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MEDICAID RISK CONTRACTING

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Recorder: ROLAND E. (GUY) KING

This panel will present the perspectives of state government, federal government, and health maintenance organizations (HMOs) with respect to Medicaid risk contracting.

MR. ROLAND E. KING: We have several excellent speakers, and we have a lot of material to cover. I'll introduce our speakers very briefly and let them get on with their presentations. Jim Roberts with Ernst & Young will lead it off and give us a general overview. He'll also talk about his experiences working with a state on Medicaid risk contracting in Hawaii. Our second presenter, Bob Cumming from Milliman & Robertson, will talk about his experience with Medicaid risk contracting in Minnesota, with special emphasis on long-term care. John Stark from Trigon Blue Cross/Blue Shield will talk about the perspectives of Medicaid risk contracting more from the point of view of the provider rather than from the state's point of view. Then, Ron Bachman from Coopers & Lybrand will wrap it all up for us and talk about his experiences as a consultant.

MR. JAMES N. ROBERTS: I'm going to talk primarily about fully capitated state programs as being the ultimate in the risk contracting. The environment or the overview is that states have been moving fairly aggressively towards programs that will do several things, primarily reduce cost. It has been a budget buster in most state budgets for a number of years. There have been increasingly aggressive programs being put into place, primarily with the objective of saving money. That's changing rapidly as we speak, especially with the welfare reform programs that are going into place. We can see the implications of block grants which will become the new federal portion of the financing of these programs. I'm going to talk primarily about the acute health care area. We're going to get some perspective on the long-term-care aspects which I'm not going to talk about.

I believe there are three basic reasons why states are capitating their programs. First, the budget tools that they had to work with originally to define and control costs were limited to, in the fee-for-service program, squashing down reimbursement rates to providers. Those tools have not proven to be overly effective from anybody's point of view. Second is reducing cost. It is probably the dominant one, and should be number one. Third is that some of the earlier fully capitated programs have also been used to expand the scope of the programs a little bit to encompass some different segments of the population, so a side strategy is trying to reduce the number of uninsured. These traditionally have required states to get a waiver because the original statutes, like federal statutes, contemplate certain requirements such as universality. There can't be a big difference in the benefit levels from one segment of the program to another. There has to be freedom of choice and certain other provisions. To put in a program that affects any of those key areas requires the state to apply for a waiver from the statutes, and those

waivers had been contemplated in the original states and through amendments of the Medicaid statutes.

There are basically two types. There's the 1115 and the 1915(b) waivers. The 1915(b), which was the original approach, was intended to be for the entire program in the state, and the 1115s were really put in place to be demonstration projects. Well, that has shifted over the last couple of years so that the major programs that have been put into place have been done through 1115 waivers, but they tend to be fairly broad in their scope. I'm not going to talk a lot about the waiver process because I think block grants are going to change all that anyway. The process to get a waiver has been fairly onerous and time consuming, although the administration, and Guy may be able to comment on this, has certainly been aggressive in trying to pick up the pace and grant those within a faster time frame.

There are three basic managed care models for Medicaid. There's full-risk capitation. That's the one I'm going to focus on. There are partial-risk capitations which tend to take either limited geographic areas or take limited service categories and capitate those. Mental health would be a great example. Many states have put in carve out mental health programs which are capitated under a competitive bid process. The third one has been fairly widely used. Many states have adopted the primary care case management model (PCCM) which basically tries to use the primary care physician (PCP) gatekeeper concept. The PCPs are paid a fee to manage the care of participants. Everybody gets assigned one, and they just get paid, but there are no financial incentives built into the program to really modify behavior.

There are studies that show that the PCCM model is fairly effective, and there are others that show it isn't. It's kind of hard to draw firm conclusions on it. Because we're talking about risk transfer models, I'm not going to talk about that one.

It's important to think about the Medicaid population in terms of its components. There are several segments of the population that have very different characteristics that are generally considered to be part of Medicaid. I guess the thing they have in common is that they're all means tested. In other words, there's an income level requirement used to access them. The dominant one in terms of numbers of participants and the one that will be affected most clearly with welfare reform is the Aid to Families with Dependent Children (AFDC), which represents in terms of participants about 70% of the Medicaid population but actually only accounts for about 30% of the costs. In terms of number of people affected, it's the biggest. In terms of dollars affected, it's not the biggest.

There are other ways of breaking this down. I've just used very broad categories. The disabled would be a separate and obviously very high-cost population, and the aged is a third category. Aged, blind, and disabled are sometimes grouped together. The other categories from AFDC represent generally very high-cost populations, even though their numbers are not as great.

I want to talk a little bit about a case study. Before I do that, though, in terms of risk, which is our dominant topic here, one of the main drivers of risk, that is, lack of predictability, is the way that the program is installed. If it's installed on a universal basis so that, for example, a private sector organization has the responsibility for delivering services to a defined and closed population, then, in a sense, there's less risk

than if the program is offered on an optional basis so that individuals can sign up for their program of choice, either staying in a fee-for-service system or choosing among several different managed care offerings.

In the optional situation, where there's a choice involved, there are risk implications that wouldn't exist in the universal model. I want to focus on that a little bit because virtually all of the programs have been installed with some element of choice. The Arizona Access Program, which is the original one, goes way back. They never really had a fee-for-service Medicaid program. There are geographic territories carving up the state, and they require that there's at least one option for every Medicaid beneficiary. The question always becomes, for an organization going into this, which portion of the population are you going to get in your program? And there's a risk then associated with that, and therefore, the possibility of the need for risk adjustment mechanisms to be in place, and that kind of ties in with some of the earlier sessions in this meeting.

Let's jump right into the case study. I want to look at it from the state's perspective—how should they set the payment levels? We worked for the State of Hawaii and designed its program. Everybody asks me how it has worked out, and unfortunately I don't know. I hope it's working out. I think it was well-designed in terms of the administrative processes. It's gone more smoothly than Tenn Care and several of the other ones that were put in under a much more aggressive time frame. In terms of the actual implications on the cost and whether utilization behavior was changed significantly or not, we don't know yet. They've just finished the first year of the program, so we're interested to start looking at data on it.

Just to give a little background here, the Hawaii Quest Program had several characteristics. It was to be and is, in fact, a global capitation, that is, a single capitation payment for each participant to one entity that is then responsible for the entire set of services. The populations that were in the original version which is not yet complete—they're going to have second and third waves of people going into the program—included AFDC foster children, general assistance people, and a special program unique to Hawaii, the state health insurance plan (SHIP) people. If you recall, Hawaii's a very unique place because it has an employer mandate, so the level of uninsured population there is very small, and I think that has a lot of implications to this project. The later phases that include aged, blind, disabled, and seriously mentally ill populations have not yet been implemented.

The objectives were to reduce costs and then to really try to make the federal match go farther. So, they wanted to bring in this SHIP population and use some of the federal match money to help pay for it, and I think several of the Medicaid programs have tried to expand the eligible population by tapping into the federal match and using the managed care savings to pay for more people.

There are several places that an actuary can start in trying to estimate the appropriate capitation rate, whether you're working for the health plan who's bidding on the work or if you're working for the state which is then going to evaluate those bids. The ideal starting point would be to use the historical fee-for-service Medicaid data because at least it's relevant to that specific population. Then from that starting point it becomes a process of adjusting for anticipated behavioral and payment rate changes. The other possibility, I think, that would be meaningful would be to start with relevant commercial

data. I think it would be the next best, and then you would just have to hypothesize what's different about the population instead of what's different about the payment and behavior. In the case of Hawaii, we actually had to use a little bit of both because the state health insurance program people were much more like, based on their morbidity characteristics, the commercial population than they were the traditional AFDC population. So, in that particular case, we had to use some mix. But you need a starting point to develop your assumptions because true managed care data in a start-up situation like this just isn't really going to exist.

Some of the issues that we had to deal with in this one were how the marketing was going to take place, how the people were going to get assigned or make a selection, and in this particular case we felt that some risk-adjustment mechanism should be in place because the marketing approach was fairly wide open, and it gave each plan the opportunity to more or less cherry-pick among the population. We thought that some risk-adjustment mechanism ought to be in place to create a more level playing field. We had this unknown new population and we could get some data on that SHIP population, but the benefit structure was so different that it was hardly relevant. Therefore, we had to adjust for the service levels and benefit changes.

One issue that states need to deal with right up front is whether they're going to use a competitive bid price or a stated price approach. In other words, they can describe the program, put in a request for proposal (RFP), and ask you to put in your best offer. There's usually a second round of negotiations to determine the actual capitation rate, or the state can, up front, say we're going to pay $142 per member, per month, take it or leave it, and you just have to come in and bid your qualifications to deliver the services based on accepting the offered price. In the case of Hawaii, they decided to use the competitive process which I think is becoming the more dominant approach, although there are some states like Tennessee that are not using that approach.

There are several other issues. Who gets to recover for third party liability auto accidents is a dominant one. Other payers might crop up, and does that money go back to the state or does the health plan have to recover that and get to keep the money? Disproportionate share is a payment to hospitals that's based on the level of the indigent population that they serve, and I don't know whether that's going to continue or whether that's going to be cut out. Whether those monies then have to be built into the capitation rates became an issue.

Reinsurance is a real interesting issue. Will the state supply some type of reinsurance for entrants? There's kind of a fuzzy period when people are supposed to enroll, and you never know whether they're in or not. They're not yet in the managed care system, but they may be assigned to a managed care company. Whether the state is going to retain some sort of fee-for-service type responsibility for those people early on is one issue. The catastrophic type claims are either on a dollar-measured basis or on some sort of a specified medical condition approach because the state's objectives are really twofold. They want to save money, but they also want plans to participate. So, they're trying to anticipate some of the key issues. In the case of Hawaii, as in many other states, there was a strong interest in attracting health care providers, who may have not been traditional managed care companies, to participate in the program through bidding. They wanted to kind of anticipate some of the concerns they might have.

I think the two points of view on reinsurance would be, if it's a managed care company whose business is financing health care and developing risk pools and having sophisticated techniques for doing that or purchasing their own reinsurance, then I think you would say it's a good thing to be privatized because one of the pieces of expertise you're trying to buy is the management of claims of all types or health care conditions of all types. The other point of view is that if you want a new type of entrant, then providing a facility for them, either a state-operated pool or access to some private sector reinsurance products, might be desirable. Hawaii selected the latter, which we did not actually advise, but those things happen.

As I mentioned, we did put in a risk adjustment mechanism here because people could choose among several plans. We explored the cost differences by population cell (based on a random sample) in a lot of different ways and just tried to pick out the ones with the demographic characteristics that were obvious and dominant. We elected to use the prospective approach to risk adjustment.

The health plans were quite resistant to retrospective risk adjustment which would mean, if the population enrolled in your plan had a certain set of diseases that occurred in their population, and it was outside the norm, then you could get paid more, or if you had healthier people, you could get paid less. That would have been the most air-tight approach, but there was a concern by the health plans about not being able to know what their real revenue was which makes it more difficult to then manage within a budget. So a prospective approach was adopted.

Here's a quick look at the relative costs in the different classifications, and in their case, the decision on the geographic split was by island because that is how everything works in Hawaii. Within each island there was a separate set of risk-adjusted factors that were based on studying and smoothing the fee-for-service data.

The approach in defining the capitation rate is one that I think health actuaries have become very facile with. It basically used a use rate and unit cost model to develop a capitation rate by category of service, and the particular version that we used had about 45 service category breakdowns (the usual sorts of things) and various specialty classes, and inpatient, outpatient. I think we have mental health and maternity-related expenses on the inpatient side split out. The exercise then became, for each service category, to estimate an appropriate utilization level (days per thousand or visits per thousand or whatever) or use rate, and then hypothesize what managed care protocols and methods and procedures and services would do to change those numbers. That gave us at least a range of reasonable assumptions to work from.

On the cost side, there were three things that we looked at to try to come up with a reasonable unit cost assumption. One of them would have been what we think the unit cost would have been if everything had stayed fee for service. So there was a little bit of historical analysis involved. We looked at the relationship of those historical payment rates to charges; in other words, what in effect was the level of discount that Medicaid had been achieving in their old fee schedules? That gave us some idea of how much room the managed care company might have in negotiating payment rates.

In other words, if Medicaid had been paying very poorly for a particular category when measured against charges, it's reasonable to expect that they were not going to do any

better and, in fact, would probably end up paying more. Or, if they were paying very generously, like close to charges, then I think it would be reasonable to assume that they could improve on those payment rates. So the relationship of payments to charges was the second thing we looked at. And then, we tried to determine what we thought could be obtained in negotiation, after looking at those two pieces of information.

I'd like to look at a couple of specific examples. As I said, we had a 45 service-category breakdown. Four of them are shown in Table 1 and describe the thought process. We'll take the intensive care unit (ICU) line first where we had a unit cost number and a frequency number. I'll look at the utilization number first. These are per month numbers. So 40 days per thousand for that particular category would represent 480 days per thousand per year, which is a fairly high number. We were puzzled as to why because that excludes obstetrics, which is an even bigger number. So, the overall days per thousand on an annual basis were more than 1,000, which, for this particular population, was very high. We couldn't figure out why.

TABLE 1
CAPITATION CALCULATION

Selected Services	Charges	Allowed	Anticipated Payment Amount	Base Utilization	Adjusted Utilization	PMPM
Inpatient Hospital Surgery, ICU, Medical	$2,000	$1,000	$1,100	40	30	$33.00
Nursing Facility	$185	$160	$160	4	4	$0.64
Outpatient Hospital Emergency Room	$180	$180	$180	50	25	$4.50
Physician Office/Home Visits	$55	$40	$40	400	500	$20.00

We did a little bit of research into it, and we compared it with a lot of other state information and other sources and still couldn't come up with a good explanation. What we finally discovered was that the state of Hawaii has a huge shortage of skilled nursing beds. It goes back to the 1980s when the certificate of need process put a huge restriction on skilled nursing facility (SNF) beds. So, there was a huge shortage of SNF beds, making lengths of stays in hospitals high. The admission rates were pretty reasonable, but the lengths of stay were longer than what you would expect to see, and that turned out to be the only plausible explanation. So, the SNF use rates are questionable too, because those kind of worked in conjunction, and we felt that this situation was not going to change.

We felt that it was reasonable to try to reduce the 480 days per thousand number in this category, but we couldn't get down to anything very aggressive in that particular

environment because you were missing one of the main tools to make that happen. We hypothesized that the reduction could go from 40 to 30. These are not exactly the real numbers, but they're sort of close. And they were paying basically 50% of the charges (it was $1,000 per day, on charges that were averaging $2,000 per day), and so we figured they weren't going to be able to get any lower than that.

If you looked at clones for hospital cost, you realized that hospitals weren't really making any money on Medicaid, and we felt that they were going to end up having to pay a little bit more generously under a negotiating strategy that would say we'll pay a little bit more reasonably for a unit of service, but we're expecting to drive the units down a lot. So, we achieved this pretty big reduction from 40 to 30, but they're going to pay a little bit more generously. We assumed that the SNF bed use rates were going to stay exactly the same. They basically used all the beds there were, and there wasn't anything in the short period of time that was going to change that. And they were paying near full charges because it was kind of a seller's market, and so we assumed that they were going to stay at the same use rate.

I'll touch briefly on ER, which has a huge 50 visits per thousand per month, which is way off the chart. We figured that was the one area that a good managed care program assigning a PCP could impact. So we assumed that would be cut in half. We felt that with a 50% reduction in volume, they would need to continue to make a reasonable unit reimbursement but try to bring the frequency way down.

Let me just summarize the process. The individual health plans were supplied exactly the same data that we were in advising the state, so both sides of the table could understand the program. I would say 75% of the effort that we put in was in trying to understand the program. Medicaid's different. There are services in there that you won't see on the commercial side, like transportation, for example. You have to pay patients' transportation to get to doctors. In Hawaii that was a very unique problem because there are ambulance people all over the place. But there are components of service. There are some counseling services and so forth that are in those programs that we wouldn't typically have a lot of experience with.

Understanding the program is key. You must know why the numbers are what they have been, and what the changes are going to do. Another part of the process is determining the areas of uncertainty. You can make some reasonable estimates of what's going to happen, but you don't know. Also, try to model several of the scenarios on those key assumptions so you can at least have a capitation rate range that you think will cover the reasonable choices. Then you can use that as a tool to kind of assess the risk.

So, that was the process we used. I think it's a somewhat interesting and representative one that could be used for the health plan or for the state side.

MR. ROBERT BRUCE CUMMING: I'm a consulting actuary with Milliman & Robertson in the Minneapolis office, and I'm going to talk about Medicaid managed care in Minnesota. I've organized my comments into three sections. I'm going to start with a brief history of the program in Minnesota, including a picture of what the marketplace looks like, and then I'm going to talk a little bit about some of the hot topics that are

getting a lot of attention in Minnesota, like rate setting. Another hot topic is the long-term-care options project. The long-term-care options project is a state-sponsored project. The purpose is to integrate the delivery and the financing of both long-term care and acute care, and in Minnesota over half the Medicaid expenses are a result of long-term-care services. Controlling and managing those costs is certainly a big deal.

In 1982, Minnesota became one of five original demonstration projects authorized by the Health Care Finance Administration (HCFA). In 1983, Minnesota set up a committee of some government people, consumers, providers and HMOs to put together a plan to implement managed care for Medicaid. I think, partially, as a result of this committee approach, it took three years before enrollment began in Minnesota. In 1985, enrollment began in three counties as part of this demonstration study, and the three counties included a rural county, an urban county which included the city of Minneapolis, and a suburban county. It tended to give a cross-section of the state. In 1990, the program was further expanded to include 100% of the eligible categories in the urban county. In 1993–94, it was further expanded to include the entire Twin Cities metropolitan area, and most recently, Minnesota has received approval from HCFA to expand the program statewide.

Many other states have implemented Medicaid managed care on a much faster basis, but oftentimes, those states have run into financial or other troubles. Minnesota has taken more of a step-by-step approach, phasing it in over many years, and I think this has provided some advantages to the HMOs. It has given them an opportunity to kind of get their feet wet and test the market without taking an enormous amount of risk, and that's because there was fairly limited enrollment in the early years. A number of HMOs lost money in the early years, but at least they were able to adjust some of their managed care programs to address the unique needs of the Medicaid population. They were also able to adjust some of their provider reimbursement agreements based on actual claim experience before they were saddled with a huge Medicaid population.

Chart 1 and Table 2 show how enrollment in Minnesota has grown from about 12,000 people in 1987 to just under 140,000 people as of 1994. That 140,000 Medicaid people in HMOs represent about one-third of the total Medicaid population in Minnesota. Enrollment has been fairly steadily growing as it continues to step by step expand the program into new geographic areas and to new eligibility categories. The Medicaid HMO enrollment in Minnesota is split up among seven different HMOs that are active in the marketplace. The top three HMOs have about 80% of the market, and it's interesting to note that two of those top three are HMOs that focus just on the Medicaid population. For U Care, 100% of the enrollment is Medicaid based, and then about 80% of enrollment is Medicaid based for Metropolitan, the third HMO listed.

Chart 2 shows some of the financial results for the past four years for Medicaid HMOs, and it's an aggregate across the five largest Medicaid HMOs in Minnesota. The light bars show dollars of income for Medicaid enrollment. Total net income has grown from about $5 million in 1991 to close to $18 million in 1994, and that growth has appeared as enrollment has expanded. Profits as a percentage of revenue have been much more stable over time, at least over the last four years, and profit has varied between about 5% and 7% of revenue for the HMOs.

CHART 1
MEDICAID HMO ENROLLMENT IN MINNESOTA

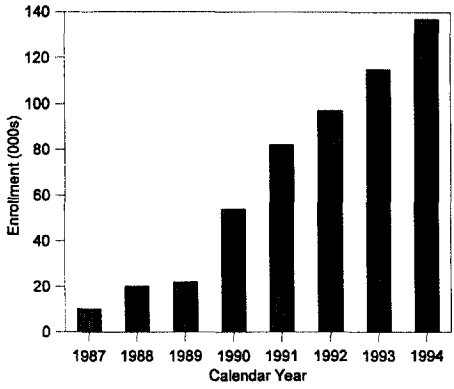
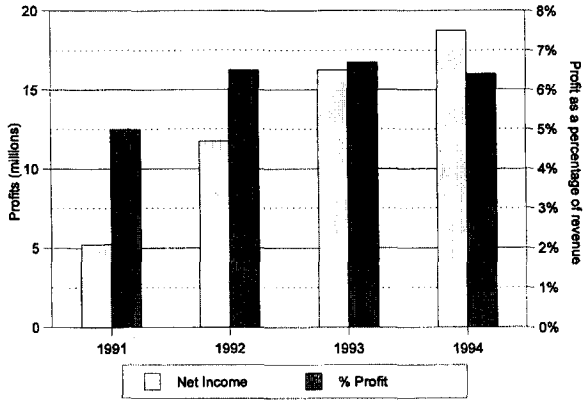


TABLE 2
1994 MEDICAID ENROLLMENT BY HMO

Rank	HMO	Enrollment	Percentge of Total
1	Medica	45,800	33.4%
2	U Care	35,500	25.9
3	Metropolitan	26,500	19.3
4	Group Health	19,800	14.5
5	Blue Plus	8,300	6.1
6	NWNL	1,000	0.7
7	First Plan	100	0.1
Total		137,000	100%

CHART 2
PROFITS FOR MEDICAID HMOS*



*Historical profits for the five largest Medicaid HMOs in Minnesota

Things weren't always so rosy in Minnesota. In the early years, a number of HMOs lost money, and three HMOs dropped out of the program, although some of them have subsequently come back in. One HMO, in particular, accounts for over half of these profits. It's one of those HMOs that focus on the Medicaid population, and that HMO has accrued over half of the total dollars of profit over the last four years. In terms of future profitability, it's likely that things will not be as rosy either. The State of Minnesota has taken note of these profits and will likely put the squeeze on the HMOs, which is to be expected.

In Minnesota we recently set up a work group. There have been a couple work groups set up to look at rate-setting issues, and we're participating in this recent work group. The group is looking over ratesetting and a number of the issues that apply. Currently, the rate-setting approach that we use in Minnesota is shown below, and this was the approach that was used to calculate the fiscal year 1996 capitation rates. Minnesota has used similar approaches over the last three to four years, although it tends to vary each year. Each year they tend to make little adjustments up and down, but the general approach has been the same, and it's a fixed-bid-type approach. The state will calculate the HMO capitation rate, and then the HMOs have to either agree to accept those rates or not. It's not the competitive bidding model that was talked about earlier.

Rate Setting for Medicaid Managed Care
(FY 1996 Capitation Rates)

Statewide Base Rate (FFS)	
×	Trend Factor
×	Area Factor
×	Age/Sex/Category Factor
×	Managed Care Savings Factor
+	Adjustments/Add-ons
=	HMO Medicaid Rate

When calculating the HMO capitation rate, they start with some historical claim experience in the unmanaged system on a fee-for-service basis. They apply some demographic factors, and then they reduce it because they want to save some money. There's a 5–10% reduction for managed care savings, and that assures the state that they would save some money. The end result is the HMO Medicaid capitation rate.

For fiscal year 1996, we took the statewide base rate based on experience during the 1990–93 fiscal years. We then trended that forward and applied a set of area factors. In Minnesota, the capitation rates have three different area factors. There's one area factor for Hennepin County which includes the city of Minneapolis. There's another area factor for other metropolitan counties. And then there's a rural area factor. And the variation between the high and low areas is about 20%. The rural areas have the lowest capitation rate, and Hennepin County has the highest capitation rate. There's also a series of age, sex, and eligibility category adjustments, and there's about 34 different cells by age, sex, and eligibility category.

The managed care savings factor ranges between 0.9 and 0.95, depending upon the eligibility category, which implies that there's a 5–10% savings. What this means is that for HMOs getting into this business, in order to be profitable, they have to lower

utilization 5–10%. They also have to lower utilization an additional amount so that they can cover their administrative expenses as well as any profit targets they might have.

The key rate-setting issue in Minnesota is what to do about the eroding fee-for-service-based claim experience. In Minnesota, as I mentioned, we take the historical claim experience, project it forward, make some adjustments to it, reduce it a little bit, and that becomes the HMO capitation rate. The question is, what are we going to do after almost all the eligible people are in some type of managed care plan? We have no more fee-for-service-based experience.

There were a number of approaches the work group looked at to deal with this issue. The first approach is called the projection approach, and that's what was used most recently. Under that approach you simply go back far enough in time so that you have a credible set of experience from which to project forward. You use that same set of experience in each future year, and you just continually apply these trend factors. You can imagine that over time the base experience may have very little to do with what you're projecting.

Another approach used to deal with this problem, and this is only a short-term fix, is what we called the area factor approach. In Minnesota, in some particular counties, almost all the eligible people are or will soon be in some type of Medicaid managed care plan, and so there will be no more fee-for-service-based experience on which to calculate the HMO capitation rate. One way to deal with that is if you have other areas within your state, you can use that experience, apply a geographic adjustment factor, and then use that as your capitation rate for the area in question.

Experience rating is another option that was examined, and competitive bidding is an option that is used in many other states, and that's also the option that the rate-setting work group favor, at least the government representatives on the rate-setting work group. So, it's likely that, in the future, Minnesota will be implementing some type of competitive bidding process, and I hope it's scheduled to be on line in one to two years. Another thing that the government looked very fondly upon, at least considering recent profits, was some type of profit-sharing deal. If the HMOs were profitable, the government would keep a portion of those profits, although I don't think they've considered what happens if the HMOs lose money.

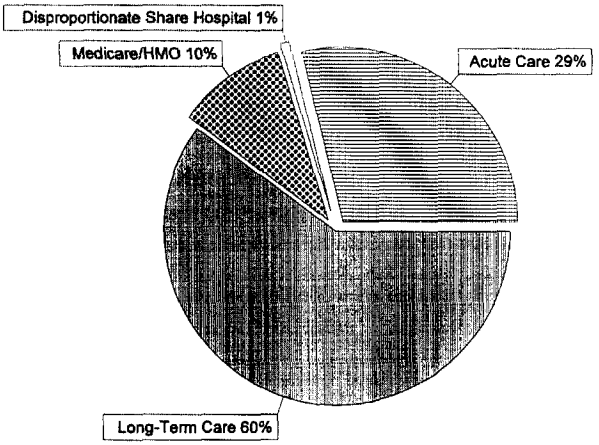
Another hot topic in Minnesota is the long-term care options project, and that is a state-run project. Minnesota recently received approval from HCFA to start this demonstration project, and it's scheduled to run for over six years. The purpose of the project is to integrate long-term care and acute care, both the delivery of the care and the financing, and try and make one entity responsible for the quality of the results and for the financial results as well. Under this program, the State of Minnesota would contract with various managed care organizations to provide long-term care and acute care, and in return, those organizations would be paid some type of overall capitation rate. The target population for this is what's known as dual eligibles, which is people who are eligible both for Medicaid and for Medicare.

In Minnesota, there are about 420,000 people in the Medicaid program. Of these, 55,000 are aged, and so that's the dual-eligible population. Thirteen percent of the total Medicaid population makes up the dual-eligible population. Seventy-five percent of the Medicaid population in Minnesota is in AFDC and related categories. And then 12% of

the Medicaid population consists of disabled people and blind people. As was mentioned earlier, this is the breakdown of the population, not the breakdown of the dollars. Seventy-five percent of the population, AFDC in Minnesota, creates only 25–30% of the Medicaid expenses. So if the state wants to control costs, they're going to have to focus on the aged and the disabled populations, and they're also going to have to focus on long-term-care expenditures.

Chart 3 shows a breakdown of Minnesota's expenses by type of service for Medicaid. In Minnesota about 60% of total Medicaid expenses goes towards long-term-care services which includes home health, nursing facility care, and so forth. Nationwide, it's much lower. It's about 35% of total Medicaid expenses for long-term care, but it's still quite significant. About 29% goes straight for acute care. Ten percent of total payments go on towards HMOs for Medicare. And then there's a small payment for disproportionate share of hospital payments.

CHART 3
MINNESOTA MEDICAID EXPENDITURES BY TYPE OF SERVICE (1993)



The goal of the long-term care program in Minnesota, as I mentioned before, is to coordinate care, both the long-term and the acute-care pieces. The hope is that will improve the quality of care and obviously the efficiency and thus lower cost. Minnesota hopes to decrease cost shifting. The current emphasis is on controlling Medicare costs, and people have been doing quite well, by lowering hospital admissions and lengths of stay. Much of that cost has shifted towards nursing home expenses and other long-term-care expenses, and that, to some degree, has shifted cost from the Medicare program to the Medicaid program. Minnesota hopes that by combining the financing for these programs, it can capture some of those savings and thus reduce some of the cost increases in the Medicaid budget in Minnesota. Another goal is to lower administrative costs, both government administrative costs and insurance company administrative costs. The last goal is to manage both the long-term care and total health care costs.

There are a number of programs already in existence that combine the acute and the long-term care. There's On Lok/the Program of All-Inclusive Care for the Elderly (PACE)

program, Social HMOs and Evercare, and these programs all differ from each other. They also differ from the long-term-care options project in Minnesota. They differ in terms of what type of population they serve. They also differ in terms of what benefits are included. For example, the PACE program only covers frail, elderly people that are in the community. It doesn't cover people that are actively in the institution. Social HMOs cover some Medicaid people, but generally, it's just a small portion of the Medicaid population. And Evercare is another program that deals with just the people that are already in the institution. In Minnesota, the long-term-care options project was designed so that it would incorporate both people that are in a nursing facility as well as people that are in the community.

This is just a summary of some of the aspects of the long-term-care options project. The benefits, of course, cover Part A and Part B Medicare services. It also covers Medicaid home- and community-based services, and those tend to be directed at the frail elderly, people that could qualify to be in a nursing home but want to stay in their home and receive home health and receive personal care attendance and so forth to make it possible for them to stay in their home.

The HMOs that contract are also going to be at risk for six months of nursing facility costs for people that enter the nursing facility while they're covered under this program. So, they're not at risk for the five- or ten-year nursing home stays, but they are at risk for a portion of the cost. And the funding for the program comes both from Medicare and Medicaid. They've built up the funding arrangements based on the Medicare capitation rates and the Medicaid capitation rates in Minnesota. HMOs will be 100% at risk for the financial results on its program right off the bat, and, as I mentioned before, the population that will be served will include both elderly that are in the community as well as elderly people that are already in some type of nursing home or institution.

Table 3 shows how they built up the rate cells for this program. There are a number of different eligibility categories shown by the columns across the top which have different capitation rates associated with them. The first column shows the different benefit components. The second column is the first rate cell which is nursing home residents (people already in an institution). Those people receive higher capitation rates, as you'd expect.

Nursing home conversions is a temporary category. It applies to people that were in a nursing home for five to six months and then came out of the nursing home. They get this category for a one-year period after they come out of the nursing home, and this provides a slightly higher payment to the health plan, even for those people that came out of the nursing home; otherwise there would be somewhat of a disincentive to move people out of the nursing home and back into the community because the health plans would immediately start to receive a much lower capitation rate. Nursing Home Certifiable in Community is another risk cell or rate cell, and that consists of people who are frail elderly but are living in the community, such as in their home or apartment. They're not in a nursing home, and those are people that would be certifiable to be receiving benefits in a nursing home, but through home health care and other home- and community-based services are able to maintain an independent residence. The last rate cell is other community-based recipients, and that would be basically the healthy elderly that are living in their homes and apartments.

TABLE 3
LTC OPTIONS PROJECT—PAYMENT TO PLANS

Benefit Component	Nursing Home Residents	Nursing Home Conversions	Nursing Home Certifiable in Community	Other Community-based Recipients
Medicare	95% of Inst. AAPCC	2.39 x AAPCC	2.39 x AAPCC	95% of Non-Inst. AAPCC
Medicaid	Inst. PMAP Rate	Inst. PMAP Rate	Non-Inst. PMAP Rate	Non-Inst. PMAP Rate
Medicaid Nursing Facility Costs	N/A	N/A	NF Add-on	NF Add-on
Medicaid Elderly Waiver Costs	N/A	2 x Avg. Monthly EW Payment	Avg. Monthly EW Payment	N/A

Our firm was assisting the state in designing some of the rates and reimbursement for the program, and most of the rates are built up from numbers that already exist. They're built up from the Medicare adjusting average per capita cost (AAPCC) rates which are calculated by HCFA. They're built up for Medicaid based on the Medicaid HMO capitation rates that already exist in Minnesota, and that's what a PMAP rate is. It's simply the HMO capitation rate for Medicaid in Minnesota.

One of the pieces that did not exist was additional compensation to the health plan for the risk they're taking for nursing facility care. As you recall, they're at risk for six months of nursing facility care, and so they needed to have some compensation for that. We've been involved in calculating that capitation rate, although, as is quite common, there have been some data problems and some delays in the programs. We haven't yet finalized what that additional piece is going to be.

The last piece of the reimbursement is for Medicaid elderly waiver services, and that's for home- and community-based services for people that are living in the community but would be eligible for nursing facility care.

MR. JOHN W.C. STARK: I'm going to discuss some of the differences between commercial HMOs and Medicaid HMOs, and, as Guy said, I'm going to be speaking from the view of the organizations that will get squeezed or will have their profits looked at. I'm going to cover several topics including regulatory issues, benefits, provider relations, managed care, and underwriting techniques.

First, I'd like to talk a little bit about the Medicaid environment in Virginia. Prior to 1992, our system was administered on a fee-for-service basis with some utilization review guidelines that came into effect in 1994. In 1992, our Medicaid agency put into effect the Medallion program, and, as Jim Roberts said, this is a PCCM-type program. It was voluntary. People could choose between the Medallion program and the current Medicaid program, but it was not statewide. It was being phased in. Now under our PCCM program the PCPs were paid on a fee-for-service basis, and they received a management fee. Over the years this ranged from, say, $1 to $2 per member, per month.

In 1994, we implemented the options program, and this is our Medicaid HMO. This went into effect the first of July. This was a voluntary plan. Medicaid eligibles could choose an HMO or the Medallion program wherever options was in effect. The traditional (if you want to call it) indemnity type plan was dropped in these areas. This covered only the AFDC population, and, as Jim pointed out, we had rates specified. There was no bid process. Plans would apply. If you were accepted, then you would participate in this program.

This year [1995] the program remained just about the same, except we had to cover the aged, the blind, and the disabled. Now, in Virginia, in the areas where this plan exists, these were only about 10% of our eligibles, and this was based on looking at the member months for certain areas. Also this year we now have to pay for transplants. These were carved out before. Beginning January 1 we're going to have a new mandatory program called Medallion II. Also, this is going to be selected on the basis of a bid process. Over the past several months, we've been helping our HMOs get the bids ready. We currently have about 4,500–4,600 people in our Medicaid HMOs, and we have them in three sites in the state.

If you're familiar with our geography, our first site is on the lowest peninsula, Hampton-Newport News area. This started in February of this year. Our other site is in Norfolk-Virginia Beach area, and our newest one is in the Richmond, Virginia area.

The first thing I'd like to talk about is our contract that we have to sign with the Medicaid agency. Don't take for granted that this will be similar to your commercial contracts. Read it carefully. You've probably heard this before. And if you have a period for comments, don't be shy about letting your Medicaid agency know your concerns.

Most commercial policies have a provision that states if a group changes carriers, and if somebody is in the hospital, the prior carrier has responsibility for that person up until a certain point, either when the person leaves the hospital or some other point is reached. Our Medicaid contract didn't have that, and luckily, this year, they changed that. That might not sound too bad, but we had a serious episode there. A mother enrolled in April. and had delivered a baby in December. Our administrative systems were just getting geared up, and we still had a few kinks to get out. We assumed the baby was at home. It's an actuarial assumption. We found out, in May, when the hospital called for a preauthorization for an operation, the baby had never left the hospital, and to make matters worse, this hospital was not in our network. So you can imagine that we ran up a fairly high bill. Make sure your administrative systems are up and running. Make sure you've read the contract because this is an open-enrollment product. You must accept all risk.

Next, I'd like to talk a little bit about regulatory issues, and I can speak from the Virginia standpoint. I'm not quite sure what happens in other states. In Virginia we have to deal both with our Medicaid agency and with our Bureau of Insurance. The Bureau of Insurance regulates HMOs in our state. We don't have to file rates for approval, yet they do approve our contracts and other materials. Also, in this setting, the Bureau of Insurance had to approve our Medicaid agency's contract with us. Also, our benefits had to meet the same standards that HMOs have to meet. What that meant was we had to increase our inpatient nervous and mental slightly because the HMO statute requires something a little richer than Medicaid. We also had to add inpatient substance abuse

because Medicaid doesn't cover that, but the HMO statute does require it. Hopefully, the capitation rates that our state put out included that. They weren't major changes, but they saved a little bit of money. For the current year, our Medicaid agency got a waiver. So, we only have to cover those benefits that are required by Medicaid.

One thing you need to make sure of is that your Medicaid agency and your Bureau of Insurance are working together. We recently got caught in a real bind. The new contract was supposed to go in place, yet some of our materials had not been approved, and we didn't feel like we could use those materials without our Bureau of Insurance signing off on them. Don't take for granted that your Medicaid agency is shepherding your applications or any of your other materials to the Bureau of Insurance. Take an active role in that.

I'd like to talk about benefits next. Some of the benefits are very similar and some are very different. In Virginia, the children's benefits are very rich. Services for adults are scaled back. For example, adults 21 and older have 21 inpatient, acute days, for a 60-day period. However, they're unlimited for children. As Jim mentioned, some of the services get carved out. For example, as I mentioned, we didn't have to cover transplants. Also, I hear some states don't cover nervous and mental under their HMOs. They're carved out under the Medicaid agency. This can be a real problem because, in theory, the HMO is supposed to manage all the care, and suddenly, when you start carving out some of this, you take that theory and start to tear it apart a bit. As Jim pointed out, capitation rates include nonmedical items.

In Virginia, we have to pay the cost of graduate medical education. We feel good about that because that supports our providers. We also have to pay for transportation, and that's fairly standard. There are access requirements, and they may differ from your commercial requirements that are imposed on you by other groups, your state, or yourself. For all I know, they may differ from Medicare HMO requirements if any of you have those. Also, we have some exclusions. We don't have to pay for disproportionate share, services provided by public schools and community service boards, and we don't have to cover individuals in the state mental institutions, nursing homes, or intermediate care facilities.

Provider relations are very interesting in this type of environment. One thing you may want to do, and we have chosen to do this, is be very generous with your PCPs. You're going to be relying on them to help change behaviors, to do more work (in their eyes), and to take on some riskier patients. You may have to pay them your commercial capitation rate or a high percentage of it. If you choose fee for service, your fee schedules will probably be closer to your commercial rates than to the Medicaid fee schedule. One thing that we had thought about was to pay our PCPs on a fee-for-service basis and capitate the specialists. This would do several things. It would be more generous to the PCPs. It would have specialists do more of the work that they're supposed to be doing and have them send more of the primary care work back to the PCPs. It sounded good in theory, and we talked probably more about it than you would think, but we decided not to do it. Some of the provider reimbursement people thought that this would confuse the issue, and confuse the PCPs, because, on the commercial side, we capitate them.

Another thing we have talked about is using specialists as PCPs, and this is especially pertinent in the AFDC population. We found that the obstetricians and gynecologists already provide some of the primary care for the mothers, and we've also found out that some of our competitors allow obstetricians to be PCPs. At one of our sites, we've contracted with a large community physician practice, and these doctors were the physicians-of-record for about 40-45% of the Richmond Medicaid population. Once we signed up with them, they sent letters to their patients notifying them that they had signed with us and were encouraging them to contact us for any further information, and it's a little too soon to tell how successful this strategy is.

Next I'd like to talk about something a little more actuarial—risk management and managed care techniques. Some of the commercial risk management and managed care techniques either aren't available or just won't work with this population. There's no underwriting. It's all open enrollment, and if you try to do anything that even smacks of underwriting, such as targeting certain risks, your Medicaid agency will probably be in touch with you as soon as they figure it out. There's no cost-sharing to control utilization, especially emergency room usage. There are no out-of-network penalties. You have to be more creative in getting your Medicaid eligibles to not go to the emergency room, to stay within your networks.

Some of the managed care techniques that work for Medicaid eligibles run counter to those that are used in the commercial world. Suddenly you'll want to encourage utilization. This is something that's pretty foreign to us. You'll want the mothers to get pre- and postnatal care. You'll want people to start seeing PCPs to make sure that an illness doesn't develop into something that requires a hospital stay. Another thing you might do is allow a longer hospital stay if a person's home life is not conducive to a successful recovery. As I mentioned before, this ties back a little bit to reimbursement. You'll need the help of your providers to really change this behavior since there are no financial incentives for the Medicaid eligibles to change. Managing the care is made very difficult by the high turnover rate. People can gain and lose Medicaid eligibility on a month-by-month basis.

There's no lock-in provision in Virginia. What this means is if someone selects us, they can select somebody else the next month. Suddenly, there's not the continuity that you see in the commercial world where people sign up with an HMO, and they stay there for about a year until the group changes carriers or has its next open enrollment. One thing you find is that it's more a combination of managed care and social work. One thing we've done in Richmond is to have membership counselors. They'll call individuals and welcome them to the HMO. They'll talk to them about their benefits and how to use their benefits. They point out alternatives to the emergency room, and generally try to educate people on this new kind of product. Another thing this will do is it will let us get high risks into case management immediately. Finally, this is used as a real gentle marketing tool. The counselor can say, "If you have friends that need coverage, just remember us."

My last topic is data. This is something that ought to wake everybody up. We're actuaries. We love this stuff, right? The best data is from your own plan if you're in this business. The next best type of data is from your state Medicaid agency. One of the things people asked us when we were starting to develop these plans is, can we go to another state to get their data? They ought to give it to us. And we balked at that. The

benefits and eligibility can vary significantly. Also, another thing to consider is what's the prevalence of Medicaid HMOs in other states? That would have a significant effect on how to interpret the data. Another thing that's probably not surprising is the data that you get from your state Medicaid agency is not normally in a form needed for actuarial analysis. For example, data was for paid dates, not incurred dates. It included the PCCM and the Medallion program data. Even though, for some of the periods that we had data it was not widespread throughout the state, we still wanted to know if this had significant effects, and we couldn't split it out.

Another thing that is problematic is when you want to capitate, you'll probably want to capitate PCPs. We capitate our primary care physicians. We also capitate other services such as durable medical equipment. Normally, the data that you'll get, at least in our experience, is not in a form where you can break out those claims easily, and, as a result, when you're doing proforma for management who needs to make a decision as to whether or not to enter this business or stay in, you can be a little liberal or a little conservative. Conservative is not bad, is it?

It is important to have clinical data, and one of the things we used this for was to sit down with our utilization review people, and make assumptions on how much we could save if we put in certain managed care techniques, pre-authorization and all that. Then we'd sit down and say, "Look at this list of diagnosis codes or current procedural terminology codes. Do you think we can really save this much?" It's kind of a useful exercise. The other thing is clinical data will help your utilization review people set up their programs. They'd like to know if they're going to see things that are similar to what they see in the commercial world.

In addition to the numerical data, you'd obviously want the actuary's report, the report from the person who developed the capitation rates. One thing our state put out was a fact book that had all kinds of information about the history of Medicaid and budget projections. It was just chock full of data, and we found it was very helpful. Talk with your Medicaid agency. We found out that in the year since this was in place, they had begun doing a little managed care of their own. They started doing audits on the neonatal intensive care unit claims. All of a sudden, those claims dropped a little bit. This was an area that we had thought we could save some money on as well, so they took a little bit of our profit away. Well, be that as it may, if we hadn't known that, we would have probably come up with an inadequate estimate of the managed care savings.

MR. RONALD E. BACHMAN: What I want to do in my part of the presentation is step back from the trees a little bit. You heard some very specific examples of the Medicaid risk. Now let's take a look at the forces and the economics that are driving us. In my business, as a consultant, I'm working with all the players around what I call the health care table. I have clients that are HMOs and insurance carriers, hospital systems, and physicians. I'm seeing all this from different perspectives.

I'm a little curious about the audience members and some of the work that you all are doing. How many either work for or are consulting directly in the health care business? I assume most people here would. How about those that are, at this point, mainly on the commercial side of the business? How many on the Medicare side? Very few. How many people are involved in Medicare risk contracts and pricing or you're developing products and offering them under the Medicare programs as they exist today or will be

doing it as a natural follow-up to that under any new legislation? How about those specifically working in the Medicaid, which is obviously the topic here. One of the things I'm seeing from that response is that this is a new area with some possibilities.

I would say that if you're an actuary working in the traditional commercial marketplace, you might not have had a great deal of experience in Medicare or Medicaid. We've seen from the techniques and the approaches and the products a lot of the differences, but there are many similarities as well, and I would say that if you're not thinking about and learning about those areas for your organizations, you're really missing where the next couple years' focus and profits are going to be in these organizations.

I like visual images, and I'd like, if nothing else, to have you leave with this thought in mind: traditionally we had two, separate industries. We had the traditional providers of care, the hospitals and the physicians, and you had the financiers of care, the insurance companies and HMOs. We now have a trillion dollar health care economy. By itself, it's the eighth largest economy in the world. It's about the size of the economy of Italy and some say about as confused. And we're going through this merging of industries.

With all of the other legislative changes that are going on in the marketplace, what I see happening is these two giant industries merging, and I'm not so sure that ten years from now people who choose an insurance program at their location of work, or even if they choose a Medicare or a Medicaid program in the future, are going to know whether that organization started as an insurance company that went out and bought their own physicians, built their own clinics, and maybe bought their own hospitals, or started as a hospital system that went out and got a license to sell insurance or obtained an HMO license and took on risk or capitation or whatever and are responsible for risk. I think much of what you hear throughout the discussions, whether it's about Medicaid, Medicare, or commercial insurance is this image of the merging of the industries and the shifting of risk.

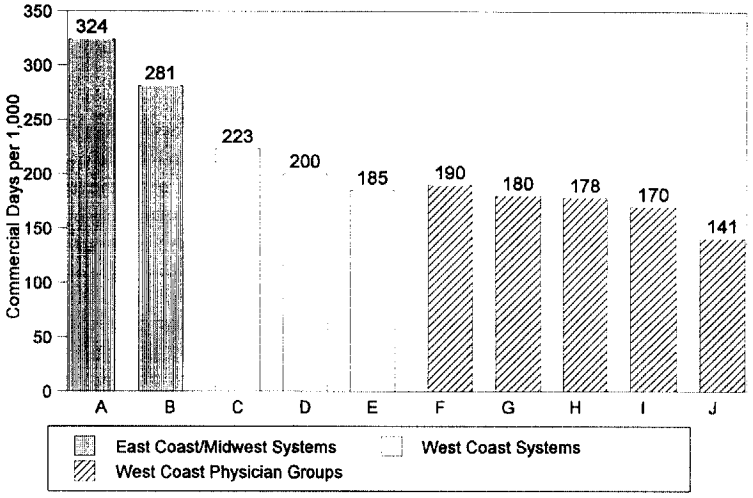
I see the hot potato of risk, if you will, shifting back to the providers of care, and it all has to do with managed care of one type or another. You have all these major players that sit around the health care table that have similar interests. They want to put as little as possible into the health care pie and take out as much as they can justify. That's the client base that I work with. Many times I feel like I'm a lawyer. I'll take the prosecution or the defense, or whomever will pay my bills.

What's driving the economics? Why are we talking about Medicaid today? And why is the House probably going to pass the Medicare legislation? What's happening with market reform? Let me show you something that to me kind of drives home the issue of the economics. One measure of cost is inpatient days per thousand. You can take a lot of different measures, but that's maybe an easy one for the general public, if not all of us, to relate to as well.

Chart 4 shows a geographic difference. On the left side we see the East Coast and some Midwest systems' days in the hospital per thousand. This is the commercial market, and I want to relate this to Medicaid and Medicare. We're still running about 300 days per thousand in many of the East Coast systems. When you go to the West Coast, days per thousand drops below 250 days per thousand. West Coast systems that are run by

physicians or directed by physicians have days per thousand below 200. We see the best practices out there with 150 days and as low as 130 days per thousand.

CHART 4
EAST COAST AND MIDWEST SYSTEMS
PERFORMING AT HIGHER UTILIZATION RATES PER 1,000



What happens when you contract out at this level, and you begin to implement managed care, and you deliver care at these levels? There's a great deal of money to be made. Who's making that money today? HMOs, insurance companies who have taken the risk in that business. You're riding that curve down over the improvements in the days per thousand. Hospital systems and physicians have felt the pain of that. The gain has gone to many of the people taking the risk in the insurance industry, but the pain has been felt by the providers. They're sort of waking up and saying, in many areas we're down into this part of the curve, and now we're being asked to take on risk in the commercial marketplace. There's no financial advantage to take on risk after all the excesses have been weeded out.

It's a great time to shift risk back to the providers if you're in the commercial business. Make it take the risk, and you can lock in your profits. But how does that relate to what we're talking about today? The two largest entities in the fee-for-service marketplaces are Medicare and Medicaid, and there's a tremendous parallel. The providers are saying we're not going to get snaked this time. We want to be involved and take that risk, and we're going to make the money off of the gains. That is why, in the Medicare legislation, you see a new animal that's being developed called a provider-sponsored organization (PSO), where the providers of care are going to be allowed, under Medicare, to take on risk directly. I think we're going to see the same thing once that's in place, and if it does pass, we'll see a successful transition of that same concept to the Medicaid and the commercial markets.

Controlling the growth of Medicare and Medicaid is going to give you the key to how we're going to balance the federal budget and balance state budgets. If you take a look at what has happened on the commercial side, by sort of looking at inpatient days as a proxy, there has been roughly a 37% decline in commercial days per thousand, which is a pretty significant change. In some areas it's even more. In other areas where you're not into the evolution of managed care yet you obviously haven't experienced that.

Let's discuss Medicare, and then we'll move on to Medicaid. On the Medicare side, in a fee-for-service market, the rates are being based on the fee-for-service, much like we heard about rates being based on the Medicaid side. The days per thousand averaged over 2,900 days per thousand population. In an HMO Medicare risk contract the average is 1,300, and it's dropping down to a thousand. I made a speech in Seattle recently where there was a California HMO representative. He said his HMO's days per thousand were down to 750. Now, if you're getting paid on the basis of a formula that starts with paying you 95% of 2,900 days per thousand, and you're able to deliver care for 750 days per thousand, there's a lot of money to be made. If the federal government can start to tap into that savings, rather than the 5% savings, there are hundreds of billions of dollars out there. And it's that savings that they're expecting to put back in to encourage the growth of the Medicare risk contracts as they open it up to new forms. That's where a great deal of the savings is going to come from on the Medicare side.

On the Medicaid side, as was mentioned, it's usually one of the biggest items, if not the biggest and fastest growing items of state budgets. The reimbursement is sort of a parallel. The average Medicaid nonmanaged care is running over 900 days per thousand, and you typically get, as was mentioned, in states 90–95% of that number as an organization. Well, with fairly minimal managed care you can get that down to about 550.

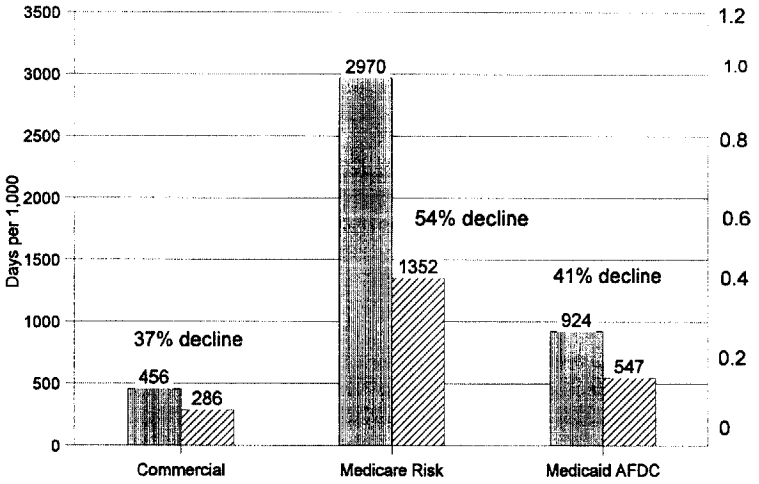
I have a client in Florida that brought that down. They were getting paid on more than 700 days per thousand, and they got it down to 250 days per thousand, which, in some commercial markets, is pretty good. They're actually delivering care on the hospital side for one-third the number of days, which is a two-thirds reduction in the days per thousand. This organization started off by capitalizing themselves with $3 million to get into the Medicaid risk business. They sold 18 months later for $64 million. There's a lot of money to be made in here, not just in the profit margins but in who owns that membership base once you put these people together.

The states are looking at that, I believe, and are saying, "We can make a lot of money. We can cut our costs by moving to managed care, and we're going to move to managed care aggressively because we can save that kind of money. We can cut our Medicaid bills in half, and we can also take a look at eligibility questions. We can take a look at a lot of the other issues of managed care." But the providers are saying, "If we're going to do that in the Medicare and Medicaid marketplace, that's the last bastion of fee for service; the biggest dollars are out there, and we want to be a player. We want to take on that risk and be able to do it directly. We're not going to get snaked like we did on the commercial side where we went through the pain and somebody else got the gain."

So the big battle right now is going to be over who, in fact, can take risk and whether providers of care can form their own networks, take their own risk, and become insurance carriers. Also, what are the requirements for those going to be?

Let's focus on Medicaid in Chart 5. We're seeing non-HMOs at 924 days per thousand, and HMOs are down to 547. This information comes from the Group Health Association of America (GHAA). The key here is that all these players around the health care table are organizing managed care organizations, and they're playing one or more against the others. You have venture capitalists and entrepreneurs that are also coming in and developing new structures and organizations and putting in some of the seed capital to do this. The economics are so strong that this is going to continue to be a hotbed of activity. It's a tremendous area for actuaries to bring in an idea of the risk-sharing and risk-shifting that's going on, to be sure that the organizations that are being set up, in fact, understand risk because most of them don't, especially on the provider side. They don't understand the risk. It's foreign to them, and they're in danger of not being able to handle it properly.

CHART 5
MANAGED CARE SAVINGS—IMPACT OF CAPITATION



We provide consulting support to a number of states around the country. Out of our office we provide support and consulting efforts to Texas, Mississippi, and North Carolina, in particular. As a firm, we work with Oregon, Washington, Colorado, and others. Most of these organizations or states are trying to find ways to get the waivers that were mentioned earlier—the 1115 and 1915 waivers, so they can put in these programs and begin to realize some of these savings. The Clinton administration has been pretty good about getting those done. They always seem to take longer, but I think 44 states now have some kind of waiver, and others are still in the works and various new forms of waivers are being requested. The savings potential here is something that they are being allowed to tap into. The next big wave, as we see it, is something called block grants. Rather than waivers from what's going on within this Medicaid federal/state program, the federal government is just going to give block grants (total blocks of money) to the states and say, "You handle it." What's going to happen is the states are going to say, "Well, we can't take the risk. We need to get these organizations involved to take the risk, and they can do sort of a pass-through." The states know that there are organizations out there that want to do this because of the money that's involved.

They're actually using, in my opinion, the marketplace to solve the problem by taking on risk to be able to deliver care and create a whole managed care structure for this population. There are many special needs and unique aspects. If you're in the managed care business on the commercial side, as was mentioned by several examples, it's not the same. Your network doesn't necessarily look the same; the benefits, the eligibility, the administration, and the data are different. It all looks different. But from an actuarial side, I would say that there's a tremendous opportunity to start thinking about areas where actuaries haven't traditionally been that involved. I think the next 24–36 months is going to be a hotbed not only for the Medicaid area but for the Medicare area as well.

MR. STEPHEN A. MESKIN: How much money was saved in Hawaii by the competitive bidding over what Hawaii would have gone out with if they had set the Medicaid rate at the beginning, or on a percentage basis?

MR. ROBERTS: If they had set the rate, they presumably would have used an analysis similar to what we provided them. So, they sort of had their secret answer in front of them, and then, when the HMOs and other organizations bid their price, they basically used their crib sheets to negotiate that price. In reality they received competitive quotes fairly similar to what they were expecting to get. Because of all the usual conflict-type problems, we were not direct participants in the negotiation process. We just gave them the up-front analysis. As consultants, we're not exactly cognizant of what the first-cut submissions were, but in most cases, they were higher than what they ended up agreeing on.

MR. ANTHONY J. HOUGHTON: I have one question. Jim Roberts mentioned that there were some nontraditional benefits in Medicaid such as transportation and special counseling. Could anyone give some indication about what percentage of the total amounts have to be spent on these special types of benefits other than on the traditional medical care?

MR ROBERTS: Honestly, Tony, I don't remember the answer in the case of Hawaii. I think the costs are going to be very different for some of those programs state by state. So, I'm not sure a global answer would be applicable. My sense is it's something like less than 5% but not much less. I think Hawaii was more significant because of the high transportation costs.

MR. HOUGHTON: Was it under 10%?

MR. ROBERTS: Yes.

MR. BACHMAN: For those of you who are trying to learn more about the area, there's a publication that I just received that I thought was very helpful and I can recommend to you. It's called "States as Payers: Managed Care for Medicaid Populations." The states and private sector are leading health care reform. This publication is a series from the National Institute for Health Care Management dated February 1995. It was actually prepared by the National Institute for Health Care Management. I thought it was an excellent write-up and has a state-by-state analysis of some of the programs and the exposures.

MR. MICHAEL GERARD STURM: This question is for Mr. Bachman. You had made reference to PSNs, a.k.a. PSOs, mentioned in the House Republican bill, the Medicare Preservation Act. That bill mentions special treatment of these organizations. I know there has been some concern lately of insuring organizations, or what type of special treatment they'll receive. Do you have any viewpoints on that? Will it be a nonlevel playing field? How do you think insuring organizations will react?

MR. BACHMAN: Well, it's a good area. It does focus more on Medicare than the Medicaid topic at hand, but I think it's appropriate because by being able to allow providers to get together and take on risk directly, we will see that paralleled in the Medicaid area. So, the test here is will it pass, what will it look like, and what kind of guidelines will wind up in the Medicare program? It's a real battle going on in Congress right now. There's a power struggle between the insurance industry and HMOs that are trying to be sure that if any new player comes into the marketplace that they are on a level playing field, particularly with respect to solvency requirements and risk-based capital needs, and those sort of issues. The legislation doesn't have any details in there. I think you can be proud of the actuarial profession's input, because the legislation actually mentions the American Academy of Actuaries (AAA) as being one of the organizations to be consulted with as the development of the provider service networks takes hold. So, there's an involvement of the Academy at that level.

There's also an Academy task force that is headed by Guy King that is taking a look at and responding to the legislative writers on that issue. They were very interested and concerned about recent meetings with the Speaker of the House's office and the legislation that's being written. What should those solvency requirements be, and can the Academy help to input to that?

There is a process going on, and there's a big debate. I believe the outcome will be that there will be a level playing field. There will be probably some upset on the carrier side that it may look too favorable towards the providers of care, and the providers of care will be upset because it looks too restrictive for them. I think the best we can come out with is if everybody is equally unhappy, we probably have done the right thing.