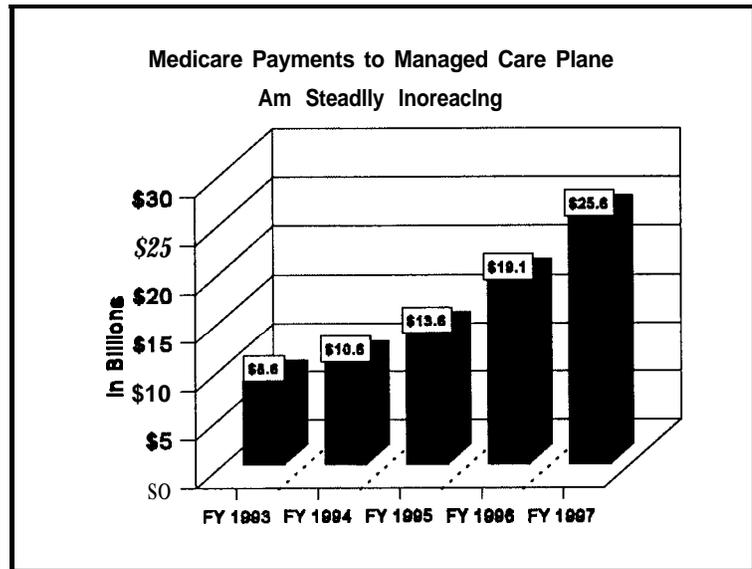
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INTRODUCTION

BACKGROUND

Managed care plans, such as HMOs¹, provide comprehensive health services on a prepayment basis to enrolled individuals. Medicare beneficiaries have the option to enroll in HMOs which contract with HCFA to furnish all medically necessary services covered under the Medicare program.

Managed care options have been available to Medicare beneficiaries for many years. Enrollment in managed care plans has been steadily increasing, especially during the last 5 years. In January 1993 there were 177 plans with Medicare contracts serving 2.5 million beneficiaries. In September 1997 there were 410 plans which enrolled approximately 5.6 million Medicare beneficiaries. Medicare payments to managed care plans have also grown significantly--from \$8.6 billion in Fiscal Year (FY) 1993 to \$25.6 billion in FY 1997. By the year 2002, it is projected that 25 percent of the Medicare population (approximately 10 million beneficiaries) will receive their medical services through some form of managed care plan.



Section 1876 of the Social Security Act, as amended by section 114 of the Tax Equity and Fiscal Responsibility Act (TEFRA), provides two methods of payment for services furnished to Medicare enrollees of HMOs--payment on a risk basis and payment based on cost reimbursement.

- Risk contracts--Under a Medicare risk contract, payment to the HMO is made on a prepaid capitation rate with no retroactive adjustments. This rate reflects the estimated costs that would have been incurred by Medicare on behalf of enrollees of the HMO if they received their covered services in fee-for-service Medicare. Risk plans are required to provide all Medicare-covered services in exchange for the capitation

¹ Our term "HMO" in this report includes both HMOs and competitive medical plans with Medicare risk contracts.

payments they receive. They must absorb any losses, but are permitted to retain profits up to the level earned on their non-Medicare business. Most plans which contract with HCFA have a risk contract. As of September 1997, there were 304 Medicare risk contracts in effect which enrolled approximately 5 million beneficiaries.

- Cost contracts--Under a cost contract, Medicare payment to the plan is based on the reasonable cost of providing services to Medicare beneficiaries. In September 1997 there were 36 Medicare cost contracts which enrolled approximately 203,000 beneficiaries. In addition, HCFA contracts with health care prepayment plans which cover Medicare Part B services only and are reimbursed on a cost basis. There were 48 plans with this type of contract in September 1997 which enrolled approximately 401,000 beneficiaries.

In addition to the above types of contracts, a limited number of beneficiaries receive Medicare services through managed care demonstration projects.

REIMBURSEMENT FOR RISK-BASED HMOs

There are two features to the somewhat complex Medicare risk reimbursement formula. The first is establishing reimbursement rates for the HMOs by HCFA's Office of the Actuary prior to the contract period. The rates are based on 95 percent of the adjusted average per capita cost (AAPCC). The AAPCC is HCFA's actuarial estimate on a county-by-county basis of what Medicare would expect to pay for similar beneficiaries as enrolled in the HMO, if the services were received under the traditional Medicare fee-for-service program.

The second feature is determining a specific plan's per capita financial requirements. A risk-based HMO is required by section 1876 of the Social Security Act to compute an ACR proposal and submit it to HCFA prior to the beginning of the contract period. The ACR computation consists of two parts. The first part is a calculation of the rate the plan would charge if it furnished the Medicare covered services package to its general membership. The second part of the computation consists of adjustments made to the rate to reflect the perceived higher costs of furnishing these services to Medicare beneficiaries.

After calculating their ACR, the plans compare the ACR to their projected average payment rate (APR). The APR is the amount of Medicare revenue the HMO expects to receive during the period covered by the ACR proposal on a per member per month (PMPM) basis. If the ACR is less than the APR (in effect, an HMO would compare their budgeted estimated costs to their estimated Medicare revenues), the plan must return the excess to the Medicare enrollee or the Medicare program using one or more of the following methods:

- 4 a reduction of the Medicare enrollee's HMO premium, (for example, a co-insurance that would have been charged by the HMO) if any had been anticipated;
- ➔ granting extra noncovered Medicare benefits (for example, performing annual physicals or providing eye wear or hearing aids) to the Medicare enrollee;
- ➔ contributing to a benefit stabilization fund that would be used in subsequent contract periods to prevent fluctuations in additional benefits the HMO provides; or
- ➔ acceptance of a reduction in the monthly payment from the Medicare program (in effect the HMO would be stating they would prefer to take a lower Medicare payment rather than provide extra benefits to a Medicare enrollee). The BBA of 1997, however, eliminated this option effective January 1998.

THE ACR PROPOSAL

The ACR proposal is designed to help both the HMO and HCFA recognize and evaluate the funds needed by an HMO that contracts with HCFA on a risk basis. These revenue requirements are to cover anticipated costs (both medical and administrative) of the plan in the upcoming year. The ACR requirement in section 1876 is designed to ensure the Medicare beneficiary was not overcharged for the benefit package being offered and to return to the HMO enough funds to cover its costs plus an additional amount normally expected in the commercial market. Essentially, the ACR process was designed to help ensure that Medicare payment rates do not overcompensate HMOs for the services they offer. When calculating the ACR proposals, plans are allowed per section 1876(e)(3) of the Social Security Act to adjust their base rate calculations by a utilization factor to account for traditionally perceived differences in the complexity and intensity of medical services furnished to Medicare enrollees compared to non-Medicare enrollees of the HMO. The burden of identifying and proving the basis and adjustments to the ACR proposal falls on each HMO and is dependent upon a fact-finding process that is based on the individual HMO's operating experiences relating to utilization and expenses. A detailed explanation of the elements that make up the ACR proposal as well as a sample proposal are provided in Appendices A and B, respectively, to this report.

OBJECTIVE , SCOPE , AND METHODOLOGY

In this review we concentrated our analysis on one component of the ACR proposal--the administration line item. The administration component covers any management, financial, and other costs which are incurred by or allocated to a business unit and are for the general

management and administration of the business unit as a whole. Items that are included in the administration component are the non-medical costs of compensation, interest, occupancy, depreciation, and amortization; also included are marketing, reinsurance expenses, taxes, and profits.

The objective of our review was to determine if the amount submitted by HMOs on their ACR proposals for administration was reasonable.

To accomplish our objective, we:

- 4 reviewed applicable laws and regulations, legislative history, proposed and final rules as published in the Federal Register, the HMO Manual, and HCFA instructions to the HMOs;
- ➔ discussed with HCFA officials the ACR process and how administrative costs were accounted for;
- ➔ reviewed all ACR proposals in HCFA's data system for the 1994 through 1997 contract periods. We analyzed the ACR data to determine trends, aberrations, and similarities. Our data base consisted of:

<u>Year</u>	<u>Number of Plans</u>
1994	173
1995	203
1996	273
1997	318

- ➔ reviewed the annual audited financial statements in the reports as filed with HCFA for the plans that had Medicare risk contracts for FYs 1994, 1995, and 1996. Plans are required to submit these so-called National Data Reporting Requirements (NDRR) reports annually to satisfy the requirements of Title XIII of the Public Health Service Act. Included in the NDRR is a statement of revenue and expenses which summarizes the plan's financial operating data. Our data base consisted of:

1994 - 116 plans (95 percent of total risk enrollment)
1995 - 130 plans (92 percent of total risk enrollment)
1996 - 199 plans (95 percent of total risk enrollment)

Our review was made in accordance with generally accepted government auditing standards. Our work was performed at HCFA central office in Baltimore, Maryland between March and October 1997.

FINDINGS AND RECOMMENDATIONS

We found that although HMOs which have a cost contract with HCFA have clearly defined criteria for claiming reimbursements for their administrative costs, no such specific criteria exist for risk-based HMOs. Under a risk contract, there is no limit to the amount HMOs can allocate to the anticipated administrative cost component of their Medicare operations as long as it is consistent with the overall methodology they use on their commercial side of business. Although this may seem reasonable, the current methodology which Medicare allows an HMO to follow enables plans to financially gain unnecessarily due to the impact that medical utilization factors have on computing the administration component for the Medicare premium. As a result, the administrative component of the Medicare premium shown on the ACR proposals is often not reasonable, is highly inflated, and results in the Medicare program paying a disproportionate share of some HMOs' administrative costs.

“*CRITERIA FOR DETERMINING ADMINISTRATIVE COSTS

Plans which have a cost contract with HCFA have clearly defined criteria for claiming reimbursements for their administrative costs. Per 42 CFR 417.564, administrative costs that benefit the total enrollment of the HMO and are not directly associated with furnishing medical care must be apportioned on the basis of a ratio of Medicare enrollees to total HMO enrollment. Administrative costs significantly related to providing medical services (e.g., facility costs and medical records costs) must be allocated to an HMO's various operating components and then apportioned to Medicare. The purpose of apportionment is to ensure that the cost of services furnished to Medicare enrollees is not borne by others and that the cost of services furnished to others is not borne by Medicare. This is essentially the same philosophy followed in all parts of the Medicare program where health care providers' administrative costs are considered as a distinct part of their operation for purposes of Medicare reimbursement.

Specific criteria similar to the above do not exist for risk-based HMOs. The only applicable criteria we were able to find is in sections 5203 through 5204 of the HMO Manual which are very general in nature. Basically, all assumptions, cost data, revenue requirements, and other elements used by HMOs in the ACR proposal calculations must only be consistent with the calculations used for the premiums charged to non-Medicare enrollees. After plans calculate a total average rate on a PMPM basis, the premium must be allocated to the components of the ACR proposal (including the administrative component) based on the actual cost experience in charging premiums to the public. The HMOs may allocate the administrative component either on a PMPM basis, a percentage basis (generally a fixed percent of the total premium for medical services), or a combination of both. According to officials in HCFA, there is no limit to the amount plans can allocate to the administrative component on the ACR so long as the method of allocation is consistent with what is used on their commercial side of operating their business.

⇒ PLANS FAVOR PERCENT ALLOCATION FOR ADMINISTRATION

We examined the methodology that plans used to allocate administration for the ACR proposals for 1994 through 1997. We compared the amounts allocated in the base rate to the ACR and the ratio between the administration component and the total medical component. As shown in the following chart, we found that most plans are utilizing a percentage computation to allocate administration in lieu of a fixed or blended amount.

<i>YEAR</i>	<i>PLANS</i>	<i>PLANS USING FIXED OR BLENDED AMOUNT</i>	<i>PLANS USING PERCENTAGE ALLOCATION</i>
1994	173	16	157
1995	203	7	196
1996	273	3	270
1997	318	0	318

⇒ MEDICAL UTILIZATION FACTORS ARE DISTORTING ADMINISTRATIVE COSTS ON ACR PROPOSALS

We were not surprised to find the overwhelming number of plans used the percentage allocation method. Allocating administration based on a percent computation grossly inflates the plans' administration needs for Medicare. The reason is that this methodology takes advantage of the effect of medical utilization factors on the administration component. The result is that the amounts for administration tend to be a product of the medical premium rather than reflecting what is needed to cover administrative costs. This can be demonstrated in the following ACR proposal (the full presentation of the ACR proposal is contained in Appendix B).

SERVICE	BASE RATE	ADJ	INITIAL RATE	UTILIZATION FACTOR	ACR
<i>Medical Related Services:</i>					
✓ <i>Inpatient</i>	\$35.94	(\$0.21)	\$35.73	4.151	\$148.32
✓ <i>See Appendix B for additional medical service detail estimates</i>	■	■	■	■	■
✓ ■	■	■	■	■	■
<i>Subtotal of Medical Services</i>	<u>113.27</u>	<u>(16.48)</u>	<u>96.79</u>		<u>329.17</u>
<i>(See Note)</i>	x.31	x.31	x.31		x.31
<i>Administration:</i>	35.11	(5.11)	30.00		102.04
Total	\$148.38	(21.59)	\$126.79		\$431.21

Note: We added this line to illustrate that this plan develops its anticipated administration costs based on allocating 31 percent of the total medical services premium.

For the medical services listed in the ACR proposal there is a corresponding utilization factor that is multiplied by the initial rate to arrive at the ACR rate.² In our example, the initial rate for inpatient services is \$35.73. This rate is then multiplied by a utilization factor (4.151) which represents the historical complexity and utilization differences between the plan's Medicare and commercial lines-of-business relative to payments for inpatient services. The result is an ACR premium of \$148.32 for hospital inpatient services. This process is repeated for each medical service in the ACR proposal.

This plan elected to use a flat 31 percent of its medical premium to allocate its administration amount. This plan, therefore, benefits in computing its administration costs from the multiplier effect of the average of all the medical utilization factors. The resulting Medicare ACR administration cost is almost three times (\$35.11 versus \$102.04) what would be charged on the commercial side. We note that for medical services, HCFA requires the plans to submit justification for each of the utilization factors. Such a justification is not required for the use of a utilization factor for the administrative component nor is the use of these factors in calculating the administrative component specifically stated in the Social Security Act, regulations, or HCFA's HMO Manual. However, the effect of the medical utilization factors impacts the computation of the administration component for those plans using a percentage factor. This is demonstrated in the following chart.

²The initial rate is the individual HMO's estimate of funds needed on an average monthly basis to provide, for example, Medicare coverage of inpatient services for a non-Medicare person enrolled in this HMO.

AVERAGE PREMIUM FOR ADMINISTRATION			
<i>YEAR</i>	<i>NUMBER OF PLANS</i>	<i>COMMERCIAL</i>	<i>MEDICARE</i>
1994	173	\$19.94	\$47.62
1995	203	\$20.27	\$71.96
1996	273	\$20.20	\$74.38
1997	318	\$20.87	\$77.30

While this method is acceptable under the currently used criteria, we do not believe that increasing the base rate three-fold should be allowable without requiring the HMO to provide supportive documentation. A large portion of administrative costs are fixed and are not a function of, nor have a direct relationship to, the volume or complexity of the medical services being provided to either Medicare or non-Medicare enrollees. Since plans are required to provide support to justify the increased costs of furnishing medical services, they should be required to furnish support to justify the increase in administration.

Officials in HCFA are proposing a change in the work sheets (details on how component parts of the ACR are derived) that must be submitted by plans in the ACR proposals. The changes require plans to submit utilization factors for all elements of the ACR proposal including administration. We support this proposal.

⇒ MEDICARE IS PAYING A DISPROPORTIONATE SHARE OF HMOs' ADMINISTRATIVE COSTS

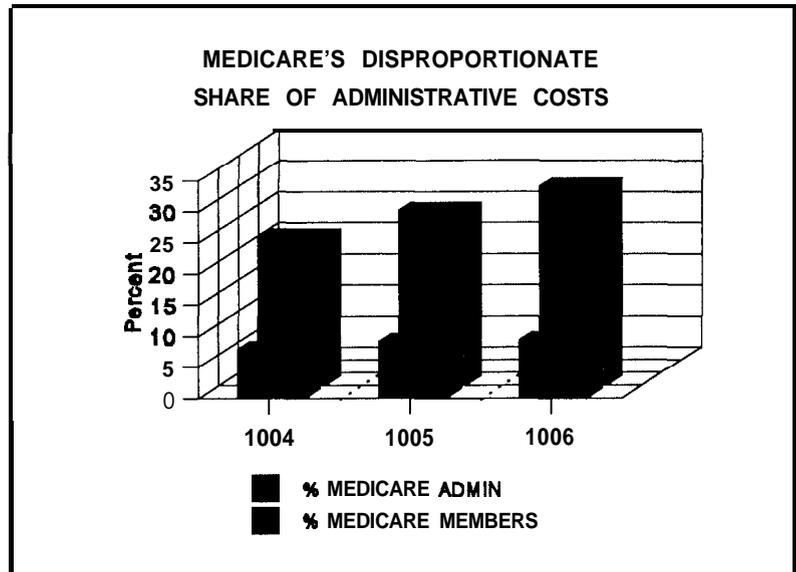
In order to test the impact of the inflated administrative amounts, we compared the total payments for administration³ (a reminder: these were the anticipated costs for administering the Medicare portion of the HMO's business) to the actual administrative expenses reported in the audited financial statements for 1994, 1995, and 1996 submitted by the HMOs to HCFA as part of the NDRR process we noted on page 4. Our analysis compared the following ratios:

- ⇒ Medicare payments for administrative costs to total administrative expenses (we included all administrative expenses on the NDRR reports that were to be used in the administrative component on the ACR proposal); and

³We computed total payments for administration by multiplying the amount shown on the ACR administration line item for Medicare times the total Medicare risk member months for each plan.

➡ Medicare enrollment (the total number of months Medicare beneficiaries were in the plans) to the total number of enrollment months for the plans.

It appears that a disproportionate share of the cost for administration is being borne by the Medicare program. In 1994, Medicare membership totaled 7.5 percent of all the plans' total enrollments. Total administrative expenses shown on the NDRRs were over \$7.35 billion and the total Medicare payments for administrative costs were \$1.73 billion. **Consequently, the Medicare program covered 23.5 percent of administrative expenses with**



only 7.5 percent of the total enrollment in 1994. There were no significant changes in these ratios for 1995 and 1996. Medicare membership totaled 8.7 percent and 8.9 percent of the plans' total enrollment for 1995 and 1996, respectively. Total administrative expenses shown on the plans' financial statements were over \$8.0 and \$9.4 billion for 1995 and 1996. The total Medicare payments for administrative costs were \$2.2 and \$3.0 billion. **As a result, the Medicare program covered 27.7 percent of administrative expenses with only 8.7 percent of enrollment in 1995 and 31.7 percent of administrative expenses with only 8.9 percent of enrollment in 1996.** We believe that Medicare's share of administrative costs should be more aligned to its share of total plan enrollment to ensure Medicare only pays its fair share of operating costs.

This disparity was even more egregious for one plan in 1994. Our review identified a plan that has had a risk contract for over 5 years and a Medicare population of just under 43 percent of total plan enrollment. This plan reported on its financial statements a total of \$287 million in administrative expenses for 1994. Based on the amount allocated for administration on its 1994 ACR proposal times the total 1994 Medicare member months, Medicare payments for administration totaled \$366 million. **Unbelievably, the Medicare program covered 127 percent of the plan's administrative expenses.** We believe this was a result of the use of the medical utilization multiplier which was applied to the base rate for administration. We believe this because the anticipated base rate for administration on the ACR proposal (before applying the utilization factor) was comparable to the average actual administrative expense shown on the financial statement report on a PMPM basis.

We found that for the 1994, 1995, and 1996 contract years, the presently used methodology allowed HMOs to overestimate their anticipated needs for administration costs by as much as \$1 billion, \$1.3 billion, and \$1.9 billion, respectively. This is a result of the ACR process which enables plans to exploit the use of medical utilization factors when computing their anticipated administrative costs to deliver their services to Medicare beneficiaries. An explanation and example of how we computed the excess amounts are included in Appendix C.

IMPACT ON ADDITIONAL BENEFITS

As previously discussed, if the plan calculated a Medicare ACR that is less than the monthly amount Medicare will pay the HMO for each Medicare enrollee (known as the APR) for the period we reviewed, the HMO was to return the excess either to the Medicare enrollee in added benefits or to the Medicare program.⁴ Because of the formula driven computation of the administrative component in the ACR proposal, we believe anticipated costs for administration have been artificially inflated and an integral part of the ACR process has been compromised. This results in a distortion of the amounts of additional benefits due to the beneficiary or savings possible to Medicare in reduced payments. Over the past several years, based on the ACR submittals received by HCFA, the differences between the APR and the ACR proposal are as follows:

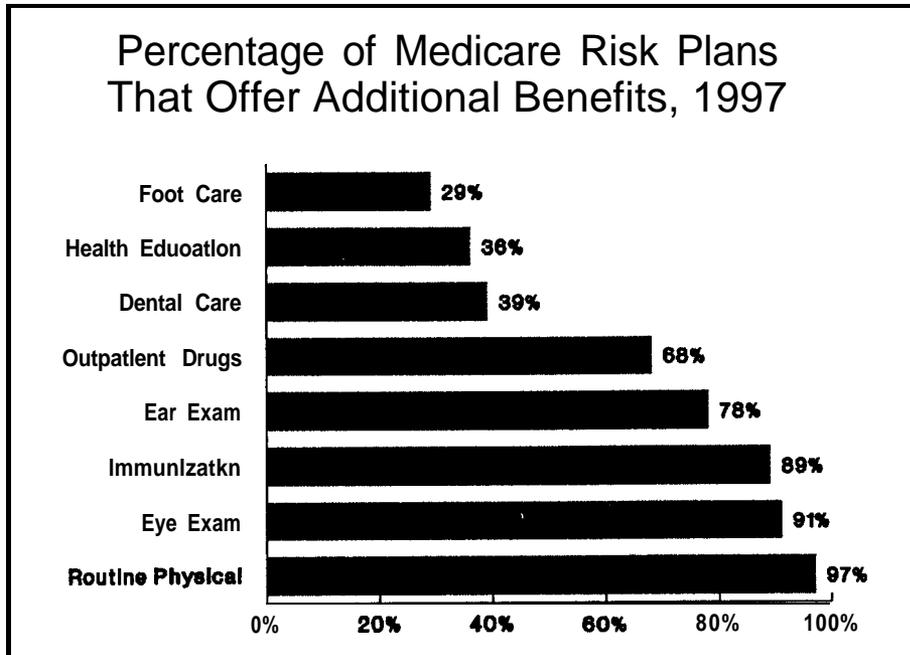
YEAR	AVERAGE APR	AVERAGE ACR	DIFFERENCES
1994	\$361.66	\$400.03	\$-38.37
1995	389.95	400.17	-10.22
1996	414.48	402.34	12.13
1997	435.43	411.13	24.30

Note: These differences reflect the average amount of anticipated premiums from Medicare (APR) compared to the anticipated costs to deliver the services to a Medicare enrollee (ACR).

A cursory review of the above numbers would lead you to believe that the HMOs are furnishing the basic Medicare package of services at a loss for 1994 and 1995 and have the ability to offer nominal additional benefits for 1996 and 1997. However, our review of the ACR proposals show that HMOs are offering additional benefits even when the anticipated costs for the Medicare package exceeded the Medicare payment. As shown in the following

⁴As noted earlier, the BBA of 1997 removed the option of returning the excess funds to the Medicare program.

chart, these benefits have included routine physicals, eye and ear exams, prescription drugs, etc.



According to the ACR proposals, the following amounts represent the average value for additional benefits (after adjusting for beneficiary copayments and premiums received by the plans) .

YEAR	DOLLAR VALUE
1994	\$42.73
1995	62.94
1996	79.24
1997	87.62

Note: These are the values of average net additional benefits offered to the average Medicare risk HMO enrollee.

The amount of these additional benefits coupled with the losses estimated by the plans for 1994 and 1995 would give a picture of a program in jeopardy. There would be no incentive for

HMOs to enter into a risk contract with Medicare. This, however, is not the case as shown in the rapid increase in HMO participation in risk contracting. A further review of the ACR proposals shows that plans are waiving the premiums they would normally charge for the extra benefits. One can only conclude that the plans are funding the extra benefits out of the excessive administration component. If this is true, it indicates that plans are aware that the amounts that they submit for administration are inaccurate and result in unjustified expenditures of Medicare funds.

Based on our computation of a more reasonable allocation for administration that could be allowed by Medicare (see Appendix C), the amounts we calculated that administration was overstated still exceeded the dollar value waived (not charged to the beneficiaries) for extra benefits. After adjusting for the value of the extra benefits, the excess administration amounts were \$456 million for 1994, \$691 million for 1995, and \$785 million for 1996. This represents approximately 4.6 percent of the risk payments made to the plans. An explanation and example of how we computed the excess amounts are included in Appendix D.

These excessive amounts allocated for administration should be returned to the Medicare trust funds. This could be accomplished without eliminating extra benefits, but rather placing a cap on the amounts allocated for benefits. This can be done in several ways while still enabling beneficiaries to enjoy the same historical level of additional benefits they are used to being offered as part of their enrollment in a Medicare HMO. By implementing our recommendation for reducing the amounts allowed for administration without a cap on the extra benefits, the plans could manipulate the ACR process through inflated estimates for additional benefits or offering benefits that would not actually be used very often by Medicare beneficiaries.⁵

Capping benefits, along with the continuation of the present HMO charges for copayments and premiums, could occur in several ways. Below are some approaches that could be implemented:

- Limiting additional benefits to the average national dollar value of the amounts waived for extra benefits normally charged to HMO enrollees (the amounts would be net of beneficiary payments actually charged to HMO enrollees). This would have resulted in potential savings of \$687 million for 1994, \$864 million for 1995, and \$966 million for 1996. These values represent approximately 6 percent of the risk payments made to the plans. An explanation and example of how we computed the excess amounts are included in Appendix E.

⁵It needs to be noted that the only requirement an HMO has is to offer the additional benefits to a beneficiary. If a beneficiary doesn't use the additional benefit, an HMO on the average saves money.

- Setting a cap based on a flat percentage of the APR--the amount the HMOs estimate to be their Medicare revenue. We computed savings by setting a cap rate based on the lesser of the actual amount or 10 percent of the APR.⁶ This resulted in potential savings of \$535 million for 1994, \$786 million for 1995, and \$953 million for 1996. This represents approximately 5.4 percent of the risk payments made to the plans. An explanation and example of how we computed the excess amounts are included in Appendix F.

With the use of one of the above illustrative options, beneficiaries would still have had available to them the added benefits they have enjoyed in previous years and the Medicare program would realize savings in its HMO risk contracts. Potentially, the savings could be redirected to fund enhancements to Medicare's managed care program such as improved beneficiary protections and enhanced quality assurance initiatives.

CONCLUSIONS AND RECOMMENDATIONS

It is estimated that by the year 2002, 25 percent of the Medicare beneficiaries will elect to have their services furnished through managed care plans. With this level of enrollment, Medicare reimbursement for managed care plans will undoubtedly exceed \$50 billion annually.

Part of the Medicare risk reimbursement formula is the ACR process to determine HMO revenue requirements in providing Medicare covered services to enrolled beneficiaries. Previous reports by the General Accounting Office have stated that the ACR process is susceptible to HMO manipulation and error. We found that the amounts for administration being allocated to Medicare on the ACR proposals are often not reasonable, and are highly overstated. Since the current ACR process enables plans to take advantage of the medical utilization factor when computing the administration component in the ACR proposals, HMOs are allowed to claim a disproportionate share of administrative costs on their Medicare operations.

We, therefore, recommended that:

- ✎ HCFA revise its criteria to require HMOs to allocate their administrative costs estimates on their ACR proposals following the same concepts used throughout the Medicare program to help ensure non-Medicare costs are not borne by Medicare. Any

⁶We compared the average value of waived charges to beneficiaries to the payment rates and determined the average waived value to be 6.6 percent in 1994, 8.5 percent in 1995, and 10.4 percent in 1996 of the APR. We selected 10 percent since it closely approximates the higher 1996 amount and would be a more conservative estimate. If we had used the 3-year period average, it would have been approximately 8.6 percent and thus resulted in even additional savings.

differences between the administrative base rate and the amounts allocated to the Medicare premium should be supported similarly as the medical component is in the ACR process. Any disparities between the base rate and the ACR rate that are not nominal should require further review by HCFA.

Tighter control placed on amounts allocated for administration in the ACR process should result in additional savings amounts between the anticipated revenues from Medicare (APR) and the anticipated costs to service the Medicare enrollees (ACR). Because of the present reimbursement formula, HMOs would be required to use these savings to fund additional benefits. Based on our review, these excessive administrative allowances have already funded substantial additional benefits such as preventive care and lower coinsurance and deductible amounts. As stated by the previous HCFA administrator, the ability of managed care plans to provide additional benefits is due in part to the inadequacy of Medicare's payment methodology. Even with these added benefits, there remained a surplus of funds over and above the amounts needed to pay for the Medicare benefit package plus a whole array of additional benefits that beneficiaries in the fee-for-service sector do not receive at Medicare's expense.

We, therefore, recommended that:

- ✎ HCFA introduce legislation that would allow the Medicare program to recover the excessive amount presently being paid for administration. Based on the BBA of 1997, the option of reducing Medicare payments to HMOs when the APR amount exceeds the ACR amounts was eliminated. We believe that the excessive administration amounts should be returned to the Medicare program.

HCFA COMMENTS

In response to our report, HCFA stated that their efforts in revising the ACR process, as part of the Medicare+Choice program, will produce a more realistic allocation of administrative costs that better reflect differences between Medicare and commercial enrollees. The HCFA also believed that the savings estimated in this report are overstated due to technical problems with our formula.

In response to our first recommendation, HCFA agreed that the criteria governing the computation of administrative costs in the ACR proposals almost certainly resulted in overstated administrative costs. According to HCFA, the new format for the ACR proposals will more accurately reflect administrative costs for Medicare beneficiaries and should result in a lesser amount of costs being allocated to Medicare enrollees. The HCFA also notes that changes brought about by the BBA of 1997 will reduce Medicare capitation payments in geographic areas with higher payment levels and require audits of the computation of the ACRs.

However, HCFA did not concur with our second recommendation to introduce legislation to recover the excessive amount presently being paid for administration. The HCFA believed that the congressional intent with the changes brought about by the BBA of 1997 was that all savings should be passed on to the beneficiaries. In addition, HCFA stated that some HMOs are reducing the amount of benefits because of reduced Medicare capitation payments. The HCFA believed that it may be appropriate to reassess our recommendation in the future once they have an opportunity to fully assess the impact of the BBA of 1997 mandated payment changes and ACR audits.

The full text of HCFA's comments are included in Appendix G.

OIG RESPONSE

We believe that HCFA's changes to the methodology HMOs use to compute administrative costs in the ACR proposals should help ensure that non-Medicare costs are not borne by Medicare. While HCFA did not concur with our second recommendation, we are encouraged with HCFA's willingness to reassess our recommendation to recapture excessive administrative amounts after assessing the impact of BBA-mandated payment changes and ACR audits. However, we believe that before this recommendation is implemented, some plans will continue to profit excessively as a result of the Medicare payment system. Given the amounts that this excess has been during the period of our audit and the tentative situation of the Medicare trust funds, the Congress may want to reassess this situation.

We are also concerned that any delay in implementing a legislative change to recover excess payment amounts will be problematic for processing future Government recoveries if audits/investigations disclose that HMOs are not providing its enrollees with the additional benefits as indicated in their ACR proposals. The HCFA encountered this situation recently as part of their evaluations of HMOs. It would be easier for the Government to ask for a recovery of these types of funds than to retroactively offer the denied benefits after the close of the contract year.

HCFA TECHNICAL COMMENTS

The HCFA offered technical comments to our report that related to our description of the ACR process and how we computed administration amounts as part of the ACR process. The HCFA commented that the ACR process is not an exercise in the estimation of funds needed to cover the costs of providing services to its enrolled Medicare population. Among the issues raised by HCFA was that the administration component includes more than marketing, enrollment, and membership costs, and that other elements included in administration were: risk reserves as a ratio of revenue that some States require HMOs to establish; elements representing revenue losses and premium waivers that HMOs use to reduce the administrative component claimed; and additional revenues that may be included in the ACR.

OIG RESPONSE

In our description of the ACR process, we used language from HCFA's HMO Manual section 5203 to describe the ACR process. As to the elements included in the administration component, we used the following: reinsurance expenses, the costs associated with the overall management and operation of the HMO, and amounts retained by the HMO as either profit or retained earnings. The cost of HMO operations include the following components: compensation and fringe benefits for personnel time devoted to or in direct support of administration; interest expense; occupancy, depreciation, and amortization of facilities and fixed assets; marketing; and other administrative expenses such as (but not limited to) claims processing, updating subscriber's records, subscriber inquiries and complaints, legal, audit, data processing, and accounting.

While we did not build into our formula an additional allowance for State required risk reserves or possible additional revenues included in the ACR proposals, we did account for losses and premium waivers (not to exceed the amount of Medicare payment). We are now in the process of examining in detail the amounts that HMOs have been including in their administrative component and specific expenses paid as part of administration. Preliminary results have indicated a slight overstatement in the formula we used to identify excess administration less waivers and additional benefits. Based on the results to date, the 5.36 percent of Medicare revenues that we projected to be excessive administration should have been 4.54 percent of Medicare revenues. Our estimate of the excessive payments for administration presently paid by Medicare as a portion of the monthly capitation payments, however, still exceeds \$1 billion annually. We will continue to work with HCFA to both evaluate the planned reviews of the ACRs as part of the Medicare+Choice program and to reevaluate the potential savings to the Medicare program if only reasonable administrative costs were allowed HMOs as part of the monthly capitation payments.

APPENDICES

COMPONENT PARTS OF AN ADJUSTED COMM-UNITY RATE PROPOSAL

The ACR proposal from an HMO consists of the following:

- ✎ **BASE RATE** - The ACR proposal begins with a base rate. The base rate is the average premium rate, on a PMPM basis, that the HMO will charge its non-Medicare enrollees during the contract period. The rate is broken down into various components (i.e., medical administration, additional benefits beyond what Medicare covers, etc.). The base rate is derived from either a community rating method or from the plan's weighted average aggregate premium. The community rating method is based on the average cost of actual or anticipated health care used by all non-Medicare members. The weighted average aggregate premium method is based on the weighted average of the aggregate premiums charged to non-Medicare members.
- ✎ **ADJUSTMENTS** - The HMO then adjusts each component in the base rate to eliminate the value of those services not covered by Medicare. Adjustments are also made to include the value of covered Medicare services that are not in the base rate.
- ✎ **INITIAL RATE** - After the adjustments are applied to the base rate, the result is the initial rate. The initial rate is the rate the plan would have charged its commercial members if the commercial package was limited to Medicare coverage.
- ✎ **UTILIZATION FACTORS** - The next step is to multiply the initial rate by utilization factors to reflect the traditionally perceived differences in volume, intensity, and complexity of services used by Medicare members in comparison to non-Medicare members.
- ✎ **ACR** - The result of the above steps is what the plan estimates its revenue requirements will be to furnish the Medicare-covered services benefit package.

SAMPLE ADJUSTED COMMUNITY RATE (ACR) PROPOSAL

SERVICE	BASE RATE	ADJ	INITIAL RATE	UTILIZATION FACTOR	ACR
<i>Inpatient</i>	\$35.94	(\$0.21)	\$35.73	4.151	\$248.32
<i>Skilled Nursing</i>	0.23	(0.01)	0.22	40.820	8.98
<i>Home Health</i>	0.32		0.32	5.450	1.74
<i>Physician</i>	43.39		43.39	2.744	119.07
<i>Outpatient Lab</i>	4.38		4.38	1.480	6.48
<i>Outpatient Radiology</i>	5.21		5.21	3.360	17.51
<i>Hospital Outpatient</i>	6.45		6.45	3.370	21.74
<i>Prescription Drugs</i>	13.34	(13.32)	0.02	4.040	0.08
<i>Emergency</i>	0.25		0.25	12.810	3.20
<i>Miscellaneous</i>	0.82		0.82	2.500	2.05
<i>Non-Medicare</i>	2.94	(2.94)	0.00		0.00
<i>Subtotal</i>	<u>113.27</u>	<u>116.48</u>	<u>96.79</u>		<u>329.17</u>
<i>Administration</i>	35.11	(5.11)	30.00		102.04
<i>Total</i>	\$148.38	(21.59)	\$126.79		\$431.21

COMPUTATION OF EXCESS ADMINISTRATION AMOUNTS

The following steps were taken to determine the amount of excess administration:

- Step ①** We used the amounts shown on the submitted ACR proposal for the administrative line item for Medicare.
- Step ②** We computed a revised amount for administration. From the annual financial statements submitted to HCFA, we determined the total administration expenses; we divided the total administration expenses by the total member months (both commercial, Medicare, and Medicaid) to arrive at a per member per month amount. The result is the revised per member per month amount for administration.
- Step ③** We subtracted Step 2 from Step 1.
- Step ④** We multiplied the results in Step 3 by the total Medicare member months. The result was the total excess administration for the plan.

NOTE: **IF** A PLAN OFFERED AN ADDITIONAL BENEFIT PACKAGE THAT EXCEEDED ANY REVISED SAVINGS AMOUNTS, WE COMPUTED A **\$0** SAVINGS AMOUNT INSTEAD OF SHOWING A LOSS. **IF** A PLAN'S REVISED **MEDICARE** PREMIUM EXCEEDED ITS **MEDICARE** PAYMENT, WE COMPUTED **\$0** SAVINGS AMOUNT.

Example:

✓ ACR administration line item amount:	\$88.18
✓ NDRR administration expense:	\$74,225,800
✓ Divided by total plan member months	2,443,437
✓ Equals per member per month administration amount	<u>30.38</u>
✓ Excess administration	\$57.80
✓ Times Medicare risk member months	228,950
✓ Equals total excess administration amounts	<u>\$13,233,310</u>

The total computed excess administration for all the plans in our review are as follows:

1994	\$1 .0 billion
1995	\$1.3 billion
1996	\$1.9 billion

**EXCESS ADMINISTRATION
LESS
AMOUNTS WAIVED FOR EXTRA BENEFITS**

- Step 1** We computed excess administration as described in Appendix C.
- Step 2** We determined from the ACR proposal the amounts (if any) that a plan was waiving for premium charges associated with extra benefits being offered to the beneficiary.
- Step 3** We subtracted Step 2 from Step 1.
- Step 4** We multiplied the results in Step 3 by the total Medicare member months. The result was the total excess administration less the amounts waived for extra benefits per plan.

NOTE: **IF A PLAN OFFERED AN ADDITIONAL BENEFIT PACKAGE THAT EXCEEDED ANY REVISED SAVINGS AMOUNTS, WE COMPUTED A \$0 SAVINGS AMOUNT INSTEAD OF SHOWING A LOSS. IF A PLAN'S REVISED MEDICARE PREMIUM EXCEEDED ITS MEDICARE PAYMENT, WE COMPUTED \$0 SAVINGS AMOUNT.**

Example:

✓ Excess administration per member per month (See Appendix C)	\$57.80
✓ Less amounts waived for extra benefits per ACR proposal	<u>27.98</u>
✓ Net excess administration allowance	\$29.82
✓ Times Medicare risk member months	228,950
✓ Equals total excess administration amounts	<u>\$6,827,289</u>

The total computed excess administration less amounts waived for extra benefits for all the plans in our review are as follows:

1994	\$456 million
1995	\$691 million
1996	\$785 million

**COMPUTATION OF SAVINGS
BY CAPPING ADDITIONAL BENEFITS
BASED ON NATIONAL AVERAGE OF WAIVED AMOUNTS**

- Step ①** We computed excess administration as described in Appendix C.
- Step ②** We used the amounts waived as shown in the ACR proposals and computed the average amount waived.
- Step ③** We used the lower of the actual amount waived by the plan or the national average.
- Step ④** We computed savings by subtracting Step 3 from Step 1.
- Step ⑤** We multiplied the results in Step 4 by the total Medicare member months. The result was the total excess administration limited to the average national amount waived for extra benefits for the plan.

NOTE: IF A PLAN OFFERED AN ADDITIONAL BENEFIT PACKAGE THAT EXCEEDED ANY REVISED SAVINGS AMOUNTS, WE COMPUTED A \$0 SAVINGS AMOUNT INSTEAD OF SHOWING A LOSS. IF A PLAN'S REVISED MEDICARE PREMIUM EXCEEDED ITS MEDICARE PAYMENT, WE COMPUTED \$0 SAVINGS AMOUNT.

Example:

✓ Excess administration per member per month (See Appendix C)	\$57.80
A. maximum amount allowed based on the national average waived amounts	\$24.29
B. actual waived amount for a plan we reviewed	27.98
✓ Lower of A or B	<u>24.29</u>
✓ Excess administration allowance	\$33.51
✓ Times Medicare risk member months	228,950
✓ Equals total excess administration amounts	<u>\$7,672,115</u>

The total computed excess administration less amounts waived for extra benefits limited to the national average waived for all the plans in our review are as follows:

1994	\$687 million
1995	\$864 million
1996	\$966 million

**COMPUTATION OF SAVINGS
BY CAPPING ADDITIONAL BENEFITS
BASED ON 15 PERCENT OF AVERAGE PAYMENT RATE**

- Step ①** We computed excess administration as described in Appendix C.
- Step ②** We computed 10 percent of the average payment rate as shown in the ACR proposal.
- Step ③** We used the lower of the actual amount waived by the plan or 10 percent of the average payment rate (APR).
- Step ④** We computed savings by subtracting Step 3 from Step 1.
- step ⑤** We multiplied the results in Step 4 by the total Medicare member months. The result was the total excess administration limited to 10 percent of APR.

NOTE: IF A PLAN OFFERED AN ADDITIONAL BENEFIT PACKAGE THAT EXCEEDED ANY REVISED SAVINGS AMOUNTS, WE COMPUTED A \$0 SAVINGS AMOUNT INSTEAD OF SHOWING A LOSS. IF A PLAN'S REVISED MEDICARE PREMIUM EXCEEDED ITS MEDICARE PAYMENT, WE COMPUTED \$0 SAVINGS AMOUNT.

Example:

✓ Excess administration per member per month (See Appendix C)	\$57.80
A. maximum amount allowed based on 10 percent of APR	\$45.43
B. actual waived amount for a plan we reviewed	27.98
✓ Lower of A or B	<u>27.98</u>
✓ Excess administration allowance	\$29.82
✓ Times Medicare risk member months	228,950
✓ Equals total excess administration amounts	<u>\$6,827,289</u>

The total computed excess administration less amounts waived for extra benefits limited to 15 percent of the average payment rate for all the plans in our review are as follows:

1994	\$535 million
1995	\$786 million
1996	\$953 million



MAR301998

DATE:

TO: June Gibbs Brown
Inspector General

FROM: Administrator
Health Care Financing Administration

SUBJECT: Office of Inspector General (OIG) Draft Report: "Administrative Costs Submitted by Risk-Based Health Maintenance Organizations on the Adjusted Community Rate Proposals are Highly Inflated," (A-14-97-00202)

We reviewed the above-referenced report that examines the administrative costs submitted by risk-based health maintenance organizations (HMO) on their adjusted community rate (ACR) proposals.

The audit found that the ACR process enables plans to exploit the use of medical utilization factors when computing their anticipated administrative costs to deliver services to Medicare beneficiaries. OIG estimates that about \$1 billion per year could be saved if the allocation of the category within the ACR termed "administration" was determined in accordance with the Medicare program's longstanding principle that Medicare only pays its applicable or fair share of needed health care costs.

We believe our efforts in revising the ACR process will produce a more realistic allocation of administrative costs that better reflects differences between Medicare and commercial enrollees. We also believe that the OIG savings estimates cited in the report are overstated due to technical problems with the formulae. Our detailed comments follow:

OIG Recommendation # 1

The Health Care Financing Administration (HCFA) should revise its criteria to require HMOs to allocate their administrative costs estimates on their ACR proposals following the same concepts used throughout the Medicare program to help ensure non-Medicare costs are not borne by Medicare. Any differences between the administrative base rate and the amounts allocated to the Medicare premium should be supported similarly as the medical component is in the ACR process. Any disparities between the base rate and the ACR rate that are not nominal should require further review by HCFA.

HCFA Response

We agree that the criteria governing the computation of administrative costs in ACR proposals **almost** certainly resulted in overstated administrative costs, at least by some plans, and that many plans are in effect funding some of their extra benefits out of the excessive administration component. As noted in the OIG report, HCFA is already in the process of modifying the ACR criteria to require documentation of the factors used to compute administrative costs and we appreciate **OIG's** support for the actions we are in the process of implementing.

HCFA's new format for the ACR proposals will require **Medicare+Choice** plans to split their administrative **component** between administration and additional revenues (including such things as profits, contributions to surplus, risk margins and any other premium component not reflected in medical and administrative expenses). In determining administrative costs, we will be using a relative cost ratio based on actual administrative costs incurred for Medicare beneficiaries in a base year (prior year) to actual administrative costs incurred to commercial enrollees in the same base year. This methodology will more accurately reflect administrative costs for Medicare beneficiaries and should result in a lesser amount of costs being allocated to Medicare enrollees. We will be using the same concept to allocate additional revenues to Medicare enrollees. Additional revenues will be established in the base year using financial accounting principles (revenue less expenses) rather than the percentage of premiums generally used by **HMOs** in the past.

The Balanced Budget Act of 1997 (BBA) made significant changes in the method for computing **capitation** payments for Medicare+Choice plans. Some of these changes, e.g., the 50-50 blend of local and national rates and the 2 percent rate of increase currently being applied in many counties, will reduce the rate of growth for Medicare **capitation** payments in geographic areas with higher payment levels. Another BBA change requires, beginning in 2000, adjusting payments for the health status of beneficiaries. Studies have shown that, to date, those Medicare beneficiaries who enroll in **HMOs** are, on average, **healthier than** the average Medicare beneficiary, resulting in overpayments to **HMOs**. **Adjusting** payments for health status may, therefore, result in payment reductions for some plans. In addition, the BBA mandates annual audits of a least one-third of **Medicare+Choice** plans, including audits of the computation of **ACRs**.

OIG Recommendation #2

HCFA should introduce legislation that would allow the Medicare program to recover the excessive amount presently being paid for administration. Based on the Balanced Budget

Act of 1997, the option of reducing Medicare payments to HMOs when the Average Payment Rate (APR) amount exceeds the ACR amounts has been eliminated. We believe that the excessive administration amounts should be returned to the Medicare program.

HCFA Response

We do not concur. In view of the BBA provisions that will affect **capitation** levels by reducing the rate of growth in payment levels in higher payment areas and risk adjusting all such payments, as well as the BBA mandate to audit ACR submissions, we do not support this recommendation. It may be appropriate to reassess such a proposal in the future once we have an opportunity to fully assess the impact of the BBA-mandated payment changes and ACR audits.

Under the BBA, the option for Medicare+Choice plans to return money to the Medicare program was eliminated. This seems to suggest Congress intended that all savings should be passed on to the beneficiaries.

Although the OIG report recommended that HCFA modify the criteria to allocate the administrative component of the ACR, it appears the OIG report also assumed that HCFA could capture the savings suggested in the report without reducing the additional benefits plans offer to Medicare beneficiaries. However, we have received reports that some HMOs have reduced benefits levels and increased premiums in 1998, and some of the HMOs indicate these changes are in response to Medicare's lower-than-expected **capitation** rates for 1998. Payments to managed care organizations for 1998 increased only 2 percent for approximately 60 percent of these organizations, and indications are that the increase in payments for 1999 will also be minimal (approximately 2 percent). Thus, it is possible that beneficiaries will again experience reduced benefits levels and increased premiums in 1999.

Technical Comments

Although we agree with recommendation one (#1), we recommend that the following technical comments be incorporated into the final report. Some of these comments could reduce the estimated impact of the recommendation.

- 0 The description of the ACR process should be modified. The ACR process is designed for an HMO to justify its pricing structure for a benefit package offered to Medicare beneficiaries using formulae outlined in section 1876 of the Social Security Act. The formulae require the HMO to adjust its commercial charges for the differences in utilization characteristics between the commercial population and the Medicare population. The ACR is not an exercise in the estimation of funds needed to cover the costs of providing

services to its enrolled Medicare population. The ACR requirement in section 1876 is designed to ensure the Medicare beneficiary was not overcharged for the benefit package being offered, and to return to the HMO enough funds to cover its costs plus an additional amount normally expected in the commercial market.

- 0 In estimating the highest amount of excessive administrative costs included in the ACR, OIG used an allocation method with which we cannot agree. OIG pointed to the regulations (42 CFR 417.564) for cost-based HMOs and used one of the two methods of allocation outlined. The method used relates to those administrative costs that do not bear a significant **relationship** to the costs of furnishing medical care, e.g., marketing, enrollment, and membership costs. Outside of the managed care program, HCFA does not pay for these types of cost items. We do not agree that the administrative component of the ACR contains only these types of cost items. Those items of administration that bear a significant relationship to services rendered should be allocated as a function of medical utilization. In addition, some states require the HMO to setup risk reserves as a ratio of revenue. If risk reserves are required by the states for Medicare enrollees, a greater amount of revenue reserves (additional revenue) should be allocated to the Medicare enrollee on a per-person basis.
- 0 The review on the distortion of administrative costs allocated to Medicare should include two additional concepts: losses and premium waivers. Losses shown on the ACR are actually a loss of revenues that could have been charged to the Medicare beneficiary/program had there been no limitation on total charges. Losses should not be considered in determining the amount of administrative costs charged, since **these amounts** may not be charged to the beneficiary and HCFA's payment is limited. In a like manner, a premium waiver is a reduction in the amounts charged to the beneficiary and cannot be added to HCFA's **payment**. Both of these elements represent a loss of revenues to the HMO. **Most of the HMOs** experiencing either or both of these elements have pointed to the generous amount of administrative component claimed in the ACR as a means of funding the loss in revenue. Therefore, we believe both of these elements are an artificial means used by the HMOs to reduce the administrative component claimed, and some allowance should be made in determining the amount of administration claimed.

- 0 It is not know-n whether OIG considered any additional revenues that may be included in the National Data Reporting Requirements (NDRR) reporting to HCFA. Since the administrative component included in the ACR contains additional revenues, we believe a comparison to the NDRR information should include administrative costs and additional revenue.


Nancy Ann-Min DeParle