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RESPONSES TO THE KAISER HEALTH PLAN OBJECTIONS TO THE FINANCE COMMITTEE HMO PROVISIONS

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I. Background

The Kaiser Foundation Health Plan has reviewed and reacted to the description of the Finance Committee HMO amendment to H.R. 1. Kaiser appears satisfied with the sections of the HMO provision relating to the definition of HMO's, quality of care, the services which must be provided by HMO's and the eligibility conditions for HMO's to qualify for special incentive reimbursement under Medicare. The Kaiser objections to the HMO provisions apparently all relate to the method of reimbursement and the extent of the bonus outlined in the Senate proposal. They state that they prefer the reimbursement mechanism in the House-passed version of H.R. 1.

Kaiser claims that the House version of H.R. 1 pays HMO's on a "rate" basis, whereas the Senate version reimburses HMO's on a basis related to costs. In actuality, both versions of the bill propose to reimburse HMO's on a "cost-related rate" basis so that the much stressed differences between "rate" and "cost" reimbursement are largely semantic.

The second paragraph of the Kaiser Foundation discussion paper summarizes the House reimbursement mechanism and this summary itself makes clear that the House reimbursement provision is cost-related. The HMO must establish its expenses or costs in order to determine its allowable retention rate, since "retention" is defined as the difference between the HMO's revenues on behalf of any group of enrollees for a given period of time and its expenses for such enrollees for the same period. Additionally, the HMO must obviously determine its expenses or costs in order to establish the amount, if any, of the funds above allowable retention and benefit and administrative costs which must be used by it to provide additional benefits, reduce premiums for Medicare patients or be refunded to the Social Security Administration.

Under the Committee amendment, Medicare paperwork would be substantially diminished, compared with present requirements for prepaid group practice plans. Where the HMO is not on a fee-for-service or cost-per-service basis it would not have to maintain or demonstrate its Medicare costs on a case-by-case basis. Rather, the HMO would indicate its total expenditures for allowable types of expense and then apply an actuarily-determined proportion as allocable to all of its Medicare enrollees.

Although both bills basically require cost-related rate reimbursement, there are at least two substantial differences in the reimbursement mechanism between the House bill and Finance Committee version and both relate to the way in which the difference between outside adjusted average per capita costs and the HMO's costs or expenses (the incentive bonus payment) are divided.

The two issues are the following:

A. Should incentive bonus payments which accrue, in part as a result of the HMO's efficiency and in part as the result of the inefficiency of others, be statutorily divided among enrollees, the HMO and the Government, or should they be divided only between the HMO and the Government, with the HMO being given latitude as to how best to utilize its incentive bonus payments?

B. How much of the difference should go to each party?

II. Reasons for Committee Action

With respect to the first issue, the Finance Committee believed that the Medicare incentive bonus payments should be allocated only between the HMO and the Government and that the HMO should be free to use its share as it saw fit. For example, it could add benefits, establish reserves, or even pay physicians a bonus. In 1970, it was the Finance Committee which originally mandated that some share of the Medicare incentive bonus payments be passed through to the beneficiaries of that organization. The Committee modified its position for two primary reasons: First, it was convinced by many HMO advocates, both within and without the Administration, that the HMO itself would be in the best position to decide how it could stimulate its own growth and expansion. One organization might feel that it should use the incentive bonus funds to offer additional benefits, another might feel that it could best use the funds to attract personnel, or expand its facilities. In this regard, the Committee was also concerned with the real possibility that beneficiaries might get additional benefits in a "good" year only to have them taken away in the next "bad" year.

Second, the Committee, by its act in including the HMO provision, believed that it was not improper for Medicare to favor one type of health delivery over another if there were reasonable expectations that this favoritism would benefit the program. However, the Committee did not believe that Medicare should, in a statutory fashion, favor one group of beneficiaries over another. Mandating increased benefits in an HMO would do just this, since it would result in some of those beneficiaries who have had an opportunity to enroll in an HMO receiving advantages (in the form of extra benefits) over persons who did not choose or have an opportunity to enroll in an HMO. This inequity would occur even though the per capita costs of at least some of these latter beneficiaries may be identical with those in an HMO because they were obtaining their care from efficient fee-for-service physicians.

With respect to the second issue, as to how much of the Medicare incentive bonus should go to each party, the Committee decided that, in view of the large amounts of trust funds involved, there should be, basically, a fifty-fifty division on all or part of the first 10 percent of

the difference between HMO costs and comparable per capita costs outside of the HMO. After dividing equally the first 10 percent of payments in excess of cost, the formula allows the HMO to retain one-fourth of the next 10 percent, to the extent there was any such difference, thus allowing overall maximum incentive payment of 7-1/2 percent to the HMO above its costs. Of course, the 7-1/2 percent is stated as a proportion of per capita costs outside of the HMO; it is a greater percentage in terms of the HMO costs. Thus, an HMO which operated at 80 percent of outside per capita costs receiving a 7-1/2 percent incentive payment would be getting almost 10 percent of its costs as a bonus. The latter method of calculating gain in relation to an HMO's own costs is the usual procedure in determining the extent of a "profit".

III. The Kaiser Foundation Health Plan lists seven objections to the Finance Committee reimbursement mechanism. The Staff has informally analyzed these objections and the objections and staff responses are listed below:

1. Objection

"Medicare payments to the HMO cannot be budgeted to meet future needs because they are subject to partial recapture. An HMO must be able to anticipate its financial requirements years in advance and plan its finances accordingly. This is impossible under the Medicare cost reimbursement formula."

Response

The basic Medicare payments to the HMO can be budgeted since all large HMO's can, as does any large business, estimate in advance what their costs will be, and indeed must make such estimates under either the House or Senate version of the bill. And, at such time, it would have the estimate of the Secretary (developed in discussion with the Secretary) as to the adjusted average per capita cost for people outside the HMO for the same projected period. This should result in a relatively high degree of certainty in projecting as to what the HMO's bonus over costs will be. This bonus, or profit, is never exactly predictable by any organization and its predictability would be essentially the same in the House and Senate version of the bill. After all, under the House version, the HMO would not be able to exactly estimate the amount which must be used to provide additional benefits or be refunded to Social Security (because this amount is related to actual cost experience in both Medicare and non-Medicare business and to the net revenues obtained in the non-Medicare business), or by which its actual costs might exceed the 95 percent of outside cost reimbursement level. Costs can be budgeted but they are not 100 percent under control as long as there are variations in prices of goods purchased and variations in illness and utilization from one year to the next.

Note:

Kaiser officials apparently have a mistaken interpretation of the House amendment as authorizing an HMO to include as costs, items of expense which are not presently allowable under Medicare; i.e., maternity costs, non-Medicare bad debts, depreciation based upon excessive or inappropriate valuation, excessive salaries, etc. This error in interpretation may be a factor in their opposition to the unambiguous Finance Committee amendment. Payment for those types of presently unallowable expense could not just be made to HMO's--all institutions would have to be paid on the same basis. If that were done, an estimated $1 billion a year would be added to Medicare and Medicaid costs initially, with the amount increasing in subsequent years.

2. Objection

(a). "A cost reimbursement formula encourages inefficiency and waste. The more money an institution spends, the more it is paid. If an HMO operates at a savings through efficiency of 10 percent it must give 50 percent of the savings to the Government; however, the HMO can keep the entire amount if it is less efficient. Further, if costs go above the community average of up to 10 percent, the Government will pay one-half the excess."

"If the HMO efficiency is between 90 percent and 80 percent of the community cost, the Government captures 75 percent of the savings and all savings below 80 percent. The maximum savings that can accrue to the HMO is 7-1/2 percent. This effectively removes most of the incentive for HMO efficiency."

(b). "If there is an efficiency reward to the HMO, it would not be available to the HMO for some time (probably 2-1/2 years) after the contract is initiated. Payments to cover costs of inefficienly operated HMO's are made immediately, which may be the total amount due."

Response

(a). As pointed out by Kaiser, the maximum bonus, efficiency savings or profit which can accrue to the HMO is 7-1/2 percent. This 7-1/2 percent is all above the amount that an HMO can receive under prese[nt] law and in fact represents a substantial incentive for efficiency. It should be emphasized that a return of 7-1/2 percent--or even 4 percent--in free funds above administrative and benefit costs, would be substantially greater than the comprehensive prepaid group practice plans report that they have been able to secure from their regular enrollment during the past several years.[1/] In fact, a number of plans have been operating with

1/ In 1970, for example, the Kaiser Health Plans, on an aggregate basis, had exactly nothing left after subtracting hospital, medical and administrative costs from membership fees.

an underwriting loss on their overall business. There are internal controls which would prohibit an HMO from deliberately manipulating its costs or increasing its utilization in order to be reimbursed at a higher rate.

If an HMO's costs were above 90 percent of non-HMO costs, it would be better off under the Senate version than the House version of the bill. Under the House version, the HMO would actually experience a loss to the full extent that its costs exceeded 95 percent of non-HMO costs for a comparable population mix. Under the Senate bill, the HMO is liable for only 50 percent of costs between 100 percent and 110 percent, and only 25 percent of such costs between 110 percent and 120 percent.

(b). Kaiser points out, further, that under certain conditions the bonus, or profit might not be available to the HMO for some time. The Committee is aware of this possibility and expects to provide that at least one-half of the estimated amount of such funds are made available within 3 months of the close of a year with interest payable to the HMO on the balance. Final settlement would also be expedited under the Committee amendment because the retrospective calculation of non-HMO Medicare per capita costs would be determined on an actuarial basis rather than requiring a calculation based upon all actual costs incurred.

3. Objection

"We find it difficult to understand why an organization would want to become an HMO when cost reimbursement could produce more money, without delay and without risk. We believe the cost reimbursement formula removes most of the incentive for an organization to be an HMO."

Response

Again, under either the House or Senate version of the bill, any group practice could elect to be reimbursed under the regular Medicare reasonable costs or charges formula. If they so chose, they would not receive any bonus revenues to use as they see fit and would be subject to reasonable charge and cost limitations (see H.R. 1). The choice in both the House and Senate versions is whether the HMO wants to seek cost reimbursement under normal Medicare rules or to seek an incentive bonus payment above actual costs. If such bonus payments are not important to HMO's, and larger actual costs reimbursement without gain is preferable, neither version will motivate additional HMO's to form and participate. HMO's, in addition, presumably have a motivation to participate, aside from the profit point. If they do not participate, they would not be able to deal with Medicare in the same fashion as they deal with their other enrollees.

4. Objection

"It is very difficult for an HMC to develop incentives for a Medicare beneficiary to join an HMO because the Government would capture most of the savings from efficiency."

Response

The HMO could have available an amount of up to almost 10 percent of its total costs which it could use in whole or part to develop incentives for a Medicare beneficiary to join an HMO. If greater incentives than this are necessary to encourage Medicare beneficiaries to join an HMO, the entire proposition might well end up being more expensive than if the HMO's beneficiaries were to remain outside of the HMO. For many years, HMO leaders have contended that quality and comprehensiveness of care were their prime attractions in competing for subscribers; now they argue that they need a large tangible competitive advantage, which only money can provide, in order to attract subscribers.

5. Objection

"The HMO takes a risk of losing money, yet there is no opportunity to build a reserve to cover losses."

Response

Again, the HMO could use part or all of any bonus incentive payments to build reserves if it so chose. Under the House bill, in which it is also at risk--in fact, at greater risk than under the Senate bill--it has no opportunity to build reserves. Furthermore, the Senate version and not the House, includes a loss carryover provision which would allow recovery of losses in subsequent years.

6. Objection

"Pure profit incentive is injected into the payment. With the efficiency being converted to pure profit to the Government and the HMO, and no requirement for the HMO to use part of its savings for beneficiaries, there is incentive for the HMO to work just for profit."

Response

The reimbursement mechanism clearly contains a bonus, or profit factor. This is the heart of the entire reimbursement mechanism. This factor is the same amount which has been described by many prepaid group practices as the "incentive amount" which can be divided up among the physicians at the close of the year in order to motivate them to keep costs down. It is difficult to differentiate these incentive payments from profit.

7. Objection

"With a payment based on cost, no benchmarks will be established by which to judge the efficiency of different systems of organizing, delivering and paying for medical services. Congress will continue to have no measure of the value of Medicare services in relation to their cost. A yardstick is desperately needed."

Response

The Senate reimbursement mechanism provides exact benchmarks by which to judge the efficiency of different systems of delivering medical services. The efficiency of HMO's can be measured quite specifically against the outside sector and other HMO's. It is not readily apparent what alternative benchmark the Kaiser people have in mind.