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PREPARED BY THE STAFF

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RUSSELL B. LONG, *Chairman*

PART 6

MEDICARE

(HEALTH MAINTENANCE ORGANIZATION)

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Health Maintenance Organization Option

HEALTH MAINTENANCE ORGANIZATION OPTION

The health maintenance organization option, included in the House bill, is intended to enable Medicare to take advantage of incentives toward economy, efficiency and effective delivery of health services possible through contracting with organizations which offer comprehensive health care services on a per capita prepayment basis. To assure that these objectives will be pursued and to avoid abuse, the staff believes there is need for several changes in the HMO provision. The most important of these changes are aimed at providing assurance that standards of quality and performance for HMO's are required and that compliance with them be subject to careful supervision and monitoring and to provide that payment to HMO's be calculated on a basis which avoids the possibility of excessive payment resulting from artificially inflated costs or unnecessarily large administrative expenses. Proposed changes are outlined below.

1. Assurance of Quality and Safeguards Against Abuse

Provisions in H.R. 17550

The House bill specifies that participating HMO's be required to meet the quality standards imposed on all Medicare providers of services plus certain other quality standards. They must offer assurance of ability to provide comprehensive health services efficiently and economically; they must have arrangements to assure that needed health services are rendered promptly and appropriately, and that the HMO must conduct open enrollment.

Proposed Staff Modifications

The staff believes that, while these are useful and desirable safeguards, there is further need to take account of the Committee's concern that all possible safeguards be incorporated in Medicare and that undesirable practices not be permitted. For example, it should be specified:

(1) that organizations below a minimum enrollment size cannot be expected to function capably as HMO's and should not be approved;

(2) that there is need to guard against excessive use by HMO's of part-time physicians and use of inadequately supervised third or fourth-year medical students and, concurrently, that there is need for specified minimum requirements of full-time qualified staff;

(3) that beneficiaries must be fully informed of the limitations on coverage of services received outside the HMO's service area and that HMO's should be required to cover in full not only emergency services but also prescribed maintenance therapy needed by Medicare beneficiaries while outside the plan's service area;

(4) that very careful surveillance of HMO practices will be needed to assure that beneficiaries are not deprived of benefits due them through devices such as scheduling appointments at inconvenient times and delaying unduly the scheduling of elective surgery;

(5) that there is need for careful monitoring of HMO enrollment and other practices to assure that there is no discrimination against poor health risks either through initial selection or through poor service aimed at forcing them to disenroll; and

(6) that there will be continuing need for audit of the quality and general performance of HMO's by the Secretary and, where feasible and appropriate, by an outside group such as a Professional Standards Review Organization.

It should be made clear that the Secretary has the necessary authority to act effectively, in all the areas mentioned above, to assure the quality of services rendered and prevent abuse of the program.

2. Basis of Payment

Provision in H.R. 17550

Payments to a health maintenance organization would be based on the lesser of an amount related to the HMO's premiums or an amount not to exceed 95 percent of estimated part A and part B costs for beneficiaries not enrolled with an HMO.

Problem

1. While in some cases the difference between a premium-related payment and payment based on 95 percent would turn out to be minimal, making payment instead at the 95 percent rate could provide to HMO's the assurance they need that efficient performance will result in availability of funds for improvement of benefit protection or lower premium costs for Medicare enrollees. Because beneficiaries enrolled with HMO's forgo coverage of certain services outside the plan's service area, some additional incentives for enrollment—such as expanded benefits or reduction of amounts they pay toward satisfaction of Medicare's deductibles and coinsurance—would be helpful.

2. There is need to assure that the payment mechanism, which is intended to reward efficiency, will not reward profiteering through recognition of artificially inflated costs or to reward inefficiency reflected in high administrative costs.

Proposed Modification

1. Provide payment on a premium-related basis subject to the maximum limit of 95 percent of the estimated benefit amount that would be reimbursed under part A and part B coverage of Medicare beneficiaries who are not enrolled in HMO's. However, when the 95 percent exceeds the premium-related basis, a single rate of payment at the 95 percent rate can be made if the HMO is to use the excess for additional services without charge to the Medicare beneficiaries or for the reduction of the cost-sharing provisions.

2. In addition to the payment based on relative benefit costs, payment would include a reasonable and carefully controlled allowance for HMO administrative costs (recognizing that an HMO has less administrative needs than an intermediary or carrier.) Such allowance for administrative costs, plus the payment (described in item 1,

above) based on 95 percent of benefit costs, shall not in combination exceed an amount equal to 95 percent of the total estimated per capita amount that would be payable if the services were to be furnished by other than an HMO.

3. The Secretary will have the right to and is expected to examine and take exception to (a) any arrangement the HMO may have with providers, including related organizations, which appear to result in an unwarranted increase in the factors bearing on the base premium or (b) the value of any added coverage or reduction on deductible.

4. In computing the adjusted premium, no more than a reasonable retention shall be allowed. The retention would not exceed the lesser of (1) the retention as a percentage of premiums paid by persons under age 65 who are enrolled in the HMO or by those who purchase care from the HMO on behalf of non-aged persons, or (2) 150 percent of the dollar retention paid by such purchasers. The other test of the reasonableness of the retention would be the level of retention applicable to HMO's throughout the country.

5. There shall be adequate arrangements for auditing, recapture, and final settlement in the event that the HMO terminates its services or changes its corporate structure during the year.

3. Composition of HMO Membership

Provision in H.R. 17550

In order to qualify as an HMO at least one-half of a plan's enrollees must be under age 65.

Problem

While such a membership composition is desirable and one that HMO's should strive to achieve, its imposition as an absolute requirement might lead to disqualification of a number of organizations whose participation as HMO's might be desirable; for example, newly-established organizations and HMO's deliberately established as part of an effort to bring adequate health care to inner-city or rural areas.

Proposed Modification

To provide flexibility in the requirement for HMO composition, this provision should be modified to: (1) permit a newly-established HMO up to 5 years within which to attain the 50-percent-enrollment requirement; provided that during such period it makes continuing efforts and progress satisfactory to the Secretary, to enroll persons under age 65 so as to achieve the requisite 50 percent, and (2) permit the Secretary in exceptional situations to waive the requirement entirely upon a finding that, because of geographic location or other circumstances beyond the HMO's control, compliance is not possible except through reduction of enrollment. (Compliance might not be possible in areas having a high concentration of older persons, such as Sun City, Arizona or St. Petersburg, Florida.)

4. Retroactive Adjustment of Payments

Provision in H.R. 17550

There is no provision for retroactive adjustment in payments made to HMO's based on actuarial projections of per capita health care costs.

Problem

The absence of a provision for adjustment in payments could have an adverse effect on the willingness of potential HMO's to elect this method of reimbursement. To penalize an HMO because of adverse experience in the event of an influenza or similar epidemic which significantly increased the rate of hospital utilization—and corresponding costs—in a particular area would be undesirable, just as it would be to reward an HMO by paying a profit not related to its efficiency but resulting from an overestimate of costs.

Proposed Modification

A provision should be added to permit determination of any retroactive adjustment of payments which might be required where there is significant differential (i.e., on a national or other large-scale basis) between projections and actual experience.

5. Enrollees Who Do Not Elect the Option

Provision in H.R. 17550

An HMO may receive payment only on a per capita basis and only for enrollees who are entitled under both part A and part B of Medicare and have elected the HMO option.

Problem

These limitations may discourage some group practice plans—especially those which have substantial numbers of enrollees who are Medicare beneficiaries but are not entitled to part A benefits or have not enrolled under part B—from participating as HMO's. There is a particular problem for organizations that have a large number of Government retirees as members, Most of these beneficiaries do not have part A coverage but, instead, have hospitalization coverage under insurance programs initiated by their governmental employer. If the organization now becomes an HMO, the only alternative for such groups would be to purchase part A "voluntary" coverage ($27 per month).

Proposed Modification

(1) It would be desirable to provide for some accommodation for those beneficiaries who would be eligible for part A coverage only by payment of the full costs of such coverage. For these beneficiaries, (who can be easily identified and treated as a group for reimbursement purposes), the bill should be modified to allow HMO's to receive per capita reimbursement for part B services only.

(2) A special transitional provision should be added to permit HMO's to continue to receive payment on behalf of individuals who were already enrolled and eligible under Medicare at the time the option became available but did not elect the option. The provision would be in effect for 3 years from the date the option became available. In these cases, the bill should stipulate that per capita payments for beneficiaries who do not elect the option be actuarially adjusted to take into account the projected out-of-plan utilization of covered services by such beneficiaries.

6. Application of Limitation on Reimbursement for Capital Expenditures to HMO's

Provision in H.R. 17550

The provisions of H.R. 17550 relating to reductions in cost reimbursement for certain disapproved capital expenditures do not provide for similar reductions where reimbursement is on other than a reasonable cost basis. Thus, it is not clear whether reductions would be made in per capita payments to HMO's which utilize providers whose capital expenditures have been disapproved.

Problem

A basic assumption of the HMO provision is that it would provide services only from fully qualified providers and be subject to all provisions applicable to other participating providers. Further, the effectiveness of the planning provision in preventing duplication of facilities would be diminished if not applied to all institutions in the area.

Proposed Modification

Modify the bill to subject HMO's to reduction in per capita payments if a provider of services which it utilizes would otherwise be subject to a reduction in reimbursement under the planning provision requirement.

7. HMO As "Provider of Services"

Provision in H.R. 17550

HMO's would become "providers of services" for purposes of participation in the Medicare program.

Problem

The "provider-of-service" status connotes a continuing relationship contingent primarily on formal compliance with the technical conditions of participation. In view of the many factors affecting the desirability of an organization's participation as an HMO—responsiveness to community needs, effective and efficient use of available resources, management of patient care—there is a need for the Secretary to retain greater authority to take all performance factors into consideration when determining eligibility to participate initially or to continue as an HMO.

Proposed Modification

Establish a contractual relationship between the Secretary and the HMO similar to the relationship which now exists under Medicare with fiscal intermediaries. Such a contract, annually renewable, would permit regular re-evaluation and afford opportunity to exert greater pressure on HMO's to maintain expected performance levels.

8. Staff Comment

The health maintenance organizations features of the bill are intended to contribute to reductions in the cost of health care delivery and improved quality of care under the Medicare program. The staff has been concerned that to the contrary the health maintenance organization provision could turn out to be an additional area of potential abuse which could have the effect of increasing health care costs and decreasing the quality of service available or rendered.

With the safeguards the staff has suggested, and with which the Department concurs, it may be that the health maintenance organization can achieve some of the goals intended by the Administration. In any event it would appear that this new program is an area where the Office of the Inspector General (approved by the Finance Committee in an earlier amendment) could make a major contribution toward assuring that health maintenance organizations are operated consistent with principles of efficiency and economy and particularly that they comply with the statute and the legislative intent of the Congress

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