

**Memorandum**

SEP 18 2000

Date

From

Michael Mangano
June Gibbs Brown
Inspector General

Subject

Adequacy of Medicare's Managed Care Payments After the Balanced Budget Act of 1997
(A-14-00-00212)

To

Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

Attached are two copies of our final report entitled "Adequacy of Medicare's Managed Care Payments After the Balanced Budget Act of 1997." The objective of this report was to analyze the impact on managed care organizations (MCO) of payment changes brought about by the Balanced Budget Act (BBA) of 1997 and the Balanced Budget Refinement Act (BBRA) of 1999 and the assertions by the industry that MCO payments are inadequate.

The BBA established the Medicare+Choice (M+C) program with the primary goal of providing a wider range of health plan choices to Medicare beneficiaries and modified the payment methodology under the M+C program in order to correct excess payments, reduce geographic variations in payment, and align MCO payments to reflect beneficiaries' health status.

Numerous comments have been made by MCO industry representatives indicating that the payment changes brought about by BBA were too severe. Among the reasons cited by the MCO industry are the unintended consequences of higher than anticipated inflation, the growing gap in funding between the M+C program and the fee-for-service (FFS) program (referred to by the industry as the fairness gap), and administrative actions taken by the Health Care Financing Administration (HCFA) affecting payments.

While some of the BBA provisions reduced payments to MCOs, the overall impact is that MCO payments for Calendar Year (CY) 2000 will be about 95.5 percent of the average amount paid in the Medicare FFS sector. This is primarily due to the overstatement of the actuarial assumptions used to establish the 1997 base rate, which inflated MCO payments starting in 1998. Since MCO payments were established at 95 percent of FFS to account for assumed efficiencies in the MCO sector, the net effect is that MCOs will be paid more than the Congress originally intended. This is in stark contrast to the industry's assertion that it was being adversely impacted by the BBA provisions.

While the effective payment rate for CY 2000 will be 95.5 percent of FFS, the rate should be 90.5 percent or lower after fully adjusting for risk selection. This may be a conservative estimate since the risk adjustment model is based on encounter data only for inpatient

services. The implementation of a comprehensive risk adjustment system based on encounter data from additional sites of service would further reduce payments.

In addition to the net positive impact of the overstated actuarial assumptions on MCO payments, the implementation of BBA and BBRA has also benefitted the MCO industry. For example:

- Because BBRA required delay of the full implementation of the health status risk adjustment factor, MCOs will receive about \$1.8 billion more in CY 2000 Medicare payments than they would have received had the full risk adjustment been implemented.
- The BBA-required minimum 2 percent annual increase in MCO payments proved beneficial to MCOs overall. If MCOs had been paid under the pre-BBA payment methodology, that is, based on annual costs in the FFS sector, Medicare payments in 1998 and 1999 would have been lower than what was actually paid to MCOs. We believe that the effect is over \$1.5 billion for CY 2000 MCO payments.

In addition, several Office of Inspector General (OIG) reviews have shown that other factors should be considered when evaluating MCO payment rates. These factors include:

- Improper payments included in the 1996 Medicare FFS payments used to develop the 1997 base-period MCO payments;
- Unaccounted-for investment income earned by MCOs on Medicare funds, resulting in about a 0.5 percent increase in MCOs' payments; and
- Excessive administrative costs, equivalent to about 1.3 percent of CY 2000 Medicare MCO payments, included by MCOs as part of their annual submissions to HCFA of revenue needs (known as adjusted community rate proposals).

Other OIG reviews have also shown that MCOs have (1) been able to avoid substantial expenditures because of the disenrollment of beneficiaries or the beneficiaries' use of nonnetwork providers and (2) received substantial overpayments involving special categories of beneficiaries (those with end stage renal disease, those dually eligible for Medicare/Medicaid, those residing in nursing homes, and deceased beneficiaries).

The cumulative impact of all these issues is that MCOs receive more than an adequate amount of funds to deliver the Medicare package of covered services, i.e., those services received by 85 percent of Medicare beneficiaries (those in the FFS program).

We recommend that HCFA consider all the financial-related work we have completed recently and use these studies to modify the present monthly rates to a level fully supported by empirical data.

The HCFA agreed with the report's overall finding that M+C payments are adequate to fund the Medicare package of covered services. The HCFA also agreed that under full adjustment for risk selection using its current model, M+C payments would be lower. The agency noted that when considering M+C payment rates and risk adjustment, it is important to remember that M+C plans have enrolled a disproportionately higher share of beneficiaries with better-than-average health status.

According to HCFA, it will move toward full implementation of a risk adjustment methodology that will incorporate diagnosis data from physician services and hospital outpatient services. The HCFA noted that the best way to address the managed care industry's concerns regarding adequate payment and to ensure a strong M+C program is to make sure that all beneficiaries have access to affordable drug coverage and to pay plans directly for providing this coverage. The full text of HCFA's comments is included as Appendix B.

We would appreciate your views and the status of any further action taken or contemplated on our recommendation 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-14-00-00212 in all correspondence relating to this report.

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**ADEQUACY OF
MEDICARE'S MANAGED CARE
PAYMENTS AFTER THE
BALANCED BUDGET ACT OF 1997**



JUNE GIBBS BROWN
Inspector General

SEPTEMBER 2000
A-14-00-00212

EXECUTIVE SUMMARY

The Balanced Budget Act (BBA) of 1997 established the Medicare+Choice (M+C) program with the primary goal of providing a wider range of health plan choices to Medicare beneficiaries. The managed care options available to beneficiaries under the program include coordinated care plans, such as health maintenance organizations, medical savings account plans, and private fee-for-service (FFS) plans. The BBA also modified the payment methodology under the M+C program in order to correct excess payments, reduce geographic variations in payment, and align managed care organization (MCO) payments to reflect beneficiaries' health status.

According to the MCO industry, the payment changes brought about by BBA were too severe and would reduce beneficiaries' access to plans and additional benefits, as evidenced by the number of plans that have abandoned or plan to abandon their Medicare markets from Calendar Year (CY) 1999 through CY 2001. Among the reasons cited by the MCO industry are the unintended consequences of higher than anticipated inflation, the growing gap in funding between the M+C program and the FFS program (referred to by the industry as the fairness gap), and administrative actions taken by the Health Care Financing Administration (HCFA) affecting payments. Some plans and the industry have projected that by CY 2004, payments for seniors' medical care in an MCO will be far lower than for seniors in the FFS program.

This report is an attempt to analyze the impact of payment changes brought about by BBA of 1997 and the Balanced Budget Refinement Act (BBRA) of 1999 and the assertions by the industry that MCO payments are inadequate. To address these issues, we analyzed data submitted by MCOs to HCFA and utilized findings from our previous reports and studies by HCFA, the General Accounting Office (GAO), and others.

MCO PAYMENT CHANGES DUE TO BBA

In order to correct excess payments, reduce geographic variations in payment, and align MCO payments to reflect beneficiaries' health status, BBA of 1997 made the following changes:

- The MCO payments were no longer tied directly to local FFS costs. Instead, payments are based on the highest of a minimum floor amount, a blend of the local and national rate, or a minimum 2 percent update.
- The implementation of a health-based risk adjustment system was mandated to match payments to beneficiaries' expected health care costs and reduce the excess payments caused by favorable selection.
- To achieve savings, growth in managed care rates was limited to growth in FFS spending less a predetermined amount. In addition, payments were reduced to

carve out graduate medical education (GME) costs that were included in the base-year amounts.

As a result of the BBA changes and HCFA's implementation of the BBA provisions, the MCO industry believes that the gap between Medicare payments under the FFS program and MCO payments has increased beyond the original 95 percent differential used to set the rates before BBA. The 95 percent of FFS differential was established based on the assumed efficiencies of the MCO concept over the FFS program. Some industry representatives project that the BBA changes will reduce the payment differential to 85 percent of FFS expenditures and that for some MCOs, payments will be significantly lower compared with FFS payments.

The following chart summarizes our analysis of BBA's impact on CY 2000 MCO payments. In this chart, we attempted to look at the issues perceived to have negatively affected payments, as well as other issues that appear to have benefitted MCOs. Where applicable, we have included a page reference in the report where additional details can be found.

Impact of BBA on CY 2000 MCO Payments

	+ (-) Percent
FFS Spending for an Average Medicare Beneficiary (starting point for MCO payments)	100.0%
Base Rate Reduction (basic effect of using only 95 percent of FFS)	-5.0%
BBA Reductions in Growth Rate (effect of the annual reduction in the national per capita growth percentage for 1998 through 2002) (see page 2)	-1.7%
Overpayments From HCFA Actuarial Assumptions and Calculations of 1997 Base Rates (see page 3)	+3.1%
Graduate Medical Education Carve-out (see page 3)	N/A
Risk Adjustment Factor (designed to recognize the health status of a plan's enrollees and more accurately reflect expected medical costs in MCO payment rates) (see page 4)	-0.6%
Beneficiary Information Campaign User Fee (as an offset to monthly payments) (see page 5)	-0.3%
Total Impact of Above When Compared With Average FFS Spending	-4.5%
Effective Payment Rate (percent of FFS): 0.5 percent above the base rate reduction	95.5%

While some of the BBA provisions reduced payments to MCOs, the overall impact is that MCO payments for CY 2000 will be about 95.5 percent of the average amount paid in the Medicare FFS sector. Since MCO payments were established at 95 percent of FFS to account for efficiencies in the MCO sector, the net effect is that MCOs will be paid more than the Congress originally intended. This is in stark contrast to the industry's assertion that it was being adversely impacted by the BBA provisions.

While the effective payment rate for CY 2000 will be 95.5 percent of FFS, the following section indicates that the rate should be 90.5 percent or lower after fully adjusting for risk selection. This may be a conservative estimate since the risk adjustment model is based on encounter data only for inpatient services. The implementation of a comprehensive risk adjustment system based on encounter data from additional sites of service would further reduce payments.

OTHER POSITIVE EFFECTS OF LEGISLATION

The previous discussion demonstrates that implementation of BBA has, in effect, increased Medicare payments to MCOs. Other matters that would have had a negative impact on MCO payments were avoided by the implementation of BBA and BBRA. For example:

- Although HCFA implemented an initial phase-in of the risk adjustment factor, BBRA delayed its full implementation. The risk adjustment factor was intended to account for MCOs' enrollment of beneficiaries who were healthier than those in the FFS sector. Had this provision been fully implemented, it would have reduced payments to MCOs by about 5.6 percent. However, the actual adjustment for 2000 is 0.6 percent. The impact of the delayed implementation is that MCOs will receive about \$1.8 billion more in Medicare payments during 2000 than they would have received had the full risk adjustment been implemented. (See page 6.)
- The BBA payment methodology requiring a minimum 2 percent annual increase proved beneficial to MCO payments overall. If MCOs had been paid under the pre-BBA payment methodology, that is, based on annual costs in the FFS sector, Medicare payments would have been lower than what was actually paid to MCOs starting in 1998. This is due to the decrease in the average incurred benefit costs for Medicare enrollees starting in 1998. If the 1998 and 1999 payments had been based on FFS expenditures (pre-BBA methodology), MCO payments would have been approximately \$4 billion less than the amount actually incurred by Medicare. We believe that the excess amount will be over \$1.5 billion for CY 2000. These amounts are exclusive of the amounts calculated for the overstatement due to actuarial assumptions. (See page 7.)

OTHER FACTORS AFFECTING MCO PAYMENTS

In addition, several Office of Inspector General (OIG) reviews have shown that other factors should be considered when evaluating MCO payment rates. These factors and their potential impact on monthly capitation payments follow:

- Improper payments were included in the 1996 FFS Medicare payments used to develop the 1997 base-period MCO payments. Not adjusting the payment rates to reflect these improper payments could result in a 7.97 percent positive impact on MCO payments (based on our review of Fiscal Year (FY) 1999 FFS payments).
- The MCOs earned unaccounted-for investment income on Medicare funds. The potential impact of this interest would be equivalent to a 0.5 percent increase in MCO payments.
- The MCOs included excessive administrative costs, equivalent to 1.3 percent of CY 2000 Medicare MCO payments, as part of their annual submissions to HCFA of revenue needs (known as adjusted community rate proposals).

Other OIG reviews have also shown that MCOs have been able to avoid substantial expenditures because of the disenrollment of beneficiaries or the beneficiaries' use of nonnetwork providers. Further, OIG audits have shown that substantial overpayments have been made to MCOs involving special categories of beneficiaries (those with end stage renal disease (ESRD), those dually eligible for Medicare/Medicaid, those residing in nursing homes, and deceased beneficiaries).

CONCLUSION

The cumulative impact of all these issues is a consistent set of facts: MCOs receive more than an adequate amount of funds to deliver the Medicare package of covered services; the base of payments on which MCOs are paid is incorrect, resulting in higher than necessary monthly capitation payments; and Medicare payments have been made to fund excessive administrative costs at MCOs.

We support the use of the managed care concept within the Medicare program. The efficiencies inherent in the managed care concept allow for most, if not all, MCOs in the Medicare program to offer additional benefits above the basic Medicare-mandated package of covered services. As stated, our work shows that MCOs are receiving more than enough funds from the Medicare program to cover the delivery of the Medicare basic package of services, i.e., those services received by 85 percent of Medicare beneficiaries (those in the FFS program). We therefore recommend that HCFA consider all the financial-related work we have completed recently and use these studies to modify the present monthly rates to a level fully supported by empirical data.

TABLE OF CONTENTS

	<u>PAGE</u>
INTRODUCTION	1
BACKGROUND	1
OBJECTIVE AND METHODOLOGY	1
FINDINGS	2
MCO PAYMENT CHANGES DUE TO BBA OF 1997	2
BBA Reductions in Growth Rate	2
Base-Year Rates Overstated Due to Actuarial Assumptions	3
Graduate Medical Education Reduction	3
Risk Adjustment Factor	4
User Fee	5
OTHER POSITIVE EFFECTS OF BBA OF 1997	6
Unimplemented Risk Adjustment Factor	6
Pre-BBA Payment Method	7
Department of Defense Costs	9
OTHER FACTORS AFFECTING MCO PAYMENTS	10
Improper Payments Included in 1997 Base-Year Rates	10
Unaccounted-for Investment Income Earned by MCOs	11
Excessive Administrative Costs	12
Medical Costs Avoided	13
Accuracy of Payments	13
CONCLUSION AND RECOMMENDATION	14
HCFA COMMENTS	15

APPENDIX A: RELATED REPORTS

APPENDIX B: HCFA COMMENTS

INTRODUCTION

BACKGROUND

The BBA of 1997 established the M+C program with the primary goal of providing a wider range of health plan choices to Medicare beneficiaries. The managed care options available to beneficiaries under the program include coordinated care plans, such as health maintenance organizations, medical savings account plans, and private FFS plans.

Before BBA, Medicare managed care rates were based on all local Medicare FFS spending, including payments for services as well as payments for GME and payments to hospitals that serve a disproportionate share of low-income and elderly patients. Managed care rates reflected local practice patterns, the health status of local beneficiaries, and local prices. This resulted in large variations across the country and within the same State. Managed care rates were reduced by 5 percent to reflect the assumption that managed care can be more cost effective than FFS. Growth in managed care rates was also tied to growth in FFS spending.

A major criticism of the pre-BBA payment methodology was that the large variations in FFS spending across the country resulted in large variations in MCO capitation payments. The BBA modified the payment methodology under the M+C program in order to correct excess payments, reduce geographic variations in payment, and align MCO payments to reflect beneficiaries' health status.

However, MCO industry representatives stated that the payment changes brought about by BBA were too severe and would reduce beneficiaries' access to plans and additional benefits, as evidenced by the number of plans that have abandoned or plan to abandon their Medicare markets from CY 1999 through CY 2001. Among the reasons cited by the MCO industry are the unintended consequences of higher than anticipated inflation, the growing gap in funding between the M+C program and the FFS program (referred to by the industry as the fairness gap), and HCFA administrative actions affecting payments. Some plans and the industry have projected that by CY 2004, payments for seniors' medical care in an MCO will be far lower than for seniors in the FFS program.

OBJECTIVE AND METHODOLOGY

The objective of our review was to analyze the impact of payment changes brought about by BBA of 1997 and BBRA of 1999 and the assertions by the industry that MCO payments are inadequate. To address these issues, we analyzed data submitted by MCOs to HCFA and utilized findings from our previous reports and studies by HCFA, GAO, and others.

To accomplish our objective, we:

- reviewed applicable laws, regulations, and legislative history concerning the Medicare MCO risk program;
- studied material prepared by HCFA's Office of the Actuary related to MCO capitation rate setting methodologies;
- reviewed reports and congressional testimonies prepared by OIG and GAO;
- reviewed the 1997 Annual Report to Congress prepared by the Physician Payment Review Commission; and
- analyzed materials prepared by MCO industry representatives.

This limited-scope review was performed in accordance with generally accepted government auditing standards from May to September 2000.

FINDINGS

MCO PAYMENT CHANGES DUE TO BBA OF 1997

Under BBA of 1997, the calculation of Medicare monthly capitation payments begins with the anticipated FFS payments for the base period of expenditure in 1997. Then a congressionally mandated reduction of 5 percent is taken to account for assumed efficiencies in managed care operations. The following paragraphs outline some positive and negative effects of the implementation of the remainder of the BBA requirements.

BBA Reductions in Growth Rate

In order to lower excess plan payments, BBA made mandatory reductions in the per capita growth rate that was being experienced in the Medicare managed care program. The growth rate was limited to growth in FFS spending less a predetermined amount for 5 years. The BBA mandated a 0.8 percent reduction in 1998 and 0.5 percent each year for 1999 through 2002. The BBRA of 1999 changed the reductions in growth rate as follows: 0.8 percent for 1998, 0.5 percent for 1999 through 2001, and 0.3 percent for 2002. As part of our analysis of the impact of BBA and BBRA on managed care payments for CY 2000, we noted that these growth rate reductions amounted to a negative 1.7 percent (the result of the annual multiplicative effect of the growth rate reduction).

Base-Year Rates Overstated Due to Actuarial Assumptions

While BBA made mandatory reductions in the per capita growth rate of MCO payments, the overall base rate required to be used as the starting point was overstated, thus negating the impact of the planned BBA reductions. The BBA required the use of the 1997 standardized county rates, as calculated by HCFA, as the basis for all future Medicare capitation payments to MCOs. These 1997 rates were calculated in 1996 based on **estimates** of Medicare's national average per capita costs for the next year. Each year HCFA updates the past cost estimates using more accurate data. Based on updated information in 1998, officials from HCFA testified before the Congress that the national cost estimates used in calculating the 1997 county rates were overstated by 3 percent. According to HCFA officials, however, BBA did not allow the 1998 rates to be adjusted for errors in projections upon which 1997 plan rates were based. Information provided to us by HCFA showed that the overstatement was actually 3.1 percent.¹ Since the 1997 rates were overstated by 3.1 percent, the base for all future M+C rates will be permanently overstated by 3.1 percent.

Using Congressional Budget Office data, we calculated the effect of the overstated capitation rates on Medicare payments to managed care plans. We estimate that the inflated payment rates will result in Medicare overpayments totaling \$1.2 billion for FY 2000. The cumulative effect is an overpayment of \$7.6 billion over a 5-year period (FY 2000 through FY 2004) and \$21.7 billion over 10 years (FY 2000 through FY 2009).

Graduate Medical Education Reduction

Another BBA payment reduction was the removal of GME payments from MCO rates over a 5-year period. During a phase-in period,² the GME payments from the Medicare program will be made directly to teaching hospitals for beneficiaries enrolled in MCO programs (i.e., an indirect medical education payment will be made to a teaching hospital for each MCO-enrolled beneficiary discharged from that hospital). The HCFA estimates that this provision will reduce MCO payments by about \$2.8 billion in FY 2004. However, no program savings will be realized since Medicare will make payments directly to teaching hospitals on behalf of MCOs for their enrollees.

¹In this summary report, the numbers contained in our December 1999 report (A-05-99-00025) that addressed this issue have been updated to reflect current HCFA actuarial estimates.

²The GME carve-out is based on an annual percentage adjustment of the payments made to teaching hospitals: 20 percent in 1998, 40 percent in 1999, 60 percent in 2000, 80 percent in 2001, and 100 percent in years after 2001.

In its 1997 Annual Report to the Congress, the Physician Payment Review Commission stated:

“Another issue related to the AAPCC [adjusted average per capita cost] is that FFS outlays include special payments that perhaps should not be passed along to all managed care plans. In particular, Medicare makes special payments to hospitals for graduate medical education and for serving a disproportionate share of low-income patients. Together, these contribute 5.5 percent to the AAPCC nationwide, although the share varies widely across counties, from 0 percent to more than 25 percent.

“Including these earmarked funds in AAPCC based rates raises two distinct concerns. First, from a technical perspective, they are partially responsible for the geographic variation in the AAPCC, contributing to some of the particularly high values. Second, from a broader policy perspective, it is not clear whether it is appropriate to pass these payments along to all managed care plans, since they are targeted to compensate specific hospitals for special circumstances beyond the costs of caring for Medicare patients.”

Representatives of MCOs have stated that the GME carve-out will result in premium increases and/or benefit reductions for enrolled Medicare beneficiaries. The industry states that plan members do use teaching facilities and that plan payments for a given case in a teaching hospital exceed payments for the same case in a nonteaching hospital. Plans claim that they have a limited ability to reflect the GME carve-out by making commensurate reductions in payments to teaching hospitals. The net result may therefore be that teaching hospitals are receiving GME payments from the Medicare program, as well as higher payments from health plans.

In an analysis of the information submitted to HCFA by hospitals in five States³ relating to beneficiaries enrolled in MCOs, we found that approximately 50 percent of the beneficiaries did not receive inpatient hospital services in a teaching facility. To include GME payment amounts in **all** MCO capitation rates would therefore inappropriately benefit some plans. Since the GME carve-out was phased in over a 5-year period, plans should have had an opportunity to renegotiate their payment arrangements with teaching hospitals. Because data are not available to determine which MCOs, based on their contracts with teaching hospitals, actually include an amount for GME in their payments, we were not able to develop the effect of this BBA carve-out requirement.

Risk Adjustment Factor

According to public comments made by MCO representatives, a large percentage of the fairness gap is attributable to the risk adjustment factor. Risk adjustment is intended to improve the accuracy of Medicare payments to health plans by increasing payments to MCOs for sicker

³The five States include California, Florida, New York, Texas, and Pennsylvania.

beneficiaries enrolled in the plans while appropriately reducing payments for healthier beneficiaries.

Studies by HCFA, the Medicare Payment Advisory Commission (MedPAC),⁴ and GAO have demonstrated that beneficiaries enrolled in MCOs are generally healthier than beneficiaries in the general FFS sector (favorable selection). This condition would create a disparity in payments when MCO payment rates (established based on the average FFS beneficiary health status) are made for beneficiaries healthier than the average. In order to adjust for the payment disparity brought about by favorable selection, BBA of 1997 required the Medicare program to begin implementing a risk adjustment methodology by January 2000. The risk adjustment is intended to recognize the health status of a plan's enrollees and more accurately reflect expected medical costs in MCO payment rates. Therefore, if an MCO enrollee is predicted to have a higher level of medical expenses, MCO payments will be higher. Conversely, if predicted expenses are lower, payments will be lower. The MedPAC predicts that the new risk adjustment system will reduce the extent to which HCFA overpays MCOs in the aggregate.

The MCO representatives' comments indicate a belief that HCFA's risk adjustment design is flawed. They believe that since the risk adjustment measures inpatient hospital utilization, it penalizes health plans that use disease management programs intended to reduce hospitalization.

Under the BBA of 1997 provisions, HCFA established that the risk adjustment factor would be fully implemented by 2004. The BBRA of 1999, however, modified the phase-in period for the risk adjustment factor.⁵ Based on the Part A data collected by HCFA from inpatient hospital information, the estimated impact on the CY 2000 payments of risk adjustment for enrolled beneficiaries is a \$200 million reduction. This equates to a 0.6 percent negative impact on overall Medicare capitation payments.

User Fee

Another BBA payment reduction to MCOs was the user fee to fund the Medicare beneficiary information campaign. The campaign is intended to provide information regarding coverage options available under the M+C program. It includes information on the coordinated open enrollment periods, covered benefits, and cost sharing, as well as beneficiary education on both the M+C program and the FFS program. The user fee was established with an annual national cap set at \$100 million for CY 2000 and beyond (subject to the appropriations process). The MCO industry believes that its contribution to the beneficiary information campaign should be in proportion to its participation in the Medicare program; i.e., its contribution should be based on

⁴Formerly the Physician Payment Review Commission and ProPac.

⁵The BBRA modified the implementation of the risk adjustment factor to 10 percent in 2000 and 2001 and not more than 20 percent in 2002.

MCO enrollment levels as a percentage of total Medicare enrollment levels. The BBRA modified the user fee provision so that the aggregate amount of fees collected would be based on the number of beneficiaries in M+C plans compared with the total number of Medicare beneficiaries. The limit on the total amount available in a FY to carry out the information campaign would be \$100 million.

We have not examined the issue of user fees and, therefore, cannot support or refute the industry's assertions. However, the \$100 million has about a 0.3 percent negative impact on overall Medicare capitation payments.

OTHER POSITIVE EFFECTS OF BBA OF 1997

The above sections outlined effects of the implementation of BBA of 1997. Other matters that would have had a negative impact on MCOs were avoided by the implementation of BBA and BBRA. These are outlined below.

Unimplemented Risk Adjustment Factor

As previously noted, BBA of 1997 required the implementation of a risk adjustment factor by CY 2000. The HCFA established that the risk adjustment factor would be fully implemented by 2004. However, BBRA of 1999 modified the phase-in period. For CY 2000, only 10 percent of Part A payments are affected by the risk adjustment factor. Thus, MCOs, in the aggregate, are being overpaid for enrolled beneficiaries who are healthier than the Medicare population as a whole. Had the full impact of the risk adjustment applied to CY 2000, MCO payments would have been reduced by 5.6 percent (rather than the 0.6 percent implemented),⁶ or about \$2 billion — a resulting financial benefit of \$1.8 billion⁷ for MCOs. This may be a conservative estimate since the risk adjustment model is based on encounter data only for inpatient services. The implementation of a comprehensive risk adjustment system based on encounter data from additional sites of service would further reduce payments.

The \$1.8 billion benefit to MCOs may be conservative given the findings in a recent GAO report⁸ that examined the impact on MCO payments due to favorable selection. The GAO reported that the aggregate Medicare payments to MCOs in 1998 were about \$5.2 billion more than they would have been if those Medicare beneficiaries enrolled in MCOs had received care in the traditional FFS program. The GAO attributes \$3.2 billion of the \$5.2 billion to the fact that

⁶Based on recent data collected by HCFA.

⁷\$2 billion less the \$200 million reduction in CY 2000 payments.

⁸"Medicare+Choice; Payments Exceed Cost of Fee-for-Service Benefits, Adding Billions to Spending," GAO/HEHS-00-161, August 23, 2000.

MCOs attracted a disproportionate selection of healthier and less expensive beneficiaries relative to traditional FFS Medicare (a phenomenon known as favorable selection), while payment rates largely continued to reflect expected FFS costs of beneficiaries in average health.

According to the GAO report, the results suggest that HCFA's new health-based interim risk adjuster, when fully implemented, may eliminate only half of the excess payments due to favorable selection. The GAO notes that HCFA plans to introduce a more refined risk adjuster starting in 2004 but cautions that "slow and uncertain phase-in schedules" mean "it may be several years before excess payments caused by health status differences are reduced substantially."

If MCOs continue enrolling healthier than average beneficiaries, payments should be reduced. However, if MCOs' enrollment mix better reflects the average FFS beneficiary mix, payments should not be reduced.

Pre-BBA Payment Method

The MCO representatives have commented that a fairness gap has been created when funding for the M+C program is compared with the traditional FFS program. As a result of the BBA changes, MCOs have commented that Medicare capitation payments (on a per member per month basis) will be significantly lower than FFS payments (on a per member per month basis). Media articles have noted that for nearly half of the M+C enrollees living in the top 100 counties, Medicare payments to health plans on behalf of beneficiaries will be 85 percent or less of FFS Medicare payments in 2004, significantly exceeding estimates of overpayments due to favorable selection by plans.

Under the BBA of 1997 payment methodology, MCO payments are based on the highest of a minimum floor amount, a blend of the local and national rate, or a minimum 2 percent update. In 1998 and 1999, payments to MCO plans were set either at the 2 percent increase or the guaranteed minimum rate. No plan was paid based on the blended rates because the combination of low national growth rates in the traditional Medicare program and the 2 percent minimum increase precluded payment rates based on the blended formula. This occurred because the budget neutrality adjustment brought all rates to an amount below the amount of the minimum 2 percent increase. The MCOs have commented that the 2 percent amount has, in effect, become a ceiling rather than a floor.

We believe that the BBA of 1997 provisions actually provided greater funding to MCOs than had BBA not been implemented. The BBA provided for a minimum rate increase of 2 percent over the prior year's rate and a dollar amount minimum. Because rates could not drop below these two levels, the aggregate amount paid under the new method was higher than what would have been paid under the pre-BBA method. To demonstrate the impact of the BBA changes, the chart on page 9 displays the average MCO payment amounts since 1991 and the national average U.S. Per Capita Costs (USPCC) rate (the average cost in the FFS sector) for the Medicare aged

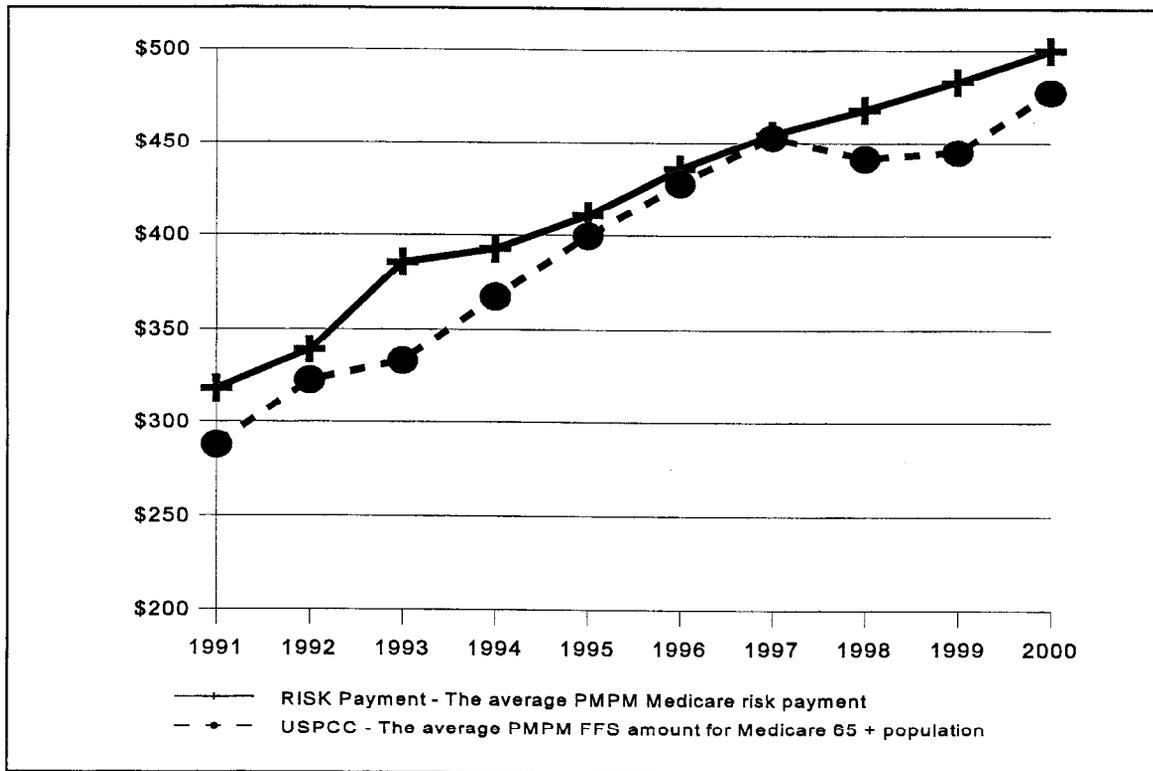
population on a per member per month (PMPM) basis. We used the USPCC for the aged population since the majority of Medicare beneficiaries (approximately 86 percent) are in this group.

The chart is for illustrative purposes only. One could argue that the average risk payment amount should be greater than the USPCC since the USPCC represents the average national payment and many MCOs operate in counties that have a higher average payment rate. A counter argument is that MCO payments should be lower since they were set at 95 percent of the USPCCs in order to reflect the assumed efficiencies inherent in the managed care concept.

However, the chart notes that for the period 1991 through 1997, the variability between the average MCO payment and the USPCC was reduced to less than \$2 in 1997 (the USPCC amount was \$452.58, and the average MCO payment amount was \$454.55). The impact of the BBA of 1997 changes is clearly shown starting in 1998, when the average MCO payment amount continued to increase while the average cost in the FFS sector declined. If MCOs were still paid under the pre-BBA payment methodology, that is, based on the annual FFS calculations and not using the 1997 base-year period, Medicare MCO payments would have been lower than what was actually paid to the MCOs starting in 1998.

If the 1998 and 1999 payments had been based on FFS expenditures (pre-BBA of 1997 methodology), MCO payments would have been approximately \$4 billion less than what was actually paid by Medicare. We believe the positive impact in 2000 will amount to over \$1.5 billion (or 3.9 percent). These amounts are exclusive of the amounts calculated for the overstatement due to actuarial assumptions, which was previously discussed on page 3.

Comparison of Average Risk Payment With Aged USPCC



Department of Defense Costs

The MCO representatives have commented that certain Department of Defense (DoD) and Department of Veterans Affairs medical costs are not included in the computation of Medicare payment rates. Plans from areas with high concentrations of military retirees have argued that rates for their areas are understated because the costs of care for Medicare-eligible beneficiaries in DoD facilities have not been included in computing the AAPCC.

In a joint review with the DoD Inspector General, we examined overlapping Government expenditures for inpatient services for DoD beneficiaries enrolled in Medicare MCOs. During FY 1997, there were 47,326 inpatient admissions for individuals aged 65 and older at 95 military treatment facilities. In a statistical sample of 2,975 admissions, 464 admissions were for patients enrolled in a Medicare MCO at the same time that inpatient treatment was provided in a military treatment facility. The report concluded that MCOs had avoided \$40 million in inpatient costs since these Medicare beneficiaries elected to use DoD facilities instead of receiving these services through MCOs. The 47,326 DoD inpatient admissions represent less than 0.4 percent of

the total Medicare inpatient admissions for FY 1997 and would not have materially increased Medicare payment amounts or the 1997 capitation base rates in the aggregate.

We have not expanded our review to examine the impact of VA medical costs or the effect of including DoD and VA medical costs in establishing capitation rates in a particular county. Therefore, we cannot support or fully refute the industry's assertions that individual county rates are too low.

OTHER FACTORS AFFECTING MCO PAYMENTS

There are several other issues that we believe provide support that Medicare payments to MCOs are higher than they should be. The following sections outline these issues and relevant past work completed by OIG.

Improper Payments Included in 1997 Base-Year Rates

As previously noted, Medicare's MCO reimbursement methodology is based on the 1997 county rates. Since these rates were based on FY 1996 FFS expenditures, any FFS payment inaccuracies in 1996 would inappropriately inflate MCO reimbursements. An OIG review examined the impact on the capitation payments of the improper FFS payments noted in our review of HCFA's 1996 and 1997 financial statements.

Our financial statement audits quantified the magnitude of improper payments as follows:

- During FY 1996, net overpayments totaled \$23.2 billion nationwide, or about 14 percent of the total \$168.6 billion spent on Medicare FFS benefit payments.⁹
- During FY 1997, net overpayments totaled \$20.3 billion nationwide, or about 11 percent of the total \$177.4 billion spent on Medicare FFS benefit payments.¹⁰

Since we developed the first error rate for FY 1996, HCFA has developed appropriate corrective action plans to ensure that providers submit claims to Medicare for services that are medically necessary, billed correctly, and documented properly. The impact of HCFA's corrective action plans was to bring the level of improper Medicare payments made during FYs 1998 and 1999 down to 7.1 percent and 7.97 percent, respectively, of the FFS payments reported by HCFA.

⁹The estimated range of the improper payments at the 95 percent confidence level is \$17.8 billion to \$28.6 billion, or about 11 percent to 17 percent.

¹⁰The estimated range of the improper payments at the 95 percent confidence level is \$12.1 billion to \$28.4 billion, or about 7 percent to 16 percent.

This reduction may have contributed to the reduction in the USPPC amounts detailed previously in this report.

Since the standardized county rates for 1997 were calculated using 1996 base FFS expenditure data, we believe that the 1996 error rate identified in our financial statement audit carried over to the 1997 MCO rates. This situation is particularly troublesome because the structure of Medicare's managed care environment should preclude the provision of unnecessary and undocumented services, the major types of payment errors found in our FFS audits.

Unaccounted-For Investment Income Earned by MCOs

Another issue that should be considered in evaluating whether MCOs are receiving the proper monthly capitation payments from Medicare is the fact that MCOs are not held accountable for the investment income they earn on Medicare funds. Medicare makes payments to MCOs on the first of every month for enrolled beneficiaries. The OIG analyzed the overall positive financial impact on MCOs from the time funds are received from Medicare to the time funds are expended.

The results of our review showed that Medicare risk-based MCOs may have earned in excess of \$100 million a year on current-year Medicare funding during 1996 and 1997, continued to earn significant amounts of investment income in 1998, and presumably will continue to earn in subsequent years.

We found that there is no present requirement for MCOs with risk contracts to account for investment income. For example, HCFA does not currently consider investment income earned by Medicare risk-based MCOs in setting MCO rates. In addition, HCFA does not require an MCO to (1) factor investment income into its annual presentation of estimated revenue requirements (the adjusted community rate (ACR) proposal), (2) use investment income to reduce Medicare expenses, or (3) refund investment income to the Federal Government.

The MCOs may invest the predetermined payments from Medicare in interest-bearing instruments until the funds are needed for program purposes, such as paying the MCOs' health care providers or employees for services furnished to Medicare enrollees. We learned that the median investment period for short-term investments was 40 days (based on the 1996 cash flow information provided to us by the MCOs) and that plans earned about 5 percent on these short-term investments.¹¹ The net result of the short-term income from an investment during the *float period* is that MCOs were effectively funded at amounts in excess of the 95 percent of Medicare FFS costs used as a basis for calculating the MCO payment rates.

¹¹The annualized rate of return on the interest from the 40-day float period is 0.4 percent.

Excessive Administrative Costs

Another area of potential overpayment is the amount of Medicare funds that MCOs allocated for administrative costs. We reported on two issues of particular concern -- the wide variation among plans for administrative costs and the types of administrative expenditures being funded by Medicare payments.

An OIG review analyzed the variances in administrative funds (as a percentage of total funds received from Medicare) among MCOs and found that regardless of the plan or model type, the variations were excessive. Our review of the administrative cost amounts recorded by 232 risk-based MCOs in 1999 on their ACR proposals showed significant disparities among plans. For example, during the 1999 ACR year, the average amount allocated by an MCO for administration ranged from a high of 32 percent to a low of 3 percent. These disparities were noted in every year of our review regardless of plan model (group, individual practice association, or staff) or tax status (profit or nonprofit). Current criteria allow MCOs to calculate administrative rates with virtually no limits. The same disparity found in our review of ACR proposals for 1996 through 1999 was also noted in the proposals submitted to HCFA for 2000.

We also examined the records of several MCOs to determine the types of expenditures being funded as part of their administrative overhead. Our review assessed whether (1) the proposed administrative costs included in the ACR proposals were reasonable when compared with the actual costs incurred and (2) the actual administrative costs incurred were appropriate when considered in light of the Medicare program's general principle of paying only reasonable costs.

Our review showed, for the nine MCOs reviewed, that costs totaling \$66.3 million would have been recommended for disallowance had the MCOs been required to follow Medicare's general principle of paying only reasonable costs. Since there is no statutory or regulatory authority governing allowability of costs in ACR proposals, the MCOs were not required to adhere to this principle. Some of the unallowable costs included:

- \$4.7 million for costs related to entertainment, gifts, and employee morale; lobbying and public relations; contributions and sponsorships; bad debts; fines and penalties; travel; and miscellaneous items. All nine MCOs reported at least one of these cost elements.
- \$3.2 million for costs that should not have been allocated to the Medicare lines of business.
- \$58.4 million in unsupported costs, including related-party costs and other administrative costs (e.g., long-term debt and other miscellaneous items.) Due to a lack of documentation, we could not determine the reasonableness of these costs.

To address the excessive administrative rate amounts, we recommended that HCFA establish a 15 percent rate ceiling. If a 15 percent ceiling had been applied to the ACR proposals for CY 2000, an additional \$500 million in the form of additional benefits or reduced payments (e.g., deductibles and/or coinsurance) may have been passed on to beneficiaries. The 15 percent was suggested because it represented the average rate (administrative ACR to total ACR) noted during the period of review (1996 to 1999).

As to the impact of limiting administrative costs to Medicare's general principle of paying only reasonable costs, we could not project our findings nationally since the nine MCOs were judgmentally selected for review. However, given the nature of the MCO risk contract, where Medicare pays a prepaid amount with no adjustments, it is possible that a significant amount of Medicare funds are being used for non-patient-related expenditures.

Medical Costs Avoided

Another area of concern that contributes to the perception of overpayments due to favorable selection is the potential avoidance of costs by MCOs. An OIG audit reviewed inpatient services paid by Medicare under traditional FFS after the beneficiaries disenrolled from managed care risk plans. The objective was to assess whether Medicare risk plans may be selectively enrolling healthier beneficiaries and encouraging sicker beneficiaries to disenroll.

We selected six managed care firms for this audit. Our review of beneficiaries who disenrolled from these six risk plans during 1991 through 1996 found that:

- Medicare paid hospitals \$224 million for inpatient services furnished to beneficiaries within 3 months of their disenrollment.
- Medicare would have paid \$20 million in capitation payments to these six firms had these beneficiaries not disenrolled, a difference of \$204 million.
- About 18 percent of the expenditures (\$41 million) was paid for beneficiaries who reenrolled in Medicare managed care after receiving inpatient care under the Medicare FFS program.

Based on our analysis, it appears that risk plans can avoid significant payments for medical services by having sicker beneficiaries disenroll, have medical services performed under the Medicare FFS program, and then reenroll the beneficiaries when they are again healthy. The loser in this scenario is the Medicare program and the related trust funds.

Accuracy of Payments

Another area that is an indicator of MCOs' receiving more funds than financially justified involves the accuracy of Medicare capitation payments. For several years, we examined MCO

payments received from Medicare based on the special status category of beneficiaries, payments for deceased beneficiaries, and the coordination of payments between FFS and MCO enrollment. The financial effects from these reviews cover multiple years and have not been projected to FY 2000.

For each beneficiary enrolled in a risk-based MCO, HCFA authorizes a fixed monthly payment which is adjusted by a set of risk factors, such as the beneficiary's age, gender, and Medicare entitlement status. An increased payment is made for certain high-cost categories of beneficiaries, including beneficiaries who have ESRD, who are in institutions, and who are also eligible for Medicaid. Each month, HCFA provides MCOs with a special status report which identifies beneficiaries for whom the MCOs received enhanced payments. The OIG found instances in which beneficiaries were misclassified, resulting in \$248 million of overpayments to MCOs.

CONCLUSION AND RECOMMENDATION

The BBA of 1997 modified the methodology used to determine MCO payments, partly because of concerns that many MCOs were overcompensated for their enrolled Medicare beneficiaries. The new methodology was designed to slow the growth of MCO payments and align payment rates with the expected health care costs of enrolled Medicare beneficiaries. However, our audit work showed a consistent set of facts. Essentially, each of our reviews demonstrated that the basis on which the monthly amounts were calculated was flawed; Medicare payments were being used to fund unnecessary administrative costs, excess profits, and investment income that was not accounted for in the Medicare payment formula; or improper payments were made to MCOs for such purposes as unsupported enhanced payments (for beneficiaries who purportedly had ESRD, were residing in institutions, or were dually eligible for Medicaid and Medicare services).

We believe that the payment rates based on 1997 data overstate the capitation rates by the overpayments in the Medicare FFS sector, which were the basis for the rates, and also by the overstatements of actuarial assumptions. We also believe that MCOs have benefitted from the delay in fully implementing the risk adjustment factor since data support that MCOs enroll healthier beneficiaries (favorable selection).

While some of the BBA provisions reduced payments to MCOs, the overall impact is that MCO payments for CY 2000 will be about 95.5 percent of the average amount paid in the Medicare FFS sector. Even though the effective payment rate for CY 2000 will be 95.5 percent of FFS, the rate should be 90.5 percent or lower after fully adjusting for risk selection. This may be a conservative estimate since the risk adjustment model is based on encounter data only for inpatient services. The implementation of a comprehensive risk adjustment system based on encounter data from additional sites of service would further reduce payments.

The results of our past and present audit work show that MCOs are receiving more than adequate funds from the Medicare program to cover the delivery of the Medicare basic package of services. We do not believe that the Medicare program should have to increase monthly capitation payments in order to help MCOs cover their costs of providing additional benefits beyond the basic Medicare package of covered services. We therefore recommend that HCFA consider all the financial-related work we have completed recently and use these studies to modify rates to a level fully supported by empirical data.

HCFA COMMENTS

The HCFA agreed with the report's overall finding that M+C payments are adequate to fund the Medicare package of covered services. The HCFA also agreed that under full adjustment for risk selection using its current model, M+C payments would be lower. The agency noted that when considering M+C payment rates and risk adjustment, it is important to remember that M+C plans have enrolled a disproportionately higher share of beneficiaries with better-than-average health status.

According to HCFA, it will move toward full implementation of a risk adjustment methodology that will incorporate diagnosis data from physician services and hospital outpatient services. The HCFA noted that the best way to address the managed care industry's concerns regarding adequate payment and to ensure a strong M+C program is to make sure that all beneficiaries have access to affordable drug coverage and to pay plans directly for providing this coverage. The full text of HCFA's comments is included as Appendix B.

RELATED REPORTS

Capitation Rates for Medicare Managed Care Plans Are Inflated Due to Improper Payments Included in Rate Calculations (A-14-97-00206), issued September 1998.

Review of Medicare Overpayments to Managed Care Organizations Due to Overstated Capitation Rates (A-05-99-00025), issued December 1999.

Medicare+Choice: Reforms Have Reduced, but Likely Not Eliminated, Excess Plan Payments (GAO/HEHS-99-144), issued June 1999.

Results of the Audit of Investment Income Earned by Managed Care Organizations With Risk-Based Contracts (A-02-98-01005), issued June 2000.

Administrative Costs Submitted by Risk-Based Health Maintenance Organizations on the Adjusted Community Rate Proposals Are Highly Inflated (A-14-97-00202), issued July 1998.

Review of the Administrative Cost Component of the Adjusted Community Rate Proposal at Nine Medicare Managed Care Organizations for the 1997 Contract Year (A-03-98-00046), issued January 2000.

Administrative Costs Reflected on the Adjusted Community Rate Proposals Are Inconsistent Among Managed Care Organizations (A-14-98-00210), issued January 2000.

End Stage Renal Disease Special Status Beneficiaries at Humana, Inc. (A-04-94-01096), issued November 1994.

Review of Medicare Payments to Health Maintenance Organizations for End Stage Renal Disease Beneficiaries (A-04-94-01090), issued February 1996.

Systems and Overpayment Issues--End Stage Renal Disease Payments to Health Maintenance Organizations (A-14-96-00203), issued June 1997.

Review of Medicare Managed Care Payments for Beneficiaries With Institutional Status (A-05-98-00046), issued April 1999.

Review of Medicare Payments for Beneficiaries Reported as Institutionalized by FreeState HealthPlan for the Period January 1, 1996 to June 30, 1998 (A-03-99-00003), issued March 1999.

APPENDIX A

Page 2 of 2

Review of Medicare Payments for Beneficiaries Reported as Institutionalized by Aetna U.S. HealthCare for the Period January 1, 1996 to September 30, 1998 (A-03-99-00003), issued July 1999.

Review of Medicare Payments for Beneficiaries With Institutional Status - Pacificare of California (A-05-97-00013), issued April 1998.

Review of Medicare Payments for Beneficiaries With Institutional Status - Group Health Plan, Inc. (A-05-97-00014), issued June 1998.

Review of Medicare Payments for Beneficiaries With Institutional Status - Pacificare of Arizona (A-05-97-00017), issued June 1998.

Review of Medicare Payments for Beneficiaries With Institutional Status - Kaiser Foundation Health Plan, Portland, Oregon (A-05-97-00023), issued April 1998.

Review of Medicare Payments for Institutionalized Beneficiaries Made to Medica Health Maintenance Organization in Minneapolis, Minnesota (A-05-94-00053), issued May 1995.

Review of Medicare Payments to Health Maintenance Organizations for Medicaid Special Status Beneficiaries (A-04-94-01089), issued July 1995.

Nationwide Audit of Medicaid Special Status Classifications Submitted by Medicare Health Maintenance Organizations (A-04-96-01119), issued November 1996.

Review of Payments to Medicare Managed Care Risk Plans for Deceased Beneficiaries (A-07-99-01283), issued February 2000.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Office of the Administrator
Washington, D.C. 20201**DATE:** SEP 14 2000**TO:** June Gibbs Brown
Inspector General**FROM:** Kathleen King *Kathleen King*
Executive Associate Administrator**SUBJECT:** Office of the Inspector General (OIG) Draft Report "Adequacy of Medicare's Managed Care Payments After the Balanced Budget Act of 1997," (A-14-00-00212)

The Health Care Financing Administration (HCFA) is committed both to ensuring that Medicare beneficiaries continue to have many health options available to them and to improving the administration of the Medicare+Choice (M+C) program. Clearly, M+C has made a positive contribution to modernizing the Medicare program. Many Medicare HMOs offered a range of preventive benefits before those benefits were incorporated into the fee-for-service (FFS) Medicare program, and they have also taken the lead in providing prescription drug benefits --a benefit still not available to beneficiaries in FFS.

The findings in this report are especially important in view of the recent public statements by Medicare+Choice Organizations (MCOs) about the effect of the payment changes enacted in the Balanced Budget Act of 1997 (BBA) and the general adequacy of M+C payment levels. The OIG found that the effective payment rate for M+C in 2000 was 95.5 percent of fee-for-service (FFS) spending, without factoring in the effect of risk adjustment that we discuss below. We agree with the report's overall finding that M+C payments are adequate to fund the Medicare package of covered services. This is reflected in the fact that, for 2000, MCOs are spending on average 22% of their Medicare premiums on benefits that are not available in the fee-for-service Medicare program.

We agree with the OIG that, under a full adjustment for risk selection using our current model, M+C payments would be lower. When considering M+C payment rates and the importance of risk adjustment, it is important to remember that studies have found favorable selection in Medicare managed care enrollment, i.e., enrollment of a disproportionately higher share of beneficiaries with better-than-average health status in managed care plans.

Page 2 -- Health Care Financing Administration Response

The BBA required HCFA to implement a risk adjustment methodology that accounts for variations in health status by January 1, 2000. HCFA is now in the process of phasing-in a risk adjustment system based on diagnosis data from hospital admissions. Under the phase-in, payments in 2000 are being reduced on average by 0.59 percent; if the method were fully implemented, payment would have been reduced by 5.9 percent, which is consistent with the findings of favorable selection in this and other analyses. Beginning in 2004, we will incorporate diagnosis data from physician services and hospital outpatient services into the risk adjustment system. The report reinforces the importance of moving toward full implementation of risk adjustment.

The OIG also recommended that several factors must be considered when evaluating M+C rates. These include:

- Improper payments included in the 1996 FFS Medicare payments;
- Unaccounted investment income earned by MCOs on Medicare funds; and
- Excessive administrative costs included by MCOs in their annual submissions of revenue needs (the adjusted community rate proposals).

The best way to address the managed care industry's concerns regarding adequate payment and the best way to ensure a strong M+C program is to make sure that all beneficiaries have access to affordable drug coverage and to pay plans directly for providing it. The President's proposal to create a voluntary, affordable prescription drug benefit would provide an estimated \$2 billion in 2001 and \$25 billion over 5 years to M+C plans for the cost of providing prescription drugs. The President also proposes to change the way M+C plans are paid by creating a competitive defined benefit program where plans would be paid through a market-based process rather than through the current administered pricing method.

We look forward to continuing to work with the Congress, OIG, and M+C plans to ensure that Medicare beneficiaries have many health plan options available to them. We appreciate the effort that went into this report and look forward to working with OIG on this and other important issues.