SOCIETY OF ACTUARIES

Article from:

Health Section News

December 1998 – No. 36

Medicare Risk Funding

by David W. Wille

This article discusses two Medicare Risk funding provisions that were radically changed by the Balanced Budget Act (BBA) of 1997. First is the variation in funding rates by geographic area and the second is risk adjustment.

Funding Variations

The Health Care Financing Administration (HCFA) releases Medicare Risk funding rates each year for each county in the country. Before the BBA was passed, these rates were known as the Adjusted Average per Capita Cost (AAPCC), and represented HCFA's best estimate of 95% of fee-for-service (FFS) Medicare costs in each county.

Traditional FFS Medicare has great variation in medical practice style and cost by geographic area. Hence, the AAPCC varied widely as well. Table 1 shows some examples.

Seniors in higher-rated counties generally had a choice of several Medicare Risk plans, all with reasonably high benefits and zero premium from the member. Seniors in the lower-rated counties generally had no Medicare Risk plans available. In the few lower-rated counties where plans were available, benefit levels were fairly low and the member had to pay a high premium.

Advocates for the lower-rated areas requested that the AAPCC be raised in the lower-rated counties and reduced in the higher-rated counties. Congress did exactly that with the BBA. This act reduces the impact of the link between FFS Medicare cost and Medicare Risk funding. The funding for any county is the greatest of three numbers:

(a) A floor of $367 in 1998, which is indexed in later years

(b) A blend of a local rate and a national rate based on the weights in Table 2.

For this purpose, the local rate is generally similar to the old AAPCC, except the cost of medical education is deducted according to a 5-year phase-out schedule. The national rate equals the national average estimated FFS Medicare cost in 1997. It grows in later years based on the schedule shown in Table 3.

The national rate for each county is input price adjusted for that county's price level.

(c) The previous year's funding rate plus 2%.

The BBA also requires a "budget neutrality adjustment." Rates in the middle category are brought down so that the total funding over all counties stays below a certain overall increase.

HCFA has released BBA-based funding rates for 1998 and 1999. For both years, every county received either (a) the floor, or (c) the 2% minimum increase. No county received (b) the local/national blend. Why did this happen? At the time the 1998 funding rates were calculated, FFS Medicare trends were very low. The counties with the floor and with the 2% minimum "used up" more than the available increase. This resulted in a 1998 "overpayment," except that HCFA agreed they will not attempt to recover this "overpayment." HCFA prepared the following explanation of 1999 funding rates shown in Table 4 on page 4.

Because of this low trend rate, the counties with the floor and with the 2% minimum once again "used up" all the available increase. This means that the medium-cost areas did not receive the relief that the BBA intended to give. It is possible that some relief will come in 2000 and later.

Risk Adjustment

Medicare Risk funding has always been adjusted by age/sex factors and by Medicare eligibility status (aged, disabled, ESRD, and institutionalized). The research indicates that age/sex factors are not the most accurate risk adjuster. The Society of Actuaries Monograph M-HB96-1 "A Comparative Analysis of Methods of Health Risk Assessment" gives more details, if you want to dig further.

TABLE 1
Varied AAPCC

County	1997 AAPCC
Los Angeles, California	622.55
Dade, Florida (Miami) Hennepin,	748.23
Minnesota (Minneapolis)	405.63
Jefferson, Nebraska	236.42

TABLE 2
Blend of Local and National Rates

Year	Local Weight	National Weight
1998	90%	10%
1999	82	18
2000	74	26
2001	66	34
2002	58	42
2003 and later	50	50

TABLE 3
National Growth Rate

Year	Annual Growth
1998	FFS Medicare growth–0.8%
1999–2002	FFS Medicare growth–0.5%
2003 & later	FFS Medicare growth

These are the reasons that Congress mandated risk adjustment as of January 1, 2000, in the BBA:

(a) This would pay each health plan more precisely based on the health status of its members.

(b) This removes the disincentive to market to high-risk seniors.

(c) Studies funded by HCFA showed that Medicare Risk plans have enrolled a disproportionate number of low-risk seniors. Thus, risk adjustment could save the government money.

continued on page 4, column 1

Medicare Risk Funding
continued from page 3

After reviewing the available risk adjustment methods, HCFA settled on the Principal Inpatient Diagnostic Cost Group (PIPDCG) model of risk adjustment, at least for the year 2000. Randall Ellis, Arlene Ash, and other Boston University researchers established the PIPDCG model. This model uses the diagnoses recorded during inpatient hospital stays. Every member is classified into one of 12 risk categories based on the most severe diagnosis. Members who are not hospitalized go into the lowest cost category. In addition, there is an adjustment for age and sex. If you want to know more, see "Diagnosis-Based Risk Adjustment for Medicare Capitation Payments" in the Spring 1996 Health Care Financing Review.

The PIPDCG model is not the most powerful model, but it has the decided advantage of requiring only a limited data set: inpatient hospital diagnoses. It is possible that in future years, HCFA will switch to a model that uses outpatient diagnosis information as well. For now, health plans must make a major expenditure of time and effort to get inpatient hospital information to HCFA for every admission since July 1, 1997, for every member. Table 5 shows the timeframes.

These are the most serious concerns expressed by health plans:

(a) Data submission is a major burden. This is especially hard for health plans that pay global capitations to provider groups and let the provider process claims. In that situation, the health plan does not have the required data. The health plan must go to its provider groups for data.

(b) The final January 1, 2000, risk adjustment score will not be known until some time after March 17, 2000, probably several months after that date. To account for this properly, a health plan must put a reserve on its books for the impact of risk adjustment. A reserve shortage will cause major earnings surprises. This late notice is also a heavy burden on providers who are paid under a "percentage of income" capitation arrangement. These providers will have a retroactive adjustment in their income.

(c) The PIPDCG system could be biased against managed care plans because they frequently treat people in a non-hospital setting who would have been treated in the hospital under FFS Medicare. The health condition of such people is not reflected properly in the PIPDCG score. HMO representatives are discussing this issue with HCFA.

David W. Wille, FSA, is Vice President at Humana Inc. in Louisville, Kentucky, and a retiring member of the Health Section Council..

TABLE 4
1999 Funding Rates

HCFA estimate of FFS Medicare inflationary trend	3.4%
Reduction required by BBA	–0.5
Correction for 1998 "overpayment"	–0.9
Net trend to use for 1999 funding	2.0%

TABLE 5
Timeframes

Discharge Date	Submit Date to HCFA by	Use of this Date
7/97 to 6/98	9/18/98	HCFA will give each health plan an estimate of their 2000 risk adjustment score by March 1, 1999
7/98 to 6/99	9/18/99	HCFA will give each health plan an updated estimate of their 2000 risk adjustment score
7/99 to 12/99	3/17/00	HCFA will use this to calculate the final 2000 risk adjustment score and will apply this retroactively to January 1, 2000

New Medicare Options
continued from page 2

Medicare. Optional supplemental benefits are allowed as long as they do not cover the deductible expenses.

Plans may have network restrictions with provider reimbursement agreements. For unrestricted plans, it is important to note that enrollees will be liable for any billed charges not reimbursed by the plan. In other words, noncontracted providers have unlimited balanced billing rights.

The amount of the MSA account contribution will be predetermined by the plan and must be uniform for all enrollees. For a given service area and plan, the community contribution is calculated by subtracting the plan's average premium requirement from HCFA's average payment rate. For each enrollee, plans will actually receive HCFA's usual monthly capitation payment (with all of the usual adjustments,

continued on page 5, column 1