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Medicare/Medicaid Risk Contracting—Profitability

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Recorder: WILLIAM J. KLUNK

Summary: Panelists discuss sources of profit/potential risks for a company entering into Medicare or Medicaid risk contracts.

Mr. John K. Heins: We have three distinguished panelists. Our first speaker is John Ninomiya. He recently left a position as vice president of health data analysis with PacifiCare Health Systems, which is the nation's largest Medicare risk health maintenance organization (HMO). He's currently pursuing his master's degree in health policy and management as well as the completion of his FSA designation. He will be discussing Medicare risk profitability from three different perspectives.

The second speaker is Jon Gabel. He just rejoined Peat Marwick in April. For two years prior to that he was the director of research with the Group Health Association of America (GHAA), which is a trade association representing over 370 HMOs nationwide. Jon has authored more than 55 articles on financing and the economics of healthcare. His topic will also be Medicare risk; he'll be focusing on bias selection and the HMO spillover effect.

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†Mr. Gabel, not a member of the sponsoring organizations, is Director of Survey Research at KPMG Peat Marwick in Arlington, VA.

Our third speaker is Steve Sherman, who is with Milliman & Robertson (M&R) in the Milwaukee office. His expertise is in group healthcare programs and healthcare providers. He has had extensive experience in both Medicare and Medicaid risk contracting, but he'll be sharing his expertise on Medicaid with you. Last but not least, our recorder, Bill Klunk is with the Richmond office of William M. Mercer. With that I will introduce John Ninomiya.

Mr. John K. Ninomiya: Although PacifiCare knew at the beginning of the year that I was going to be leaving their service in May, they were very excited about my attending this meeting and speaking to this group. I think they feel, as I feel, that Medicare risk is a very significant product area, both in terms of its potential profitability and also in terms of being potentially a solution to some very serious social problems that we face with respect to funding the Medicare program.

I'm going to talk about profitability from three perspectives. First from the perspective of regulators, particularly in terms of the adjusted community rate (ACR) process. I'll also talk from the perspective of the health plan, and finally from the provider perspective.

REGULATORY PERSPECTIVE

Well, I guess the general underpinnings of the regulatory and payment mechanism behind Medicare risk are probably fairly well known to this group. Basically the payment mechanism is set up in such a way that fee-for-service Medicare is taken as a benchmark (i.e., what it would have cost to provide services to people under normal fee-for-service funding). From that benchmark, the government, in order to save money, takes 5% off the top. Beyond that, these payments to the health plans are capitated risk payments. There are no retrospective adjustments, no cost reporting. This was quite a breakthrough when it was first introduced as part of the Tax Equity and Fiscal Responsibility Act of 1982 legislation.

There are restrictions, however, on profitability as defined in the ACR process. (I guess regulators believe in market processes and competition and the invisible hand of the market—but not too much.) To the extent that the ACR provides excessive profitability, additional benefits must be provided to the Medicare beneficiary.

There are some issues with this general framework. First, there's the issue of risk adjustment, specifically whether the 95% of what it would have cost under fee-for-service medicine is really 95%. Jon Gabel will be speaking a bit more to some of those very serious issues.

Second, you have to question, in some areas, whether the fee-for-service is a good benchmark. For example, in some rural areas the standard of care means driving

200 miles to go to the hospital in Tinyville. In these areas, the healthcare cost and, therefore, the adjusted average per capita cost (AAPCC), are extremely low and aren't really set up to fund an HMO-style program with reasonable access to care. Similarly, we know that in some parts of the country there are substantial fraud and abuse in the Medicare program, and there is arguably overutilization in certain markets. All of that gets reflected in the AAPCC payment.

Third, there's the issue of the tail wagging the dog. As we move into markets with penetration in the 30–40% range, you start to wonder whether pricing based on fee-for-service medicine continues to make sense when nearly half the market is already in Medicare risk contracts. A further issue is bias selection. If healthier people are going into the Medicare risk contract, then what's left in fee-for-service, which is the basis for the pricing, is going to be a sicker population that will overstate what the true AAPCC should be.

There's also a question of whether the tail needs to be connected to the dog at all. When I talk with colleagues who try to operate Medicare risk contracts in some lower payment markets, they look at me and look at the payment rates in some of these southern California markets, and figure they are based on corruption, graft, evil, or something of that nature. They question whether it is fair that the AAPCC should be hundreds of dollars less per member per month in certain other markets. That's an important policy question.

Finally, there's the issue of whether the 5% savings is a reasonable thing or not. I guess to a certain extent the value of services being provided to beneficiaries being 5% less opens some questions as to whether Medicare is in some sense a program that should be providing the same actuarial estimated value to all participants or whether the government really should be free to take 5% off the top.

Let me talk just briefly about the ACR process. I would summarize the ACR process as follows. (For those of you who have done one, I think you can nitpick about this.) This is just a broad sort of conceptual overview. Basically profits from Medicare risk, generally measured as a percentage of premium, should not exceed those on commercial group business. This is the first requirement of the ACR. Second, profits would be defined for this purpose as anything other than healthcare cost, so profits would include marketing, administration, etc. Compliance with this requirement, however, is based on prospective estimates of relative commercial and Medicare risk costs. Therefore, there are no retrospective adjustments. Whatever you can reasonably justify up front is what goes into your ACR, and no one checks afterwards to see whether that came out to be true or not.

Finally, any excess profits (again with this strange definition of profits) are deemed savings and are used to finance additional benefits, and so the calculation goes on and comes up with an ACR. To do this, one simply takes the base rate, which is based on a commercial program cost, and adjusts it to an initial rate, which reflects what it would cost to provide Medicare-style benefits to commercial beneficiaries. Then one makes a "volume and complexity" adjustment (also known as the utilization factor) to reflect the differences in utilization and unit cost between your commercial program and Medicare risk. The result is an ACR, which is, according to regulators, what it should cost to provide Medicare benefits to a Medicare population.

As an illustration of this, let's say that your commercial program had a $22 per member per month cost for inpatient hospital. You would adjust then, and in this illustration you'd add on a dollar because, maybe, your commercial HMO program didn't cover as much mental health and chemical dependency as Medicare does. And then you might take off ten cents per member per month because your commercial program does not have these lifetime limits on inpatient care. Your adjusted initial rate then is $22.90. You make a complexity and volume adjustment based on your historical data: 1,000 days per 1,000 for Medicare versus 200 days per 1,000 on your commercial HMO implies a factor of five. An average cost per day of $1,500 versus $1,400 implies a complexity adjustment of 1.07. So the volume and complexity factor is 5.35, and the ACR is 122.

Finally, you add up all of these adjusted community rates, you add in profit as a constant percentage of premium, or actually as a constant percentage of healthcare cost. That is compared to the average payment rate (APR), which is your estimated AAPCC based on demographic adjustments unique to your enrolled population. Any deficiency of this APR versus calculated healthcare cost and administration can be charged as a member premium, or any surplus, on the other hand, must be used to enhance benefits. Your other option is to give the money back to the Health Care Financing Administration (HCFA); however, I haven't heard that many plans are doing that. This is an ACR calculation example.

There are some issues with the ACR, and because I have filed them for ten years for one of the largest plans in the country these are some fairly opinionated observations. What's wrong with the ACR process? First, an historical problem that has been somewhat remedied recently is the issue of the commercial rate basis. About ten years ago, when we started doing this, we asked HCFA what is the appropriate commercial rate basis for all of these calculations? They would say, whatever you filed with your state regulators they have appropriately scrutinized it and it stands the test of reality. In fact, that made a lot of sense in some heavily regulated markets in the east. In some other states, though, as many of you are well aware, the

requirements for rate filings with the states are either very minimal or nonexistent, so the basis upon which this entire structure has been erected is not necessarily sound. Recently HCFA has moved towards making sure that whatever you say your commercial rate basis is, it actually ties out to your actual revenues a little better; they have recognized that as a problem.

Second is the issue of capitated services. When we were developing, at PacifiCare, what we thought was the value of capitated services (and we tend to capitate a lot of things), we initially went to HCFA and said we generally know what our cost per capitations are going to be under the Medicare risk program next year; therefore, the ratio between that and what we're paying on our commercial program must be the volume and complexity factor. They said that was wrong; you have to do it based on some sort of utilization and some sort of unit cost. Then we asked if that meant we have to do it based on physician encounter data that do not come in very accurately and completely and about which we must make a lot of fairly subjective judgments before they are even somewhat reasonable. They said, that's what we have to do, and that was frustrating.

A related issue is the issue of complexity versus unit cost. And again, a lot of the ACR thinking was developed by people who came out of staff model backgrounds. Kaiser had a lot of input into how this was initially set up. They talked about the intensity of service as a unit cost driver, but they didn't really talk about the issue of what goes on in the marketplace. Medicare and fee-for-service are notoriously a very bad pair.

In addition to comparing the actual level of utilization and intensity and case mix of services there's a very significant issue that enters into your cost under Medicare risk, which is the fact that Medicare fee-for-service doesn't pay that well. Providers are willing to accept a lot less money than would be theoretically fair based on adjustments for clinical complexity and utilization. That's not taken into account, and that leads to some serious problems in the accuracy of the ACR.

Another issue is that a constant percentage of healthcare cost is what you're allowed for administration. Again, at my former employer, we had some markets where we sold a lot of small-group and individual products. Our loss ratios tended to be very low in those markets. Therefore, in those markets our loss ratios on Medicare risk could also be very low. That's how the machinery works. On the other hand, we had some other markets where we sold a lot to very large groups. Our medical loss ratio was quite high, and in those markets that was the acceptable loss ratio for Medicare risk. So again, Medicare risk is so different in terms of its administrative requirements of being an individually enrolled program that one wonders if it is equitable to have this constant percentage of healthcare cost in your margins as

being what is permitted, but that's the way it is. In sum, this whole process becomes somewhat disconnected from reality, just on the basis of how you're supposed to do it.

Beyond that we have issues with the review process. A former chief actuary of HCFA once offered the comment that the people who review the ACR are from an actuarial perspective, not qualified to do so. Indeed, the people who review the ACR are people who have financing and accounting backgrounds, and once a year they have hundreds of these things fall on their desks that they have to process really rapidly. I think the quality of the work would be open to question. I think that to do a real ACR that really meant a lot would be a challenging job for an actuary, but I think for someone who comes out of an accounting background, who has to do hundreds at once, all at the end of the year, it's not reasonable to expect any sort of quality outcome. Again we had the issue with ACR of do you really believe in market forces, or do you believe in regulatory oversight?

And then we have the premium waiver problem. Once you've gone through all of these calculations you often come out with a number in your ACR that proves that you could really charge a lot more for your Medicare risk product than you intend to charge; therefore, that shows up in your ACRs as waived premium.

Several years ago, HCFA became quite concerned about this. It was concerned that the industry was not being very profitable at this business, and that it was competing so intensely that it was selling everything at a loss. Now you know and I know, based on the way the ACR works, that it does not necessarily represent how you are actually financially doing on this program. Much of what shows up there is simply an artifact of how they have told you to do this calculation. But we had people from HCFA come out to our lab and they were very concerned and asked us if we were alright, if we were sure we were making money at this. We said, yes, we're making some money at this.

HEALTH PLAN PERSPECTIVE

Next I'd like to talk about profitability from the health plan perspective. Key determinants of profitability include environmental factors and some issues with the delivery system and some other things that I've just lumped together as other factors. Under environmental factors, we have the AAPCC or APR, which is a term that HCFA uses to bid. We can compare PacifiCare Health Systems to the U.S. per capita cost (USPCC). This is from some of PacifiCare's key markets, the actual AAPCC and the APR, net of their demographic adjustments, and there is quite a spread in the level of reimbursement. Some of the markets were actually fairly close to the U.S. national USPCC. Other markets, like Los Angeles, are quite high,

and some markets that they were just moving into in south Florida, for example, are even higher than that.

A great deal of attention gets paid to the AAPCC payment rates and the APR. What this says to me is that there's a lot of potential viability in this program, even in markets that are at or potentially a bit below the national average payment rate. Now when you get into the bottom 25% of markets, which are largely the rural markets, I think you need to start questioning whether the program is going to fly. But I think that within a large range of payment rates there's substantial viability in the program.

Another issue that you have to look at for potential profitability would be the size of the market. You must consider not only the overall metropolitan statistical area (MSA) size but the percentage of people who are Medicare eligible, which can range from the high single digits in some MSAs, like Dallas for example, to near 20% in some of the south Florida counties.

Another environmental factor that is important to profitability is market acceptance of managed care and risk. Being first in the market with a product like Medicare risk is not always advantageous. There is a learning curve in the market. People need to know about this and come to accept and understand that it is a stable, ongoing, legal sort of thing. So being first isn't always good. Being second can actually be quite helpful in terms of your profitability and ability to penetrate the market. Competition and rates, both with other Medicare risk products in the market and with Medicare supplement products, can be important to your success in the marketplace. Provider issues are important such as over- or undersupply of providers in a given market, whether providers in a market currently accept the assignment, or whether they still balance bill the remaining allowable amount. Also consider the issues of delivery system integration and sophistication (i.e., what's out there that you can contract with).

Delivery system and contracting are clearly central to your profitability. First consider the transfer of risk and incentives. In my opinion, Medicare risk seems to be a product that is extremely volatile and highly leveraged. It is a product in which sharing of risk and incentives with providers seems to be pretty much unavoidable, and the nature of the sharing cannot be limited to a 10% withhold which you hope that providers won't notice when they don't get it back. It needs to be fairly profound in nature, and I'll show some models of how that might work in a moment.

I think when you're doing this, it is important to understand whether you think of risk transfer as a means or an end unto itself, where "unto itself" would mean that I,

the insurer, am transferring risk so that I don't have to worry about risk at any level whatsoever. Risk transfer and incentives "as a means" means that I, as an insurer, want to set up a program that will, over the long term, ensure that we have a viable delivery system that makes money, is prosperous and that the health care providers have every incentive to create that delivery system. So again, depending on whether you view risk transfer as a means or an end, you can end up with very similar sorts of contracting arrangements. But I think the way that management looks at it can be very important in terms of their philosophy and ultimately the success of the program.

Who then is going to take this risk on the risk-bearing delivery system? I think the issue is making sure that there is a provider that is ready to take on this sort of program. (I would argue that this is a more difficult program to succeed in than just a commercial HMO program, where if you can knock a few days per thousand off the inpatient stage, you can share that back to everyone, everyone can give up their withholding, and you make some money.) This is really difficult and requires, I think, a risk-bearing delivery system that has good internal leadership (position leadership as well as administrative leadership) and that has the infrastructure and resources to contract with you on a risk-bearing basis.

Now I'll talk about how my former employer would go about dealing with these contracting issues. At the top level there would be a premium coming in; there's both the APR payment from HCFA and a member premium that would be put into the pot. There would be a contractually defined split between the health plan, the physician group, and the hospital. The health plan would retain responsibility for out-of-area claims and perhaps certain other ancillary benefits; they would take responsibility for marketing, administration, and have some load for profit. The physician group in an Individual Practice Association would be contracted to provide all physician services. It could provide services directly as a group or contract out; it had that subcontracting responsibility.

Then there is the hospital, both outpatient (OP) and inpatient (IP). The hospital (with IP and OP) could be capitated or we would set up some sort of a risk budget. Actual hospital claims based on per diem or diagnosis-related group (DRG) or case-rate contracting would be compared to that budget, and money would be paid back to the physicians, to the extent that hospital utilization came in under that budget. In the case where the hospital was capitated, you would use the same process; however, you would just look at the utilization of hospital services, value them according to some agreed-upon methodology, compare the dollar amount of services based on the valuation to the actual capitation and, to the extent that the physicians kept utilization under the level of actual capitation, maybe the hospital would give the physicians back some money. On the other hand, to the extent that

the physicians didn't abide by their utilization management rules and utilization went through the roof and we blew through the actual capitation, perhaps the physicians would give the hospital some money.

Clearly, based on that sort of structure, one can evolve a health plan that has a level of guaranteed profitability. Now there are issues with what happens when your providers blow up entirely and you have to go bail them out, but there can be a large degree of insulation from risk. The question for the health plan in this scenario is, having gotten out of the insurance business, what does the health plan actually do anymore? That is a question that some capitated providers are asking rather vigorously during contract negotiations.

Some final perspectives on profitability from the health plan perspective. If you have contracted away a lot of your risk, then a lot of potential for profitability is really based on volume and administrative efficiency. One issue is the willingness of providers to roll over their existing Medicare patient base into your program, as opposed to only participating on an incremental membership basis. This is very important because if all of their Medicare patients go over to Medicare risk, then they will take Medicare risk seriously, and it is a product that demands being taken seriously. The second issue, of course, is marketing expense: covering your fixed cost and all at once having a few thousand members on the roll, rather than having to build up to that over time. In addition to that there are other types of marketing issues with the types of direct response marketing that you might do.

PROVIDER PROSPECTIVE

Finally, I would like to talk about this from the provider perspective. First I'd like to talk about what I meant earlier when I said this is a highly leveraged sort of product. This is either a health plan concern, to the extent that the health plan is maintaining substantial risk in the product, or, if everything is capitated out, this becomes a provider concern. Some numbers will illustrate this principle of leverage. (These numbers are not some sort of universal U.S. average number. They are taken from a particular market that we did projections for some years ago, based on actual PacifiCare experience.) Of course, Medicare utilizes a lot more healthcare than commercial, a fairly obvious sort of observation. What is interesting though, is the ratio between various types of care. How much more overall utilization and how much more expense is there?

The ratio of Medicare to commercial cost per member per month is 3.67; however, when we split it into various types of care, we notice that primary care comes in at a ratio of 2.55. Specialist medical doctor comes in at a ratio of 3.24, and hospital (including hospital outpatient, outpatient surgery, etc.) comes in at a ratio of 4.54. So there's four times more utilization in hospitals, whereas for primary care it's

something like only two times more utilization. What this means (to me anyway) is that, in Medicare risk, your primary care doctor certainly has a high-volume role and not just in terms of providing more services per member per month. The primary care doctor, to the extent that he or she is involved in some sort of gatekeeping utilization management function, is less important as a provider of care but more important as a manager of care. There are these huge dollar amounts out there in hospital care that could potentially either break the banks or generate some savings, which again can go back to the primary care physician or to the health plan. In that sense, we would say that management drives profitability in these programs, and that's a sense in which this is a highly leveraged program.

In terms of measuring profitability from the provider perspective we see a couple of different things. There are various cuts you can take at fee-for-service equivalency. First, there are your income sources, including capitation, fee-for-service payments, stop-loss payments, incentive program payments, co-payments, co-insurance, and coordination of benefits, which occasionally comes up, although not much on the Medicare side.

Referral costs are costs that a capitated entity incurred for providing care through subcontracted providers. These providers perform services that are capitated but not provided by the health plan's internal physician group. You would value services rendered based on either fee-for-service charges, Medicare fee-for-service rates, etc. You would do this calculation comparing either income or income less fixed outside costs as a percentage of the valuation of services internal to your capitated group. Or you could just do the value of all services rendered as a ratio to all income.

Again, when you have a primary care medical group accepting full physician capitation, and, therefore, responsibility for all specialist care, you enter into another type of leveraging (i.e., a situation where to the extent that the capitated group is managing what it's spending outside well, those profits would go back to the capitated primary care physicians). In any case, you can compute a fee-for-service equivalency or income divided by services, or you could turn that around and calculate a loss ratio. Again, the issue with referral cost is whether you net them out or include them.

MEASURING PROFITABILITY

I had an experience in which one of our providers contracted with a consulting actuary. This was an actuary who came out of an employee benefits consulting background. So this actuary was looking at our Medicare risk contract, and had done some reading and had heard about this thing called the ACR. He obtained a copy of it and, based on that, told his client that it was waiving all of this premium.

It means that the fair value they should be charging should be a lot more money. You're being shortchanged, and you should argue a lot about the contract. Well, using the ACR in this fashion is clearly problematic. I wanted to offer the thought that it's not very accurate. It's something like taking statutory financial for a life company and saying that you can look at those and get a deep understanding of the future profitability of the life company. It just doesn't make any sense. However, it has been done, so I thought I'd note it.

How could you best assess the profitability of a program? One way would be to reprice all the services provided to a fee-for-service Medicare equivalent, based on local resource-based relative value system payment rates, DRG payment rates, etc. You could compare that to the capitation that is being paid and determine how many cents on the dollar you would have received under regular Medicare. An issue that comes up within the DRG payment categories is acuity or intensity of services. There are also issues of administrative expense and billing (providers in a fee-for-service setting attempting some balance billing). I think that would be the fairest way to do this.

What I would tell providers when I was at my former employer was that they should consider the notion of doing well versus doing better. A Medicare risk contract can't say that what we are going to pay a provider is necessarily fair or just or reflects their cost of becoming educated or the late hours they spend or the many ethical dilemmas that they face. What we can say, though, with a fair degree of certainty, is that there's a good potential for doing better than they would have under a fee-for-service Medicare payment.

There are other approaches to measuring profitability. One task that we were given at PacifiCare was to look at targeted income. We made some assumptions about what would happen if doctors were to roll over their entire patient bases into Medicare risk contracting. The assumptions included 700–900 patients being a complete practice (for primary care), overhead expenses that you would have in having this fixed cost staff, other hard dollar expenses, things that you have to subcontract that you were capitated for that you weren't set up to provide directly. We would look at that and, based on this theoretical notion of having all of your practice devoted to Medicare risk, we would ask how much total income would doctors receive? And that was a very interesting task. Again, we could make some fairly good cases about Medicare risk being able to deliver incomes that were very competitive in the market, for primary care physicians in particular. Much of it was driven by the notion of leverage, the participation that the health plan would give the primary care physician, and all of the savings that were achieved on the hospital side and on the use of specialty physicians.

Having done all these calculations, I ask, what actually happens within an IPA or medical group? In terms of who gets what money, there are a fair number of these entities operated on some sort of fee-for-service base draw, where all of the money that comes in from the outside was lumped into a pool. Then they look at the value of the services under fee-for-service that had been provided and they paid everyone *X* cents on the dollar based on the discounts inherent in the contract and on a reduction for administrative expenses, etc.

Many capitated entities that our plan was dealing with, in a more sophisticated market, tended to move toward salary plus bonus arrangements with the individual physicians. There would be payments for productivity, patient satisfaction, and financial utilization results either on a group or individual level. So there is this whole issue of mushing together versus trickling down. Do the incentives that you spend a lot of time engineering as the actuary actually trickle down to the individual physician? The answer is, no. The average physician usually does not know that under Golden Senior Care 2000 Plus the referral services pool is offset against the physician incentive fund; whereas, under other programs it might be the opposite. They don't really understand that.

In that sense, the understanding of the incentive is what really drives behavior. The opportunity with incentives is not that we're going to be able to go back and ding the doctor for $2 per member a month if things don't come out right. The thing that's important about incentives is creating the level of belief that it is important to behave in a fashion that will contribute to the long-term success of the health plan and the provider entity. So it's the level of belief that you create with incentives that matter, in some sense, more than the potential to take money back.

Who does mind the dollars and cents then? Well, we've seen the growth of large sophisticated provider entities, who have professional management of various types, who are often either hospital-based or provider-based entities, or who may be publicly traded companies. We see professional managers, lay people, or physicians who take over, and these are the people who are generally scrutinizing your contract and who do know which risk pool flows into which risk pool and understand all that; these are the people who are going to be gaming your system, so that understanding is out there. It just comes from people other than the doctors. The provider administrators are the ones who are auditing your payment arrangements, monitoring profitability as best they can, managing or gaming the system, working with this internal mushing together of all the funds and the payments of individual physicians. They also serve as a buffer between the health plan and providers in terms of what sort of spin control they put on things. They might say that PacifiCare is a good health plan, and we are making a ton of money on them. On the other

hand, they might say PacifiCare is a bad health plan, and you shouldn't be too pleased to be a part of that. They are controlling how the doctors perceive that.

BEYOND PROFITABILITY

To close, then, I think there are a lot of issues that go beyond profitability. From a strategic perspective there's the issue of your provider contracting arrangements: what you want the provider arrangements to evolve into over time. Would you give up some short-term profitability in order to finance the development of a risk-bearing system? There are also issues regarding provider exclusivity, which to a nonstaff model plan can be a very important issue. Getting your providers to say that you are the only Medicare risk contract that they will take part in may be very important.

Other strategic issues might include operational issues, especially for a provider-based entity. Hospital-based entities, in particular, operate from a lot of perspectives that don't always make bottom-line sense; they have to do with cementing their physician relationships and controlling larger books of business outside of your Medicare risk contract. The second issue beyond profitability would be provider self-determination. I would distinguish this concept from provider autonomy, which generally seems to mean that physicians can do whatever they feel like. Provider self-determination, rather, would be the ability of providers to participate in managing the cost of their product, to have some financial participation in the rewards from successfully managing their product, to compete like other business entities in a marketplace based on cost, quality, and service. In that sense, they have the ability to take more control of their destiny and to move toward being part of a solution to a social problem rather than a generator of a social problem.

Finally, from the health policy perspective, I think a lot of time has been spent (and certainly I spent a lot of time over the past ten years) discussing with the HCFA whether the AAPCC was too high or too low. This is very important. A great deal of money is tied up there; however, I think if we really had the kind of visionary leadership that we probably will never have in HCFA (or probably really can't have because it's ultimately all driven by what happens with Congress), we could focus on more important issues. Do we really care if we are paying 1% or 1.5% or 5.7% too much or too little in the AAPCC? Over the long term, the real question is, to what extent can we move people away from this totally unmanaged inter-generational Ponzi scheme setup that we have in fee-for-service medicine? To what extent can we move them from that into a system that potentially can have some accountability for cost or some accountability for quality? Compared to that, arguing about a few percentage points on the AAPCC seems rather shallow.

Mr. Jon R. Gabel: I want to present findings from two studies that I commissioned in my former job at the Group Health Association of America. The irony of these studies is that they were conducted by Jack Rogers at Price Waterhouse, who is one of my competitors; I think the studies are done very well.

Now let me bring you back to the winter of 1995. Recall that the Republicans, for the first time in 40 years, had just taken over control of the House and the Senate. They wanted to balance the budget in seven years, and they had to cut $270 billion from the Medicare program according to their plan. Representing the HMOs at this time, we, of course, thought the way to save money was to promote risk contract HMOs for the reasons that Mr. Ninomiya just very eloquently described.

You may also recall at that time that the Congressional Budget Office (CBO), which scores all legislation, said that risk contracts were not saving money from Medicare. They were losing money. The basis of this was the Mathematica study, which looked at data in 1989 and 1990 and concluded that Medicare was losing about 6% on each HMO member. The reason they were losing money was because the healthier beneficiaries were enrolling in the risk program via selection. So Medicare was paying more than if they had remained in fee-for-service.

We wanted to disprove the Mathematica study and we wanted to demonstrate that the HMO group was the best way to save money. Now we have two studies; the first one is going to look at the question of bias selection. Do the healthier people really go into the Medicare risk program by demographic cell? It doesn't matter if the people who enroll in the HMO are all 65–70 years old. What really matters, from bias selection, is whether the people who are 65–70 years old in the risk program are essentially the same as in fee-for-service. If that's the case, Medicare is not losing money.

Let me give you our conclusion. Medicare is saving money on the risk program; we did not find selection effects, and more importantly, from the second study I'll show you, we found a spill-over effect. That means that the very presence of HMOs in a market forces physicians to change the ways they practice medicine, and they practice more conservatively. As a result, fee-for-service costs are lower with the presence of HMOs. That was our conclusion.

Let me add, in presenting these results, that we have the perspective of Main Street and Wall Street. And Main Street and Wall Street, as you well know, can hear the same music but hear a different song. When Main Street hears Beethoven's "Ode to Joy," Wall Street hears it as "Death Knocking."

The best illustration I can give you is back in 1994, when I was at GHAA, we did a survey, which we did every year, of annual increases in premiums. We reported for the first time that premiums were declining. At the association our mind-set was on Main Street; it was on Capitol Hill. We were going to show them how wonderful HMOs were in controlling cost. We had a press conference and a press release, and, next thing I knew, my phone was flooded with all kinds of phone calls from the investor community. We collapsed all the people who were paying my salary. I had sent their stocks down about 20% in a very short period of time. It took about a week or two for the stock to bounce back, but there was a question for a week or two about who my next employer was going to be.

BIAS SELECTION

Now let's go to the bias selection study. Our objectives were to examine whether HMOs enrolled healthier individuals to see whether Medicare was overpaying for those individuals and to estimate how much the people who enroll in HMOs would cost, if they had enrolled via fee-for-service. The data we used were from the Medicare Current Beneficiary Survey. This is a household survey per thousand elderly, which HCFA conducts. I think it's an excellent survey. From the household survey we have data on such items as product conditions, self-reported health status, social demographic characteristics, attitudes about healthcare, supplementary health coverage, and most importantly, for the fee-for-service population, you have a summary of their claims experience so you can match all this other information to the actual claims experience of each beneficiary.

What were the methods we used? What was most important was we tried to replicate the Mathematica methodology. We argued that a couple of years later the program had grown and the people who were in the program had matured. They were regressing towards the mean, meaning that people who are healthy are going to tend to be sicker over time and look more like the other population. So we selected all the people in HMO risk programs, which amounted to 371 people in the sample. We matched them with everybody from their county who was in the same demographic group, meaning the demographic cell of the AAPCC controlling for age, for institutional status, for Medicaid status, for age, and for sex. So we're matching these people. There were about 1,700 in the match sample.

Our observation unit is the individual, and I will tell you what we did. First, we made descriptive comparisons between the risk population and the match sample. Then we used the econometrics technique to ask questions such as, what if these people who are in the HMO had been enrolled in fee-for-service? How much would they have cost based on their characteristics? When we did the econometrics work, we used a two-part model. The first equation says, what's the probability of this individual using Part A services or Part B services? And then second, if they

do use services, how much do they use? After we get the regressions we take the characteristics of the people in HMOs, we plug in their characteristics into that same regression, and we can estimate how much they would cost fee-for-service. I understand I've gone through this very quickly, but I want to emphasize the results rather than the methodology.

Let's go to the results. First, as you probably know as actuaries, if you had one variable to predict people's use of services, other than last year's use of services, it would be people's self-designated health status. When we compared the two populations, the fee-for-service group and the HMO risk group (again this is the match sample), we found that the people in HMOs were slightly healthier. They had slightly more people who are in the excellent category. On the other hand, they were on the poor side; there were slightly more people who are in the poorhouse but overall healthier on the HMO risk side.

Then we looked at chronic conditions, which again, as you know, are very good predictors of next year's utilization. When we looked at chronic conditions we found, I believe, a balance of imbalances. Sometimes HMOs had a sicker population, and sometimes fee-for-service had a sicker population. For example, the fee-for-service population was more likely to have cancer but less likely to have had diabetes. It was more likely to have angina and other heart diseases but less likely to have hypertension. This population was more likely to have hardening of the arteries, and less likely to have emphysema. The HMO population is more likely to have a broken hip, have partial paralysis, but the two populations were equivalent on the loss of a leg diagnosis. So when you look at chronic conditions they look very much the same. We also looked at the demographics, and one thing was very apparent. People who go into the HMO risk program tend to have lower income overall than those who go into fee-for-service. They are much more likely to be African Americans; they're much more likely to have lower levels of education. This itself seemed to make a difference between the two populations.

We did our econometrics work, which means we plugged in the attributes of the people in HMOs, and said, how much would they cost in fee-for-service? The result was that statistically there was no difference between the two groups. Now recall that when Mathematica used the same dates they said there was actually an 11% difference, but when you include the 5% discount going to the risk program you get an overall 6% difference. Our conclusion was they were equivalent, so based on this alone, there's a 5% savings to the Medicare program. That is the conclusion of part one.

We move to part two which shows the spill-over effect, which is in a sense a more important story. Let's just think about the spill-over effect for a moment. Think of

physicians who practice medicine. They probably have a difficult time distinguishing between whether a fee-for-service patient or a risk patient was in the office. If an HMO forces them to be more cost conscious in ordering ancillary services or in their hospitalization patterns, they will probably behave similarly when a fee-for-service patient comes in. This is the basis of a spill-over effect.

We are not the first people to study the spill-over effect. I can cite some of these earlier studies. There's one by Welsh. There's one by Mathematica. There's one by Baker, and this is the fourth one. Every one of them found the spill-over effect. In fact, the Mathematica study found a very strong spill-over effect, so strong that they said it was implausible and discounted it in their final results. If they had paid attention and had taken their own work seriously, they would not have concluded that Medicare is losing money. Instead they would have said that Medicare is saving money as a result of the risk program.

Our objective here was to examine the effects of risk enrollment on Medicare fee-for-service cost and see how Medicare outlays change as the risk population increases in a county. Let me just tell you about the study data. The data are from the Office of the Actuary, the AAPCC master file, 1988–92. It includes data on county enrollment and expenditure data. We supplemented it with data on the area resource file on things such as the number of hospital beds per capita and the number of physicians per capita. For our study methods, we used a fixed-effects econometrics model, which means that each county has a dummy variable where we try to capture unobserved variables. What we're trying to measure is the changes over time with risk populations in a certain county. We tried to use different specifications to ensure that we had robust coefficients, meaning that they didn't seem to fluctuate greatly when we changed the regression specification. We weighted by enrollment, meaning we wanted Los Angeles County to have more weight than some rural county in Nevada. Our key variable is the HMO risk penetration rate. Our central hypothesis is, as risk penetration rate goes up for Medicare, that the fee-for-service cost, and all other things held constant, go down. We also wanted to look at the overall HMO penetration rate because many people said it wasn't the total number of people on Medicare and the total in HMOs that made a difference. Nobody had ever tested this before, and we did this for the first time in the study. Our other variables included income per capita, physicians per capita, and hospital beds per capita.

We thought that there would be great potential, even within the risk program itself, to reduce the number of hospital days, which is a major savings. In the risk program alone, there are tremendous differences in descriptive data and the number of hospital days per thousand members. Hospital days per thousand are as low as about 1,000 in the west and as high as about 2,500 in the east.

The data showed that from 1988 to 1992, more people were being enrolled in fewer counties in the U.S.. They tended to be the higher AAPCC areas (for example, Miami, southern California, Arizona, Oregon). Just 25 counties had the majority of the people actually in the risk program.

Before I get to the results, I just want to say what I believe are the advantages of Price Waterhouse over the previous study. Number one, they had more recent data. Number two, we were able to isolate the effects of the Medicare risk penetration versus the overall HMO penetration and decide which one is really doing the work. Number three, I thought there were some technical econometrics improvements.

Now we get to the results, and we find different specifications. We were happy with the robustness; they were in the same direction, meaning that they don't seem to be that different. They indicate that (everything else held constant) a 10% increase in the county risk penetration rate reduces fee-for-service cost by 7%. That means that if we could increase the risk penetration rate from 20% to 30% in a certain county, fee-for-service cost per capita would be 7% less, which is a strong finding.

Let's take this out to the aggregate. If you could increase enrollment from 6% to 8%, it would save about $2.1 billion. If you could increase it to 10%, it would save $4.6 billion. If you could increase it to 20%, which is a very substantial increase, you would save about $17 billion. At the extreme, and with a great deal of uncertainty, if you get to 40%, you get about a $40 billion savings. In other words, we thought there were great savings for Medicare if they could increase enrollment in the risk program as a result of its spill-over effect.

Let's look at the aftermath of the study. I have left GHAA, but the study was actually leaked out by its authors which maybe got it more publicity than if we had held a press conference. In April, *The New York Times* cited the study on its editorial page as a reason for promoting risk contracts to save Medicare. The Republicans in the House cited the study, and it entered into the debate. The CBO and HCFA are now replicating these studies, attempting to disprove them. HCFA is working on 1994 data, which has a substantially larger risk population, but their data are not complete yet. They will be coming out with their results fairly soon, and, needless to say, HCFA's Office of Research and Demonstrations is furious about the study. From my point of view, the fact that all these organizations have taken the study seriously, speaks to the credibility of the study and the fact that it was well done.

What are some conclusions we can make from the study? We're going to have to go back to Wall Street and Main Street. First, I'm going to speak from Main Street's perspective and from Capitol Hill's perspective. Number one, I believe Medicare (rather than losing money on Medicare risk contracts) is earning money; therefore, Medicare should promote risk HMOs. From the point of view of the HMOs themselves, the bad news is HMOs will become victims of their own success. The more they penetrate the market, the lower fee-for-service cost will be, the lower the AAPCC will be, and the lower their profitability will be.

Now let's turn back to Main Street. If the CBO took our numbers seriously (and you know how very substantial the savings were), there's some very good news. If they were to use our numbers, it looks as if the federal government could spend like a Kennedy Democrat, tax like a supply-side Republican, and balance the budget all at one time.

Mr. Steven J. Sherman: We're going to change tracks and move from our senior citizen population to government programs for our poorer population. I'm going to talk about Medicaid, which is a federal/state program to provide medical coverage to poor people. I'm going to focus on major financial and clinical and operational considerations that my associates and I have found are really vital for a risk-bearing organization to take into account, if they want to be successful covering this population.

First, I want to talk about very basic things pertaining to Medicaid. Let's take a look at who's covered. I have some 1990 data as published by HCFA; I like to use this data. What I find striking is that we're seeing that Medicaid programs are covering about 20% of Americans ages zero to five. I guess the reason I think that's interesting is because your family has to be fairly impoverished to get into this program and, in almost all cases, you're in a single family household to get in that program. That's telling us that about one-fifth of the kids ages zero to five in America back in 1990 were in families with low incomes, probably below $1,015 a month.

Now I want to look at the defined eligibility groups that people can be in to qualify for Medicaid programs. In this presentation, I'll be focusing on Aid to Families with Dependent Children (AFDC)-related programs. These are programs related to assistance for families with children. I think everybody's probably aware of AFDC recipients. These are the families that receive cash grant welfare through the AFDC program, which if you live in Wisconsin as I do, you hear about the AFDC program everyday in the news. There's much activity towards reforms and changes in this program.

The second group is a whole group of programs that I call additional children. You might hear them referred to as Sixth Omnibus Budget Reconciliation Act (SOBRA) children, which relates to the Act of Congress that requires states to include some extra children from families where the family income is a little above the normal level that you'd have for Medicaid enrollment. Finally, there are aged, blind, or disabled groups, which I won't get into very much in this presentation. These are people who qualify for supplemental social security income (SSI) grants because they are aged, blind, or disabled. Obviously this population is going to be older and more disabled than an AFDC-related population.

In addition to the groups I just mentioned, which the federal government requires to be covered, there are also some optional eligibility groups that states can cover at their discretion. States like to cover these groups because the federal government will pick up a portion of the cost for covering them. First you have children and pregnant women at higher income levels than are mandated in the AFDC program. You also have medically needy eligibility categories. These are generally people who I would describe as near poor, but they have medical problems that are going to make them poor after they pay their medical bills. There are other programs that vary quite a bit from state to state.

I want to focus on a program's financials, so I want to lay out some of the basics. First, as I already mentioned, Medicaid is a program that's jointly financed by the state and federal governments. The capitated programs that put provider entities or health plans at risk have really been driven or motivated by the state governments; the states are trying to get control of their expenditures. What we'll see when we go through reimbursement is that states pay a fairly low reimbursement to providers, and states have really put their foot down on increases in provider reimbursement. It's important to keep in mind, as you look at accepting capitated risk for Medicaid populations, that the states have not been successful in controlling their expenditures by controlling their provider reimbursement. I think you can take that as a warning as you're looking to take on this population. In the words of George Harrison, "It ain't easy."

So states have developed capitated programs. From the states' perspectives, a capitated program is a great deal, because they can lock in costs. For the first time in years they'll actually have a good idea of what the cost per person in the program is going to be in the next year, and, similar to what was talked about in Medicare, the states also will lock in some savings for themselves. What I usually see is the state will base a capitation on its expected cost of the fee-for-service program minus 5–20%. For actuaries who are giving financial advice to organizations looking at

accepting capitations, it's important to look at how the states are developing their acceptable capitations, so the organizations know exactly what they're dealing with.

To go into capitations a little more in detail, one thing to think about is that a lot of states now have competitive bidding programs, where the state won't tell your client or your organization what the capitation rate is. Rather, you'll be delivered a lot of data and the state will ask you to come up with a best and final offer. Based on my experience, and based on the experience of some other people in the firm that I've talked to about this, I think the same issues apply in a fixed capitation environment as in a competitive bidding environment. In the collective experience of a lot of people who've dealt with competitive bidding, states have a fairly narrow range of where they expect your bids to come out, and if your bids don't come out for every eligibility category in their range, the state will give you lots of help adjusting your bid.

From the health plan's perspective, what we're left with at the end of the day (when we look at how the capitation is developed) is that your plan or organization is going to have to generate significant savings from what has been going on in your community in the fee-for-service system. Usually, in addition to the 5–20% savings that the state gives itself, you're going to have to generate savings in medical costs that are big enough to cover your plan's administration and your plan's profit margins as well. In most of the work I've done, I'll see that the necessary cost savings are going to have to amount to somewhere in the neighborhood of 25–35%, or possibly even more, of the fee-for-service cost estimate.

In terms of talking about the basics of AFDC-related Medicaid programs, I want to talk about some of the key financial management issues. We'll look at utilization, benefits, fee levels (which is really provider reimbursements), demographics, and administration. What we see in utilization is that the most crucial areas for savings are going to be in the hospital inpatient, the emergency room, and other hospital outpatient areas. These are the areas that, if you get a chance to look at your state's AFDC data, you'll see large utilization numbers and room for savings. Again, it's going to be important (in the words of another healthcare expert), to "focus like a laser" on these issues, because you're going to need a lot of savings.

I'll just throw out some general utilization numbers from a lot of different plans. On the hospital inpatient side, we look at fee-for-service Medicaid programs. I'll see utilization varying in a range from the high 400s to the high 600s or low 700s in terms of days per thousand. Then we look at health plans that we collect in my firm's HMO survey. We see the utilization numbers running more in the neighborhood of 300–500 days per thousand for managed health plans. In most of the

projections I do for clients, it seems like they usually need to get down somewhere into the 300s in order to have a successful program.

On the emergency room side, the utilization that we see in fee-for-service programs varies immensely based on what type of primary care infrastructure or system is available for the impoverished population in a community. The highest utilization I've ever seen was 1,200 emergency room visits per thousand. That was in a somewhat urban, somewhat rural area in upstate New York, where they had absolutely no health centers and the Medicaid reimbursement was low enough that the doctors could just refuse to see people. A more normal emergency utilization in a fee-for-service program would be in the 600s or the 700s. It seems like successful plans really need to bring emergency room utilization down quite a bit from those levels.

I want to look at benefits briefly. If you're familiar with these programs, this will be basic information; but if you're not, you might find it interesting. The Medicaid programs have extremely broad benefits. The way I normally look at it is they cover just about everything. Benefits include dental, chiropractic, transportation, and what I like to call nonmedical social services.

I want to focus on the transportation a bit. When we think of our commercial plans, we think of transportation as paying the ambulance when grandma has a heart attack at home or something like that. In an ADFC program, what we're really talking about is routine medical transportation. Those of you who live in urban areas probably see those vans driving around town with a big sign on them. They can pick up people in wheelchairs. It's really important, in your plan, to have routine medical transportation to make sure that the patients that you're going to be responsible for can get to their providers.

In the nonmedical social services, I think it's important to be aware of care that is beyond what we, in M&R guidelines style, would describe as necessary medical care. If you talk to clinical people, particularly emergency room people, you'll find that there are a lot of situations in which people in this population just have to stay longer in the hospital. With the children in the populations, you're going to come up with situations where you will have inpatient admissions without what you would consider a necessary diagnosis for a commercial population. I throw those into the nonmedical social services category.

You should also be aware that in several states there are limitations on the services provided under the fee-for-service program; I see this mostly in the southeast. One of the more common limits is the number of hospital days, and another common limit is the number of physician visits. For a health plan looking to accept capitated

risk for this program, it's important (if you're looking at a state where these limits existed in the fee-for-service system) to ask the person who calculated the capitation for the states whether they're going to be asking you to provide unlimited benefits for these services.

Fee levels are just an amazing subject for Medicaid. I recall back in about 1989, the first time I worked on a Medicaid project for our client, they sent me the fee schedule, and I told them there must have been a mistake. Their system must have divided all the numbers by three. They said, "You must be new to this kind of work." We all need to learn from our clients and other people in our companies. Medicaid fee levels are low; they're usually very low. They are sometimes what I would describe as, from a physician's perspective, catastrophically and unbelievably low.

There's a published study that looked at, I believe, 1992 or 1993 fees; I think this was published in a periodical called *Health Data Research*. The conclusion of that study was that on the average across the country Medicaid reimbursement averages about 70% of Medicare reimbursement. What was really interesting was the data they presented on a state-by-state basis. When you look at the data that way, you'll see that the fee levels are 30% of Medicare in some states, and 120% of Medicare in other states. That 30% is a really low number if you take a look at the relationship between billed fee levels and Medicare allowable fees in a lot of states.

In a risk program, if you're taking risk for Medicaid services, you need to be really careful about how you pay the providers. In most programs, the fees paid to providers are going to have to align with the Medicaid fees, rather than aligning with Medicare or commercial fees. There's just not going to be the revenue to your program to allow you to pay any higher fees.

The last comment is related to stop-loss. Since we're all actuaries I'm sort of preaching to the choir on this one, but it's really important for Medicaid. Any arrangement you get into that has a stop-loss or an outlier arrangement will be defined in terms of fees or charges or reimbursement. The results will radically vary the value of that stop-loss arrangement, whether it's based on billed charges on your negotiated reimbursement or on the states Medicaid fees.

I'll go through demographics briefly. AFDC demographics are a little different than the demographics you'll see for our commercial population. You're going to get a lot more kids. You're going to get a lot more young women, and you're going to get very few men over 30 or 35 in this program. The demographics for SSI groups are going to be much older, and the demographics will vary based on the portion of SSI eligibility that's being included in the program. Also, it's important to be

mindful of the demographic compensation of the enrollment that your health plan or your provider organization is going to get. That's particularly important if you're in a market or a region where people have the choice of joining an HMO or getting the Medicaid services through a fee-for-service reimbursement program. One remedy to that situation is that at this point the majority of states have capitation rates that vary by quite narrow demographic categories.

Administration is another issue you need to be mindful of. There's a lot of issues that will come up in terms of working with your state Medicaid agency that make administration for Medicaid enrollments a lot more complicated than you might expect. In addition to the administrative task, there's also a certain need for marketing. The health plan will need to do some type of marketing if Medicaid eligibles have a choice of health plans or, even more so, if there's a choice between enrolling in health plans or staying in the fee-for-service sector.

Marketing for Medicaid is a very interesting issue, because there are immense federal regulations that your marketing program will need to comply with. What we normally see is that a marketing program will be focused on what I would call soft marketing rather than hard marketing, using things like billboards and sponsoring community health fairs, and so forth. The administration of eligibility tends to be fairly difficult and fairly expensive for Medicaid populations. If you look at your state's data, you'll probably see that most of the people in an AFDC program are not staying there for more than six months. You have people coming on and off the program, and you also have another issue (which I don't think anyone truly understands) called retroactive eligibility. There's a lot of back and forth issues that a plan will have with their state agency based on what happens when an AFDC recipient has been in your plan for six months and then the federal government comes back and says, these people are disabled and they have been for the last six months. Therefore, they were covered under Medicare for the last six months, so you get into a lot of work sorting out those issues.

Other factors are important in evaluating whether the state's capitation is a good deal. For example, there's access to providers. Our first speaker talked about this as it pertains to Medicare, and I think the same issue relates to Medicaid even more strongly. If you're coming into an area where the provider reimbursement was low enough that there weren't many providers willing to treat the AFDC population, then the utilization that's underlying your capitated rate is very likely to be understated, and the resulting fee-for-service equivalent (that your state's agency will use to determine an acceptable capitation rate) is also likely to be lower than realistic.

I'll mention stop-loss protection but because we're all actuaries I won't go into that. Demographics, again, is an important issue to look at. Specifically, the capitation

should be set up in a way that's going to immunize you against getting a population that has a different demographic profile than the entire enrollment for the program in your state or in your county.

Another thing to look at is guaranteed eligibility. In some states, the state agencies have come out with a program that, when they put a person into an HMO, will guarantee that person will remain eligible for the AFDC-related HMO benefits for a certain period of time. I think the most common periods I've seen are three months or six months. At times, states have threatened to lower the HMO capitations to make up for this extra eligibility. I have not seen a state that's actually done it, but that's another thing to keep in mind when you're looking at capitation rates.

I want to close by briefly running through what I would call keys to success for a Medicaid program if you want to take on ADFC enrollment and be successful at it (i.e., have black ink on your bottom line). I think these are the things that you need to do and what you might notice is that most of these things are going to be clinical-type imperatives rather than actuarial things we need to do. First, you need a delivery system that's oriented towards the Medicaid population. You need a delivery system that's experienced in dealing with the needs of this population and that's accessible to the population. That means that if most of this population lives uptown and you have a network that is surrounded by a downtown hospital, you're going to have some problems because the people that you'll be enrolling will get sick and will keep on going to the uptown hospital's emergency room, where you have no control over what's happening.

A second important factor is outreach. It's really important, particularly if you're in a situation where managed care for AFDC is new, to educate people on what the delivery system is and how the delivery system works. You may be dealing with a population, particularly in a large urban area, where no one in your population has ever been in a managed care plan before, and they are accustomed to getting all their medical care at the emergency room. Your member outreach people have a huge task ahead of them to tell people how to use the system. The second point under outreach is access to office services. In addition to telling people they have to go to the physician's office, they need to be treated in a way that they find acceptable when they get there. If the waits are too long or if it's really tough to get to the physician's office, you're going to see a lot of your AFDC enrollment going back to the emergency room. It's an old habit and it's hard to break.

Managing emergency room use is vital for two reasons. One is looking at the emergency room expense, and the second, which is more important, is that we have a need to move the population from the current environment of getting care in the emergency room to getting care in a primary care-driven environment. One

thing we've seen used successfully is a triage program. The health plan helps the people at the emergency room direct Medicaid recipients to a provider when they come in and it's not a real emergency. To make that work, there are two basic things that the plan has to do. One is you have to pay the emergency room a triage fee, so the hospital can feel like it's getting something for this work. The second thing is that there has to be somewhere to send the patients after you send them out of the emergency room, which really goes back to a network issue. One key to success is that the primary care providers need to have extended hours. Eight to five doesn't really work with the AFDC population. They're going to need to get a lot of their service after normal office hours. They tend to start the day fairly late.

Again, we need to dwell on routine medical transportation. If it isn't easy for the patients to get to the providers, and if it's easier for them to get to the emergency room, they will go to the emergency room, and they will be treated there. It's important to remember that, for the most part, this population has no cars, many are without a phone, and many are single-parent households with a sick child, which is about the highest stress situation I can imagine.

I think we already discussed marketing. It's important to have a marketing program to get the enrollment that a panel needs to cover the fixed expenses of a startup. With the provider-contracting issue, I think every plan that wants to work with AFDC needs to go back and convince the providers to accept fees that are more in line with the Medicaid fee levels. A plan is going to need fees at this level in order to break even financially. It's important that the providers are educated on the population needs. This goes back to my earlier comments: the providers need to be ready to serve this population. It isn't the same as a population of union and nonunion employees and their families.

I really want to point out that it's very important to stress preventive care in these programs. In a contract from the state you will see requirements for preventive care. The health plan is going to need to document that they're in line with these "Healthy People 2000" type goals or there will be some type of fine to pay, or some other sanctions from the state. It's a real challenge if you have HMO enrollments with an average length of stay of six months, to figure out how to develop some reports to give evidence that your kids are getting their immunizations. There's a program called Early Prevention Diagnostic Screening and Treatment. If you look at a contract with the state, you'll see there are requirements regarding when kids have to have their visits and when kids will have to have their immunizations. From a financial basis, you need to take into account that as you're enrolling kids who've been with us for a few years (maybe four-year-old or five-year-old kids) your health plan will be responsible for seeing that these kids are up-to-date on their

immunizations. This means that if you're doing the job right, there's going to be a lot of expenses bunched up on the front end.
To be successful, they're going to have to treat this enrollment as a separate line of business. I've never seen anyone be financially successful unless they focus on Medicaid enrollment with the exact same level of intensity that you're focusing on your commercial enrollment or other major lines of business.

Mr. Brent Lee Greenwood: I have this question for Jon Gabel. I find your study very interesting and I look forward to reading it in more detail. You indicated that the HMO saved on the fee-for-service cost maybe about 7%. I'm assuming that was for counties where the HMO penetration was high, which likely would correspond to very high AAPCC, meaning there might be a lot of fat in that particular area. As we know, there's proposed legislation that will artificially raise the AAPCC in counties that are less than the USPCC. My question to you would be, considering there might be less fat and rising penetration in those counties that have the lower payment rates, how would your results and conclusions differ for those particular counties? If the AAPCC actually increases, will it actually cause an increased demand and an opposite effect on the fee-for-service because there's more money coming into those counties?

Mr. Gabel: Those are very good questions. First of all, as I see it, our research could not answer the questions that you ask. My guess is that it would not have a substantial effect if that HMO penetration moves into those counties where there are already problems with access to care. On the other hand, most of the expenditures in the U.S. are, fortunately, in just those very few high-cost metropolitan areas, so maybe that 7% figure wouldn't hold. We've been using 2–7%, but I think that overall, for the country, we would still have a negative effect on spending.

Mr. Ronald E. Bachman: There are so many new organizations beginning to get into the Medicare risk arena that had been traditionally in commercial areas. What, in your opinion, is the importance of understanding the uniqueness of the claims adjudication process with respect to the Medicare business. I'm referring to government definitions of covered expenses or even eligible providers. How much difference is there? How critical is that to a startup operation that may not have any prior experience in processing underlying Medicare replacement products?

Mr. Ninomiya: I think that it's probably a significant issue; it would probably get back to the nature of the contracting arrangements that are in place. I think that a lot of the minutiae of what's covered and what's not covered under fee-for-service Medicare gets kind of lost in Medicare risk because the coverage is broader and we try not to administer things like lifetime limits and so forth because it's just administratively too complex.

Mr. Bachman: Maybe it's not as important as my underlying question is concerned. You're saying it's not as important for the ones started up, it has not been a major issue.

Mr. Ninomiya: It hasn't been a significant issue.

From the Floor: Jon, regarding the study, it seemed that your basic premise for somebody hearing this for the first time, was that you wanted to prove the other study wrong. You wanted to prove that your clients who were paying for this were saving money. It seemed like a biased assumption at the beginning, and I would suggest that as HCFA is doing a review of that study, it's not unheard of that the government may have some biases in what its trying to perform. I would suggest that maybe the AAA would be a good party to intervene here because I think the critical policy question is whether or not these are saving money.

Mr. Gabel: I was being very frank about the motivations of my client. We always believed that we would have the analytic community of the country closely scrutinizing what we did. There was never any doubt in my mind, and there never was a question about it. What we had to do had to be valid. We were going to be subject to audit. We believed in the marketplace for ideas, as well as the other forms of the marketplace. So we've always thought that this was a high road to take not a low road to take. I'd be interested in any other alternative organizations to critique whatever was done.

Mr. Harvey Sobel: I have a question for Steve. I like your comments on looking at the state that the HMO or health plan is in as a determinant of financial success. Our experience is that some states have moved from a more benign, we'll pay 95% of the fee-for-service rate to (as you pointed out) a competitive bidding situation, which right away strips out margins in any of the rates. It makes me wonder, as you look down the road whether the unrelenting drive to save money, which you pointed out as a factor, will constantly be chipping away at the health plan's ability to make money?

Mr. Sherman: That is a real concern that I tend to have in most programs dealing with the four, because they don't have a lot of power. I guess my view of the competitive bidding programs that I've dealt with is that they set floors and they set ceilings for what's an acceptable bid. In the cases where we've had a meeting where they ask the bids for certain categories to be revised, it's come out that (for some of the demographic categories) we were lower than they were allowing (and for some of the categories) we were higher than they were allowing. As long as states maintain these floors I think there won't be the problem in what you're

talking about. I agree that could be a significant problem, if states do remove the floor.

With respect to your first comments about profitability in different states, one of the issues I've dealt with for a client up in northern Wisconsin is that it's added a program called "Healthy Start" to the capitated program. What makes "Healthy Start" different from AFDC is the only people that are in this program are pregnant women and their children (for a certain length of time after the child is delivered). Almost all the claims for the pregnant women are maternity claims, and the state was asking the same thing they were asking for with an AFDC program. They are expecting these managed care plans to get a 10% savings on the cost. It was a problem because looking at the state's fee-for-service data, we found the average length of stay for these women that were having the children was already less then two days. Thanks to some recent legislation, the HMOs are asked to guarantee two-day lengths of stay for maternity, so that's a situation where it was almost impossible (just looking at these "Healthy Start" mothers) to come out appropriately. It was basically a subsidy that was going to have be made up on the other populations.

I think your statement is good for people who are looking for plans. It's good to keep in mind that you really have to scrutinize these arrangements and decide (based on what your plan will be able to do working with this population and its providers) what is really the goal? Is this really feasible?

Mr. Richard S. Foster: I have one comment and one question. The comment has to do with Jon Gabel's studies, in particular the spill-over study. It's a very complex study and some questions have been raised about technical aspects of it. I believe the authors freely admit that they tried something in excess of 100 specifications for their model but ended up using the one that had the strongest causation or the most significant effect. Another issue that was raised had to do with the technical accuracy of some of the econometrics techniques. In particular, many of us who have done work like this know that when you transform variables, it's very critical to adjust the standard of errors that you get. Otherwise, there's a bias in the standard error and it typically goes in the direction of making it look more significant. In fact, my understanding is that this was not done with the spill-over study. I think more needs to be done, and I like Ron's suggestion about having the Academy involved. With respect to the first study, about whether HMOs save or cost Medicare money, I would also like to point out that Sally Burner in our office is also attempting to replicate this study with updated and improved data. I can guarantee, as the chief actuary for HCFA, this study will be done fairly because we want a good answer. We don't have an ax to grind; this will help us do our work better.

Now my question is for John Ninomiya. You pointed out quite clearly some of the difficulties involved in the current ACR/AAPCC approach. What do you think about an alternative that would be based on competitive bidding?

Mr. Ninomiya: I think competitive bidding would be a very good alternative. I think that over the years GHAA committees would have meetings with HCFA, and HCFA would say, "Let's have a demonstration project. Let's have competitive bidding. Why don't you HMOs go out there and bid against each other." We would say, "Well, what would happen to the people in fee-for-service, to the extent that fee-for-service costs more than we bid? Would they be asked to pay more money?" And the answer from the HCFA folks was no. We can't really touch fee-for-service because that's a political sacred cow. So we would invite you to knock each other out and beat each other over the head, but we could never touch fee-for-service Medicare. So that's why we never really got into the demonstration project phase. I think a competitive bidding system is an excellent system. I think that's where things need to go eventually. But I think that it will only happen when fee-for-service Medicare is one of the bidders and the inefficiencies in that program get to be expressed in terms that the individual beneficiaries will have to pay for.

Mr. Gabel: Let me just make a comment. I think the first Mathematica study was very well done and that's why we chose to replicate it. I thought some of the other approaches, such as prior enrollment, really missed the essence of most of the population. I am working with Tom Rice, who is the editor of *Medical Care Research and Review* to publish Jack Rogers' study and then to have a counterpoint discussion with people from Mathematica and people from HCFA. I'd be very glad to talk about all the points. We hope the journal will publish all the points, and we'll have a counterpoint discussion. I believe what will come out will be the best public policy that we can find.