Overview of employer capitation activities

by Kevin E. Moley

This article addresses a new initiative of the Health Care Financing Administration (HCFA) to contract on a group basis with: employer self-insurance plans, unions, group health insurance companies, and Taft-Hartley Health and Welfare Funds for groups of Medicare beneficiaries. Under this new concept, Medicare beneficiaries may elect in the future to obtain Medicare coverage through their group insurance plan rather than through traditional Medicare, with HCFA paying the premiums. This Medicare demonstration will bridge the gap between employer plans, which coordinate with traditional Medicare coverage, and employer-sponsored health benefit plans. This will make available to Medicare-eligible retirees similar, if not the same, managed-care alternatives as are currently available to active employees.

Among the highest priorities of the Health Care Financing Administration's (HCFA's) research, demonstration, and evaluation agenda for fiscal years 1987 and 1988 will be the study of the feasibility of the so-called employer-at-risk capitation concept. The term employer-at-risk is somewhat misleading because HCFA is willing to contract on a risk basis not only with employers but others. These include unions, combinations of employers and their unions (including Taft-Hartley Health and Welfare Funds), and even broader combinations of employers, unions, their insurers, or others responsible for the medical expenses of health care to groups of Medicare-eligible retirees. Estimates are that as many as 6 million beneficiaries could be covered by such plans.

In short, HCFA desires to test expansion of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 which authorizes contracts with federally qualified health maintenance organizations (HMO's) and competitive medical plans (CMP's) to allow contracts with employers, unions, and insurers. The Department of Health and Human Services will be asking Congress as part of the 1988 legislative agenda for the authority to expand the TEFRA statute in this way. The Administration voucher bill, S. 1985, most recently introduced by Senator Durenberger (R., Minnesota) on December 18, 1985, contains a provision allowing HCFA to contract with such entities as employers, unions, insurers, and others for the provision of the Medicare benefit package.

These legislative initiatives reflect the Reagan Administration response to the marketplace. Specifically, the demand side of the market equation (i.e., retired Medicare enrollees and their former employers or unions who are still responsible for providing Medigap insurance) is looking for relief from the inflationary trends in an unmanaged fee-for-service system and from the administrative burden of a confusing dual claim system. They are also seeking to improve continuity of care, which is more likely to be available through managed care under one payer.

According to hearings published by the Senate Finance Committee, some studies estimate that the average person 65 years of age or over either pays $1,660 a year out of pocket or is reimbursed through a retirement plan or a Medigap policy, despite Medicare coverage.[1] The bulk of these expenses are paid for through employer-sponsored health retirement plans. According to a study sponsored by the Department of Labor, nearly 60 percent of employees participating in health insurance plans also were promised retiree health insurance benefits. A 1985 study of 200 large corporations, conducted by the Washington Business Group on Health, indicates that 95 percent offered medical coverages to retirees. Although there is widespread coverage, this type of benefit has become a growing expense to private industry. For example, a study of medical expense plan costs by AT&T indicated an increase of 18.2 percent per year between 1970 and 1983. Many employers are having to come to grips with the reality of the unexpected increases in their frequently unfunded liability for Medigap insurance, resulting from the dramatic rise in the front-end deductible. The Medicare deductible has risen from $400 in 1985 to $492 in 1986, and will reach $520 in 1987, which is partially caused by the decrease in the average length of Medicare hospital stay. As long as employers and unions are contractually or morally obligated to continue to provide Medigap policies covering the deductible and copayments to their retirees, and as long as fee-for-service medical expenses continue to rise, employers funding retiree insurance have incentives to consider alternative delivery systems to provide basic Medicare benefits for retirees through managed care systems.

As the Administration's legislative initiative in this area goes forward, the time is ripe for HCFA to pursue demonstration projects that test ways of responding to these marketplace demands with the "employer-at-risk" capitation concept. Given the variety of organizations interested in doing such demonstrations, now is the time to change the name from "employer-at-risk" to "Medicare Insured Group."

Certainly, what all these organizations have in common is that they represent group insurance for Medicare-eligible retirees. There are significant

[1]The various studies cited are contained in a report prepared by the staff, U.S. Senate, Special Committee on Aging. Hearings before the Subcommittee on Savings, Pensions, and Investment Policy, Committee on Finance, Senate. Washington, Sept. 9, 1985.

Reprint requests: Sheila B. Duvall, Health Care Financing Administration, Office of Prepaid Health Care, Room 317H, Hubert H. Humphrey Building, 200 Independence Ave., SW., Washington, D.C. 20201.

questions that will have to be resolved before HCFA can proceed even on a demonstration basis with this concept. For instance, what constitutes a group? What number of Medicare beneficiaries will be needed before contracting with such a group is efficient to the government? The question of experience-based rating and prospectively priced renewing poses a number of concerns.

Tentatively, HCFA has decided that although the adjusted average per capita cost (AAPCC) should be used as the pricing mechanism for enrolling individual Medicare beneficiaries into TEFRA risk-contracted HMO's and CMP's, the question of adverse or biased selection can be more directly addressed by using experience-based rating. This approach would reflect prior utilization in determining the level of payment to Medicare Insured Groups. We are tentatively exploring the use of experience-based rating so that HCFA's level of payment to Medicare Insured Groups could be set at 95 percent of their average projected cost (APC).

The APC could be based on a formula using prior cost and utilization of each Medicare Insured Group as a payment level. An APC set at 95 percent of what the group as a whole would otherwise have been expected to cost Medicare still provides real savings to the Federal Government and reduces the concern for biased selection in the group. There are a host of questions and concerns surrounding the issue of experience-based rating, not the least of which is the adequacy of the data needed to construct an experience-based rating formula. Other questions include the details of the experience-based rating formula itself and the methods for the renewal rating, through prospective pricing, of such groups from one year to the next.

In the world of commercial group health insurance, the renewing of rates for group cases remains an inexact science. Despite the existence and use of rather exact data bases to drive commercial experience-based rating formulas of group health insurers, the vagaries of the health portion of the Consumer Price Index combined with unexpected anomolies in utilization create problems in forecasting future rates to correctly calibrate for expected changes in utilization and inflation. More often than they would like, group health insurers find themselves on the losing side of the financial equation (i.e., more dollars in claims being incurred than premium dollars to cover them). In the private sector this may result in the group health insurer absorbing the loss in the subsequent renewal without trying to make up for that loss. If other elements of its contractual obligation with the employer or union remain satisfactory, the group health insurer will probably retain this group. Alternatively, if the group health insurer takes into account the loss sustained in the prior period and offers higher renewal rates to the group client in order to recoup all or part of the previously sustained loss, it might lose the client through competition from another group insurer able and willing to "experience-rate" the group without having to take into account the prior loss. These scenarios are of interest to HCFA because they clearly demonstrate the Federal Government's dilemma in renewing Medicare Insured Groups. In order to establish a system with long-range potential for business certainty and fairness, HCFA will have to establish its renewal formula at the inception of any Medicare Insured Group demonstration and assure its continuation throughout the life of the demonstration.

The most commonly proposed renewal process involves using all or some component of the yearly increase in AAPCC. For example, the average yearly increase of the AAPCC, prorated per capita, for the counties in which the demonstration would cover retirees, might be considered. The dilemma is that any measurement using AAPCC will not take into account the actual experience of the Medicare Insured Group and consequently may not conform with commonly accepted methods for renewing group health insurance business in the private sector. Renewal, therefore, would not take into account the group whose experience is either better or worse than the rate of increase accounted for by the average increase in AAPCC. For instance, if actual experience indicates an increase in excess of the AAPCC increase, the sponsor of the Medicare Insured Group would be forced to absorb a loss, unsettling the balance of this type of reimbursement formula. Despite prior assurances concerning commitments and contractual agreements between HCFA and the Medicare Insured Group, the potential for finger-pointing remains high.

Even though the initial experience-based rating and prospective pricing renewal formulas would have to be mutually agreed upon, the data used for its development would primarily fall within HCFA's domaine. In retrospect, this could lead the Medicare Insured Group to question the underlying assumptions on which the original 95 percent of average projected cost was based. HCFA, of course, could argue that the utilization controls of the Medicare Insured Group, for whatever reason, proved inadequate to restrain costs within a fair and efficient target of 95 percent of the APC. Unfortunately, this development might quickly lend itself to political solutions. Although participating retirees in Medicare Insured Groups might receive more generous benefits than are available under the current Medicare program, the mere threat of contract termination poses possible problems for HCFA. In this case, it could mean being forced to either write off the demonstration as a failure or revise the renewal formula for political reasons, which would set an unfortunate, possibly disastrous financial precedent. HCFA is committed to avoiding such situations by extensive pre-contract negotiations.

Organizations wishing to contract with HCFA as Medicare Insured Groups are aware of these potential pitfalls, which accounts for their interest in "experience rating" and renewal formulas using some form of risk sharing through the use of risk corridors, stop losses, or other underwriting techniques commonly used in the commercial marketplace. The

use of these techniques is inappropriate to the degree that they provide payment of more than 95 percent of average projected cost because of the issue of payment equity. HCFA would oppose any techniques that would establish a two-tier system benefiting one segment of Medicare beneficiaries at the expense of those not eligible to be covered by a Medicare Insured Group.

One way to monitor the equity issue is through use of a control mechanism, which would match the individual Medicare beneficiaries in a Medicare Insured Group to payments under the AAPCC system, aggregating those data and comparing them with the average projected cost for the group. This comparison information may be desirable not only from a research and demonstration perspective, but also from the standpoint of determining what costs or savings would be generated had the same group of beneficiaries enrolled in TEFRA HMO's or CMP's versus a Medicare Insured Group.

Certainly much thought must be given to the problems of experience-based rating and prospectively priced renewal of Medicare Insured Groups. HCFA has much to learn about risk management. Therefore, it will be necessary to work closely with outside groups. These groups will include prospective Medicare Insured Groups as well as commercial group insurance carriers, their clients, and other experts in the field that can offer HCFA the benefits of their experience.

A critical legal concern is how State insurance regulators may oversee the sponsors of Medicare Insured Groups. Many combinations of employers and unions are self-insured under the regulations of the Employment Retirement Income Security Act, 1974. Even those such as General Motors use an insurance carrier for some administrative services. However, in a system where HCFA makes a payment in the form of the APC to such a self-insured combination, the State Insurance Commissioners might be concerned that the group is acting as an insurance carrier and is thereby subject to licensing and other statutory requirements. These are questions HCFA is exploring through the National Association of Insurance Commissioners and other authorities in the field.

The concerns outlined above are particular to the Medicare Insured Group concept and relate to our relationship with the groups as risk-takers and not with the groups' individual Medicare-eligible retirees. Of paramount concern is how this concept affects the individual Medicare beneficiary. TEFRA has given HCFA considerable experience with Medicare beneficiaries in prepaid plans. It will be essential that the lessons learned be applied to Medicare-eligible retirees in a Medicare Insured Group. A program of continuing education is essential in order for Medicare beneficiaries to understand the difference between traditional fee-for-service Medicare and that provided through a prepaid plan. To some degree these problems will be mitigated in the case of new retirees who will be coming directly from their employer or union plan into a similar if not the same employer or union retiree plan. They will encounter little or no change in their health care delivery system. In other cases where older retirees participate in a Medicare Insured Group demonstration, there may be immediate changes in their health care delivery system which can exacerbate the problems generally confronted by Medicare beneficiaries moving from traditional fee for service to a prepaid plan. Further, there is a good chance that some Medicare Insured Group demonstrations might offer choices of services to their Medicare-eligible retirees along the level of "triple" or "double" options by utilizing HMO's and preferred provider organizations (PPO's) as well as managed fee-for-service systems with some form of prior authorization for hospital admissions, mandatory second surgical opinions, and other utilization controls. They may offer these options with varying degrees of beneficiary cost sharing, e.g., 100 percent coverage for care rendered through the HMO option, 90 percent coverage for care rendered through the PPO, and some lesser percentage coverage for care rendered through fee for service. In some respects, an older retiree may face a host of unfamiliar choices for health care protection and security, but new retirees coming directly into a Medicare Insured Group from employment might face little or no change from what they have experienced throughout their employed career.

HCFA has found it necessary and important to advise each beneficiary who enrolls in a TEFRA risk-contracted HMO or CMP on the implications of their choice to join a prepaid managed health care plan, so they will be assured an informed choice. Some similar, albeit plan-specific, communications are likely to be necessary to notify Medicare-eligible retirees of their rights, liabilities, and obligations within a Medicare Insured Group.

It is important to note that individual Medicare-eligible retirees enrolled in an employer- or union-sponsored health insurance plan retain the same rights as any other Medicare beneficiary, including the right not to participate in the plan or plans offered by the Medicare Insured Group or to disenroll from such a group for whatever reason they so choose. The underlying philosophy of the Reagan Administration is promoting competition through consumer choice, making available to beneficiaries the same options in the health care delivery systems as are available to their fellow Americans under age 65.

This article has outlined only some of the concerns and considerations that must be addressed before a Medicare Insured Group contract can be signed, demonstrated, and become an operational option of the Medicare program. As difficult as some of these problems are, we in HCFA believe they are solvable and solvable sooner, not later. In fact, we expect to be demonstrating the Medicare Insured Group concept in 1987.

Considerable interest has been expressed in doing such demonstrations and more interest is expected now that HCFA's Office of Research and

Demonstrations has issued its research and demonstration agenda in the *Federal Register*. From within the universe of interest that is expressed, HCFA's Office of Prepaid Health Care in conjunction with the Office of Research and Demonstrations would like to pursue several such Medicare Insured Group demonstration contracts, depending on the size of the groups chosen. It would be desirable for groups to range in size from a few thousand Medicare-eligible retirees to many thousands of Medicare-eligible retirees. We would expect such groups to represent diverse experience with Medicare utilization. For instance, those groups that have paid for "rich" benefit packages for their workers might, as a result, have driven up Medicare utilization even though they might on average also have a healthier than average population when compared with Medicare demographics. On the other hand, an employer who already contracts with an HMO or whose group insurance uses prior authorization, mandatory second surgical opinions, and other utilization screens in its employee plan might have driven down utilization. In either case, we would hope an experience-based rating formula paying 95 percent of average projected cost would afford a true 5 percent savings to the Medicare trust fund.

Diverse groups have expressed interest in undertaking such demonstrations. Some preliminary discussions have been held. Most notably, former Secretary of the Department of Health and Human Services (DHHS), Joseph Califano, now a board member of Chrysler Corporation, expressed interest in such a concept in an April 1986 speech to the Economic Club of Detroit. If such diverse interests as a major U.S. employer and its unions, former President Jimmy Carter's Secretary of DHHS, and President Ronald Reagan's Secretary of DHHS can agree on this concept, surely enough talent can be attracted to find workable solutions to the problems already mentioned and others not yet foreseen.