SPECIAL REPORT OF THE
JOINT LEGISLATIVE
AUDIT AND REVIEW COMMISSION ON

Evaluation of a Health Insuring Organization for the Administration of Medicaid in Virginia

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

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COMMONWEALTH of VIRGINIA

Joint Legislative Audit and Review Commission

Philip A. Leone
Director

Suite 1100, General Assembly Building, Capitol Square
Richmond, Virginia 23219

(804) 786-1258
FAX (804) 371-0101

January 6, 1992

The Honorable Ford C. Quillen
Chairman
Joint Legislative Audit and Review Commission
Suite 1100, General Assembly Building
Richmond, Virginia 23219

Dear Delegate Quillen:

Submitted herein is the JLARC staff special report, Evaluation of a Health Insuring Organization for the Administration of Medicaid in Virginia. This study was mandated by Item 13 of the 1991 Appropriation Act, as a part of our comprehensive review of the the Medicaid program.

The study evaluates the potential benefits of converting the Virginia Medicaid program to an insured arrangement, using a private insurance company to administer the program. The report was presented to JLARC and to the Commission on Health Care for All Virginians on December 17, 1991, and was authorized for printing and distribution by JLARC at that time.

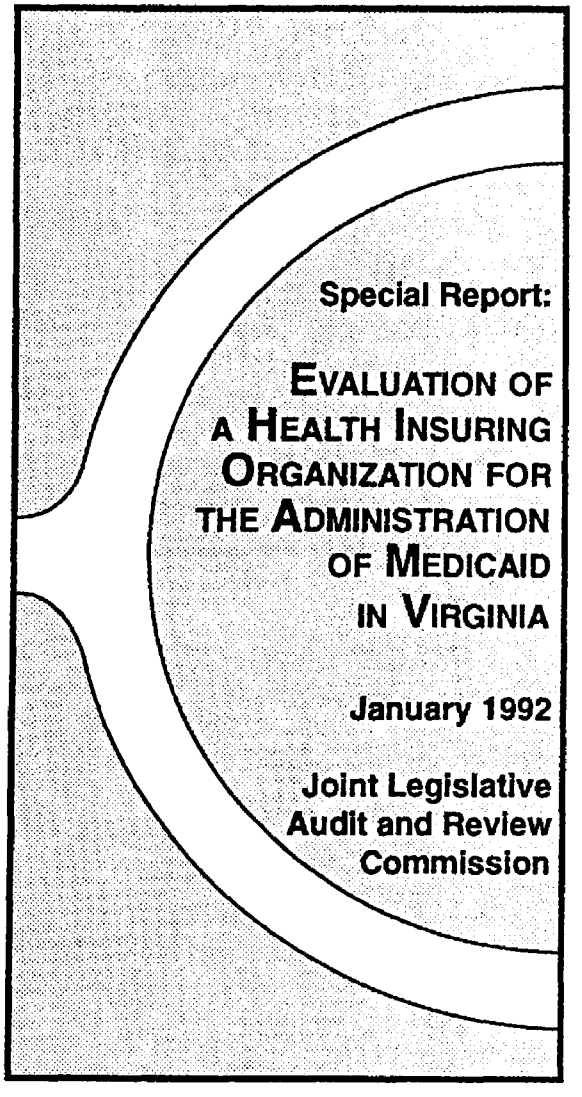
I would like to acknowledge the assistance of the Department of Medical Assistance Services, The Computer Company, and Electronic Data Services Corporation in completion of this report.

Sincerely,

Philip A. Leone
Director

PAL/gt

JLARC Report Summary



The Virginia Medical Assistance Program (Medicaid) is a federally-mandated, State-administered program to provide basic health care services to low-income Virginians. Under federal regulations for Medicaid, states have some flexibility in how they administer their Medicaid programs. Currently, three basic administrative models are in use: the state agency model, the fiscal agent model, and the health insuring organization model. These models differ in the extent to which they use private contractors to perform some of the administrative functions of the program.

This special report examines the potential benefits of a health insuring organization for the Virginia Medicaid program, and assesses the potential for program cost avoidances. The review was mandated by Item 13 of the 1991 Appropriation Act.

Administration of Medicaid Programs by the States

The state agency model uses one or more state agencies to perform all of the functions necessary to manage the Medicaid program, including determination of recipient eligibility, claims processing, utilization review, etc. This model is also called "self-administration." Currently, 15 states use this approach to manage their Medicaid programs.

Under the fiscal agent model, the state Medicaid agency contracts with a private company to perform claims processing and related functions. The state agency retains responsibility for other functions. This approach is used most often to manage Medicaid programs, with 32 states and the District of Columbia currently operating with fiscal agents. Virginia is among the states using the fiscal agent model for management of the Medicaid program.

The health insuring organization (HIO) model is a variation of prepaid health insurance for Medicaid recipients. Under this approach, the state contracts with an insurance company for the provision of health care services to the Medicaid eligible population, and the state pays monthly premiums for each eligible recipient. The insurance company reimburses Medicaid providers for the services provided to insured recipients. Currently, only two states use the HIO model

statewide for administration of their Medicaid programs.

The Benefits of Insured Medicaid Programs Have Been Aggressively Promoted

Health insuring organizations have been promoted as providing significant benefits for state Medicaid programs. These benefits are generally ascribed to the private nature of the insurance purchased through the HIO. Because program benefits for the Medicaid-eligible population are managed by a private insurance company, private market incentives are said to be incorporated into the funding of the program. These incentives are said to reduce program costs, while improving access to health care for program recipients.

The five benefits most often cited are: (1) the risk of benefit cost increases is transferred to the private insurance contractor, (2) private market incentives ensure that program costs are controlled, (3) state program costs are more stable from year to year, (4) federal funding is increased, and (5) the return from the investment of public funds is enhanced.

The Transfer of Risk is Limited in an HIO

The HIO model for the administration of Medicaid involves the purchase of prepaid health insurance for the Medicaid-eligible population. The current HIO model, however, does not constitute a fully-insured program. In fact, under the current HIO model, the state continues to self-fund all but a very small proportion of benefit costs. Little risk is actually transferred to the insurance company.

In effect, the HIO uses a "quota share," which modifies the insurance arrangement to provide for a cost settlement at the end of the coverage period. Based on the quota share negotiated as a part of the contract, the state pays a portion of costs in excess of the premiums and the insurance company absorbs a portion of the costs. Except for the limited quota share liability of the contractor, the state remains liable for all benefit costs and administrative expenditures.

Market Incentives in an HIO Provide No Apparent Improvement in Cost Management Performance

The HIO has been promoted as a tool to help states limit increases in benefits for Medicaid. The cost savings and avoidances generated by the HIO model are supposed to be the result of private market incentives. Five specific types of cost management activities have been identified as being key to the savings from the insured approach. These are utilization review, benefit limitations, recoveries from liable third-parties, duplicate auditing, and hospital field audit recoveries.

A review of federal requirements and the cost management actions in use in Virginia, however, indicates that these five cost management actions are not unique to the HIO model. In fact, all are requirements of federal Medicaid regulations and are in place in Virginia and most other states. So, the key components of HIO cost management are the activities which all states must use in order to comply with federal regulations. And in fact, all of these activities are used by DMAS and its fiscal agent to manage costs in Virginia.

The promise of substantial savings from these cost management techniques was the impetus for a proposal that Virginia consider modifying its Medicaid program to adopt the HIO model of administration. One proposal for the Virginia program has promised savings of $35 million. However, a review of the $35 million in potential savings found that the estimate was not based on any objective analysis of specific improvements which might be made in the administration of the Virginia Medicaid program. Rather, it is a general projection of savings based on the

experience in the Texas HIO program. It does not appear to account for the significant cost management efforts already under way in Virginia. Therefore, it should not be considered a valid estimate of the likely impact of implementing an HIO in Virginia.

These findings indicate that adoption of the HIO model will not automatically result in cost management improvements. Instead, it appears that the successful performance of any administrative structure in managing benefit costs depends on the specific techniques adopted by the state, and on how well the techniques are implemented by responsible state agencies and program contractors.

Program Funding Under an Insured Program May Be Less Stable

With the rapid growth of the Medicaid program in recent years, it can be quite difficult to accurately estimate premiums for an insured program. This has been the experience in Texas as a result of a premium structure which was not sensitive to the use patterns of recipient groups. In combination with the quota share incentive structure, the misprojections of premiums makes the funding for the insured arrangement more unpredictable. Program reserves do not appear to have insulated the Texas program from this problem. In 1991, consultants working for the Texas Legislative Budget Board reviewed the Medicaid HIO arrangement and concluded that the existing quota share arrangement was less predictable than self-funding.*

Funding of Reserves Will Increase State Budget Outlays

One unintended consequence of the insured arrangement is increased state budget outlays. This is the result of the need to build program reserves within the Medicaid trust fund. This is an integral part of any insurance-based approach, and is seen in both of the HIO programs currently operating. The consultants in Texas concluded that the state budget outlays for an insured program will always exceed the outlays for a self-funded program (fiscal agent or self-administered approaches).

Investment Performance in the HIO May Be Weak and Contrary to Existing State Law

The investment of funds in the various accounts used to manage the payment of Medicaid benefits is an important issue because of the amount of the funds involved. The HIO is cited as providing enhanced opportunities for investment earnings because of accelerated investment of federal and state funds in the trust account. In Texas, however, the performance of investments in the HIO has not been as good as that for other Texas funds invested by the state. In Virginia, the performance of State investments has also been better than the rate guaranteed by the typical HIO arrangement.

Additionally, to the extent that premiums might be considered public funds even after payment to the contractor, investment of those funds by the contractor could require revisions to the statutory provisions for investment of State funds in Virginia. Under the current law, it does not appear that the management of Medicaid trust fund investments by a private contractor would be permitted.

* As a result of significant funding shortfalls in the Medicaid program, the Texas Legislative Budget Board contracted with Lewin-ICF, a nationally recognized health care consulting firm, for an evaluation of the HIO arrangement in Texas. The Lewin-ICF report (Evaluation of Medicaid Finanacing Options, Final Report, July 1, 1991) has been used by the State of Texas to modify the Medicaid HIO. This report is available for review in the JLARC offices.

The Benefits of the HIO Arrangement Appear Questionable

These concerns raise serious doubts about the usefulness of the HIO as a means to better manage the Medicaid program in Virginia or to contain program costs. In conclusion, therefore, the HIO cannot be viewed as a quick fix for escalating Medicaid benefit costs. Further, the substantial costs and disruption to the program in order to implement an insurance arrangement appear unwarranted given the limited nature of any benefits likely to be achieved. It does not appear appropriate for Virginia to consider modifying the basic administrative structure of Medicaid at this time.

Recommendation. *The State should retain the fiscal agent administrative structure for the Virginia Medical Assistance Program.*

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I. Introduction

The Virginia Medical Assistance Program (Medicaid) is a federally-mandated, state-administered program to provide basic health care services to low income Virginians. The program was created by Congress in 1965 as Title XIX of the Social Secruity Act. Since its creation in 1965, the program has been greatly expanded. Nationally, more than 25 million low income individuals received medical care under the Medicaid program in 1990. Program expenditures in that year totalled $68.7 billion.

In Virginia, the Medicaid program became operational in 1969. Medicaid was first administered by the Department of Health, but was later transferred to a separate agency established specifically to manage the program. Today, the Department of Medical Assistance Services (DMAS) is responsible for administering the Medicaid program.

Approximately 490,000 low income Virginians were eligible for Medicaid in FY 1991, and about 428,650 eligible persons received medical care under the program. Of the 21,300 providers enrolled in the program, more than 17,000 medical professionals, hospitals, and other facilities provided care to recipients. Program costs for FY 1991 totalled approximately $1.3 billion. Administrative costs for the program were $59 million, including costs for eligibility determination.

Because the Medicaid program is administered by the states, the states have some flexibility in how they structure the program for the determination of eligibility, the processing of claims, the payment of benefits, and other administrative functions. Currently, three basic administrative models are in use: the state agency model, the fiscal agent model, and the health insuring organization (HIO) model. This report examines the potential benefits of converting Virginia's Medicaid program from the fiscal agent model to the health insuring organization model. An assessment of the use of an HIO in Virginia was mandated by the 1991 General Assembly.

ADMINISTRATION OF MEDICAID BY THE STATES

The states are responsible for the administration of Medicaid under broad guidelines established by the U.S. Department of Health and Human Services (HHS) and the Health Care Financing Administration (HCFA). There are three general models which states use to manage their Medicaid programs. The models represent a range in the use of private contractors to carry out various functions.

The State Agency Model

The state agency model uses one or more state agencies to perform all of the functions necessary to manage the Medicaid program, including determination of recipient eligibility, claims processing, utilization review, etc. This model is also called "self-administration." Currently, 15 states use this approach to manage their Medicaid programs. The states which self-administer their Medicaid programs are:

Illinois	Minnesota	Oregon	South Dakota
Maine	Nebraska	Pennsylvania	Utah
Maryland	North Dakota	Rhode Island	Wyoming
Michigan	Ohio	South Carolina	

In Pennsylvania, for example, the Department of Public Welfare (DPW) is responsible for administration of Medicaid. The agency performs all functions related to eligibility, utilization review, and provider enrollment. Eligibility processing is completed by the counties. DPW contracts with a private company for claims data entry, but the state is responsible for issuing checks to providers.

The Fiscal Agent Model

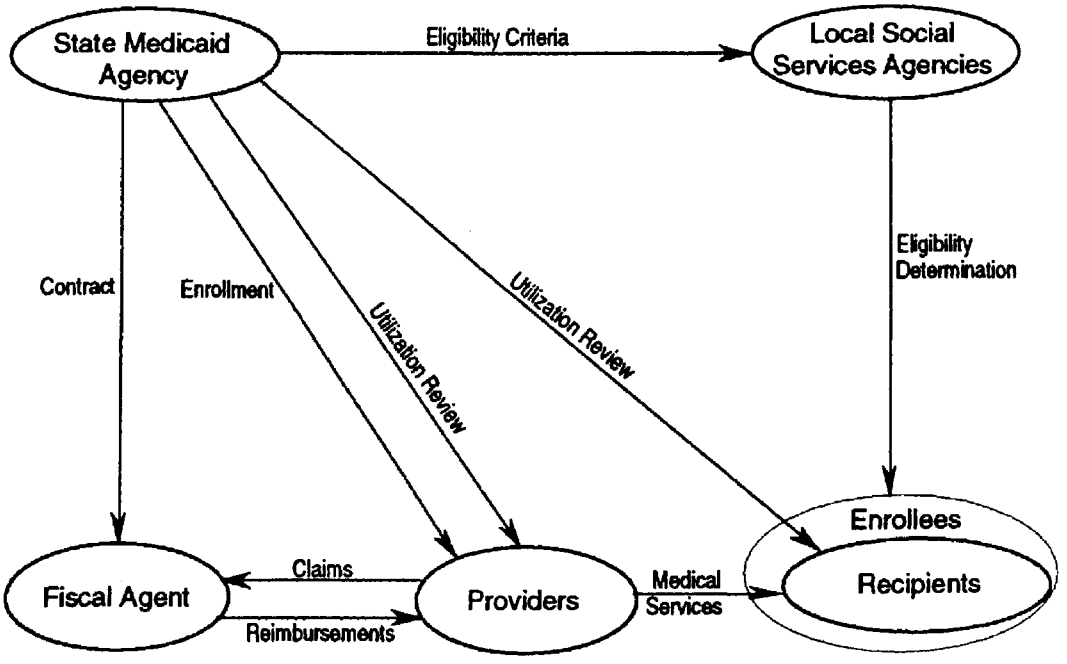
In the fiscal agent model, the state Medicaid agency contracts with a private company to perform claims processing and related functions. The state agency retains responsibility for other functions. This is the approach used most often to manage Medicaid programs, with 32 states and the District of Columbia currently operating with fiscal agents. Virginia is among the states using the fiscal agent model for management of the Medicaid program:

Alabama	Georgia	Mississippi	North Carolina
Alaska	Hawaii	Missouri	Oklahoma
Arkansas	Idaho	Montana	Tennessee
California	Iowa	Nevada	Vermont
Colorado	Kansas	New Hampshire	Virginia
Connecticut	Kentucky	New Jersey	Washington
Delaware	Louisiana	New Mexico	West Virginia
Florida	Massachusetts	New York	Wisconsin

State Agency Responsibilities. The Department of Medical Assistance Services (DMAS) is the designated State Medicaid agency and has primary responsibility for administration of the Medicaid program in Virginia. DMAS has responsibility for the development of program policies and procedures; enrollment of providers to serve the Medicaid eligible population; establishment of reimbursement procedures and rates for physicians, hospitals, nursing homes, and other providers within broad federal parameters; and utilization review of providers and recipients. DMAS also administers the contract for fiscal agent services and plays a major role in the adjudication of claims as a shared responsibility with the fiscal agent (Figure 1).

Figure 1

Medicaid Fiscal Agent Model
(Based on the Virginia Program)



Source: JLARC staff analysis of Virginia Medicaid fiscal agent contract.

Other State agencies also have responsiblities related to the Medicaid program. The recipient eligibility process is administered by the Department of Social Services (DSS) under policies and procedures established by DMAS. Local departments of social services are responsible for actually making eligibility determinations. In addition, the Department of Rehabilitative Services determines if applicants meet the criteria for participation in the program under provisions for the disabled, and the Department of the Visually Handicapped determines if applicants meet the criteria for participation under the provisions for the blind.

Health care providers are certified for participation in the Medicaid program by one of two agencies. The Department of Health certifies institutional providers such as hospitals and nursing homes, while the Department of Health Professions verifies that non-institutional providers are licensed practitioners and are eligible to participate.

Fiscal Agent Responsibilities. The fiscal agent's primary responsibility is to manage all functions related to receipt and processing of claims submitted by health care

providers. In this role, the fiscal agent is responsible for operating and maintaining the Medicaid Management Information System (MMIS). Included among the fiscal agent's responsibilities are receipt of claims, data entry of claims data, adjudication of claims, and distribution of payments to providers. In addition, the fiscal agent provides enrollees with monthly eligibility cards and verifies the eligibility of recipients for providers.

In some states, the fiscal agent may have other duties, such as provider enrollment and training. In Virginia, however, the fiscal agent's responsibilities are all directly related to the processing and paying of claims.

Program Funding and Disbursement to Providers. While the State contracts with a fiscal agent for claims processing and disbursement of funds to providers, control of Medicaid funds remains with the Department of Medical Assistance Services and the State Treasurer. Program funding is provided by a State appropriation and federal matching funds.

The program funding and disbursement process begins with the submission of claims by participating Medicaid providers. The fiscal agent processes the claims and determines whether payments should be made. For valid claims, the fiscal agent writes checks for mailing to the providers and makes a request to DMAS for funds sufficient to pay the claims it has processed. The provider checks are held for mailing the next week.

Based on the request from the fiscal agent, DMAS makes a weekly draw against its federal matching funds and forwards a voucher to the State Comptroller. The State Treasurer makes a weekly deposit of State and federal funds to the State Medicaid Trust Account. As providers present checks for payment, the depository bank transfers sufficient funds to cover the checks from the Trust Account to the fiscal agent's Zero-Balance Account and pays the providers. This process means that the fiscal agent only has access to funds needed to pay claims on any given day.

The State Treasurer also manages and invests the funds in the Medicaid Trust Account. Interest from the Trust Account is credited to the State general fund. The fiscal agent does not need to concern itself with the investment of funds in the Zero-Balance Account because the account only holds funds necessary to cover the checks to be paid by the depository bank.

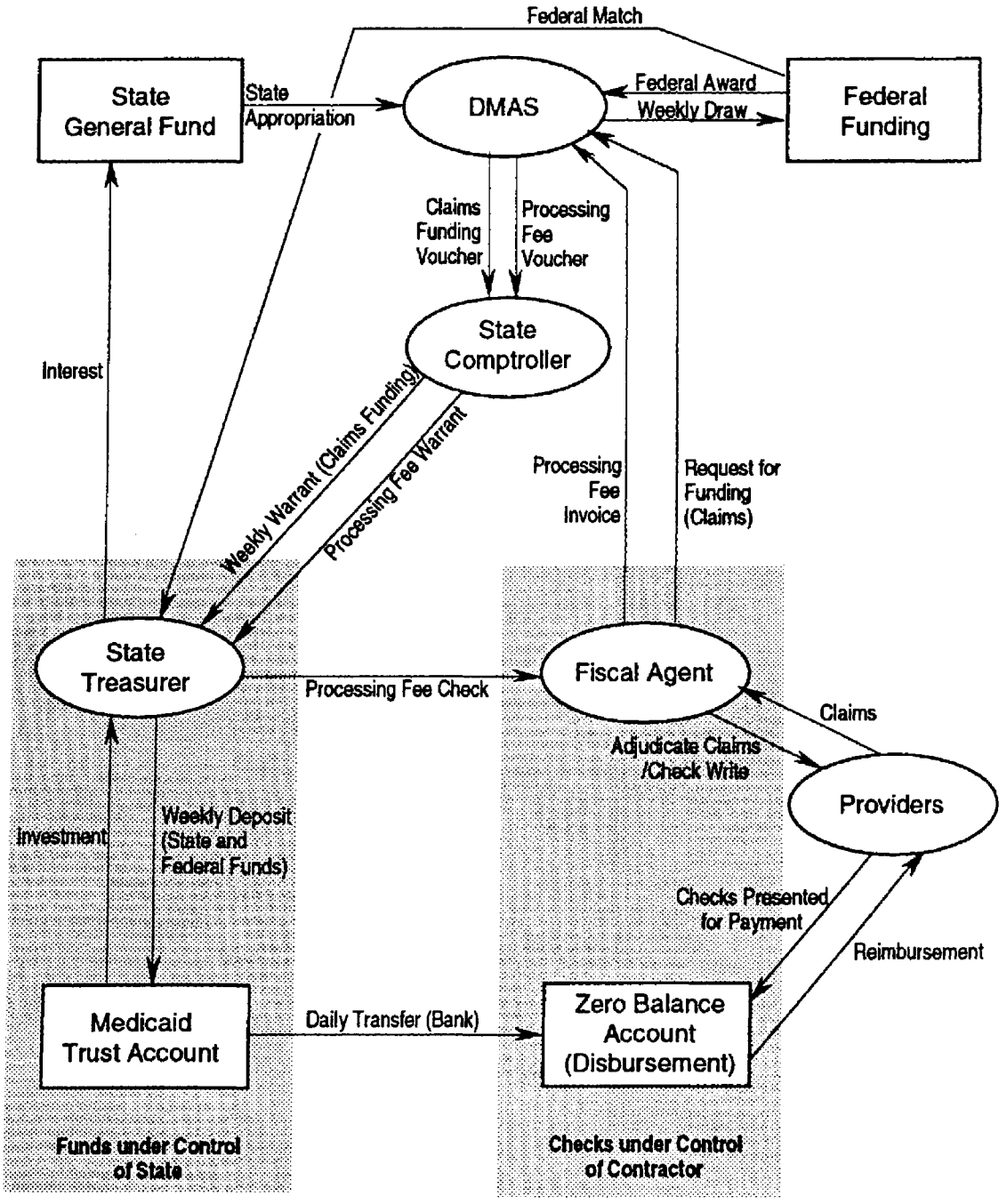
The fiscal agent is paid for the services it provides by means of a processing fee. The processing fee, which is negotiated as a part of the fiscal agent contract, is paid monthly, based on the number of claims processed. Currently, the processing fee in Virginia is $0.522 per claim processed. The complete flow of funds for the program is shown in Figure 2.

The Health Insuring Organization Model

The health insuring organization (HIO) model is a variation of prepaid health insurance for Medicaid recipients. Under this approach, the state contracts with an

Figure 2

Flow of Funds for the Medicaid Program
(Based on Current Virginia Process)



Source: JLARC staff analysis of Virginia Medicaid fiscal agent contract.

insurance company for the provision of health care services to the Medicaid eligible population, and the state pays monthly premiums for each eligible recipient. The insurance company reimburses enrolled health care providers for the services provided to insured recipients.

A key feature of the HIO approach involves the sharing of program risk and operating savings by the state and the contractor. To the extent that actual incurred costs of providing medical services exceed the premiums paid, the state and the contractor share in funding the shortfall (85 percent state funds and 15 percent contractor funds, for example). Program savings are also shared by the state and the contractor. It is the sharing of risk that is cited by HIO proponents as ensuring improved management of the Medicaid program by the insurance company.

Currently, only two states use the HIO model statewide for administration of their Medicaid programs — Texas and Indiana. Texas was the first state to use an HIO for a major portion of its Medicaid program. The typical arrangement of functions in an HIO is shown in Figure 3 (based on the Texas program).

With the HIO model the insurance company performs most of the functions related to administration of the program. However, federal regulations prohibit the HIO from directly providing any health care service to recipients; it must contract with third parties for services. This restriction distinguishes the HIO from health maintenance organizations (HMOs), which may provide direct care to recipients.

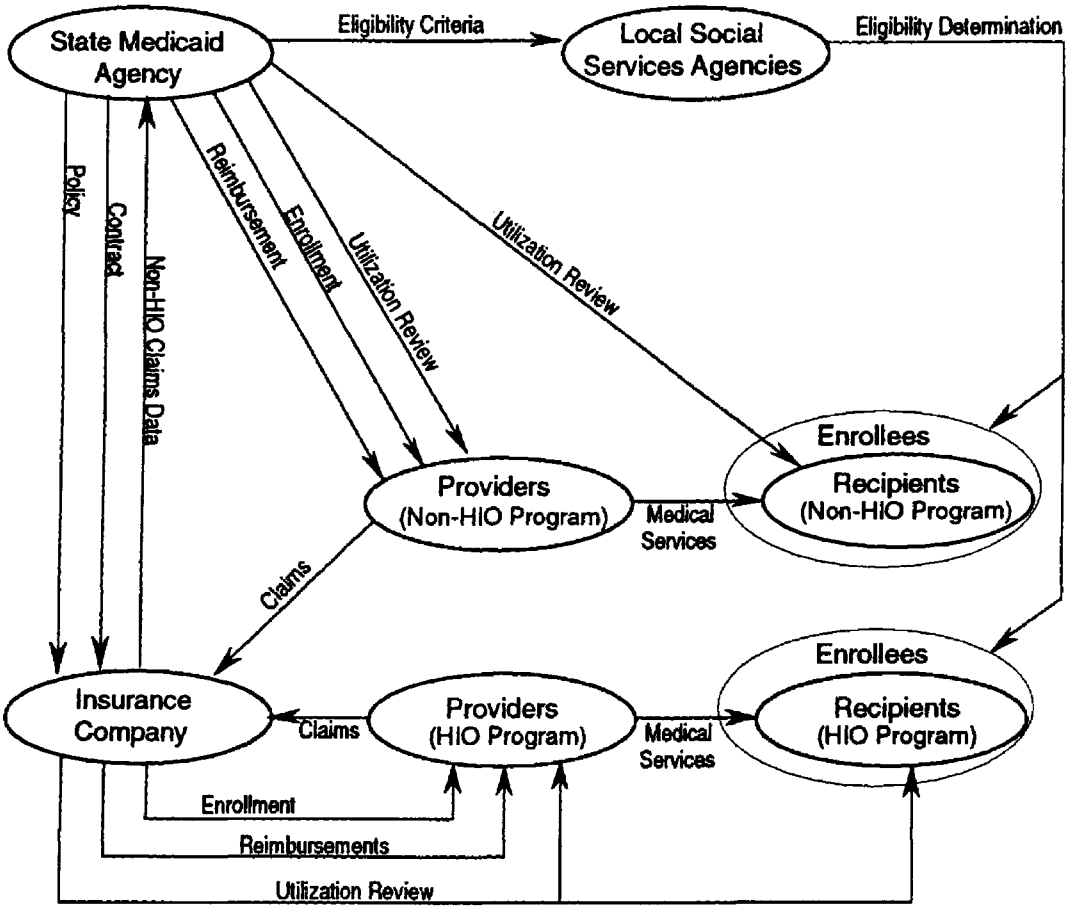
State Agency Responsibilities. Though the insurance company has primary responsibility for administration of the Medicaid program in an HIO, some functions remain with the state agency. The most important of the duties retained by the state is the development of program policy which complies with federal law and regulation. Under an HIO, Medicaid policy continues to be set by the state legislature and the state Medicaid agency. Consistent with this responsibility, the state also retains responsibility for determining the scope and nature of the benefits package to be provided to eligible recipients within federal guidelines.

The state performs all functions related to eligibility determination for recipients. (Federal regulation prohibits states from contracting for eligibility determination.) It is appropriate for the state to determine eligibility because it also determines eligibility for other social services and benefits for low income and disabled persons. Of course, the state is also responsible for administration and supervision of the HIO contract.

As noted above, some portions of the program may not be included in the HIO. In Texas for example, long term care and pharmacy benefits are not administered as part of the HIO. Because some portions of the program may remain outside of the HIO, most of the functions for management of the program must be maintained by the state Medicaid agency. The state may self-administer the portions of the program not covered by the HIO, or may contract with a fiscal agent. This can make the processing of claims somewhat more complex, but the basic process of adjudicating claims is similar to the process in a purely self-administered or fiscal-agent arrangement.

Figure 3

Medicaid HIO Model
(Based on the Texas Program)



Source: JLARC staff analysis of Texas Title XIX Medicaid Contract.

Insurance Company Responsibilities. In an HIO Medicaid program, the insurance company assumes responsibility for a broad range of functions. The insurance company receives and processes claims and makes all disbursements to providers. It plays a primary role in the adjudication of claims, and is responsible for federally mandated utilization review activities. In its role as claims processor, of course, the company also assumes responsibility for operation of the automated information systems for the program.

The contractor is responsible for provider enrollment, training, and relations. This is an important function because it has a significant impact on access to care for eligible recipients.

The HIO Medicaid model is a prepaid health benefits plan. This means that the insurance company receives premium payments in advance of the provision of services to recipients. As a result, the company is responsible for the investment of program funds. Under the self-administered or fiscal-agent models, investment of the state and federal funds is typically a duty of the state treasurer.

Program Funding and Disbursement to Providers. Significant differences between the fiscal agent and HIO models can be seen in the funding of the programs. In contrast to the fiscal agent model, with an HIO the insurance company is largely responsible for management of both state and federal Medicaid funding, including management of the Medicaid trust fund, investments, and disbursements to providers.

Payment of premiums is made monthly in advance of any medical services for the eligible recipients. The premium is a negotiated, fixed monthly payment for each eligible recipient. It consists of a pure premium (amount to cover the cost of care) and an administrative premium (amount to pay the contractor for administrative services).

As can be seen in Figure 4, the flow of funds under the HIO model is more complex than that for a self-administered or fiscal agent program. Figure 4 shows the flow of funds for the Texas Medicaid HIO prior to recent changes made in the program. The funding process is essentially the same in Indiana.

The funding process begins with the payment of premiums to the insurance company. The premiums are deposited into a Medicaid trust account, which is managed by the insurance company. Administrative premiums are transferred to an administrative disbursement account for the use of the company. Pure premiums are retained in an incurred claims liability reserve. A portion of these funds are also set aside in a risk stabilization reserve.

The trust account funds are invested by the insurance company. The state receives a portion of the investment yields (guaranteed at the 90-day Treasury Bill rate in Texas, for example) and the company retains a portion.

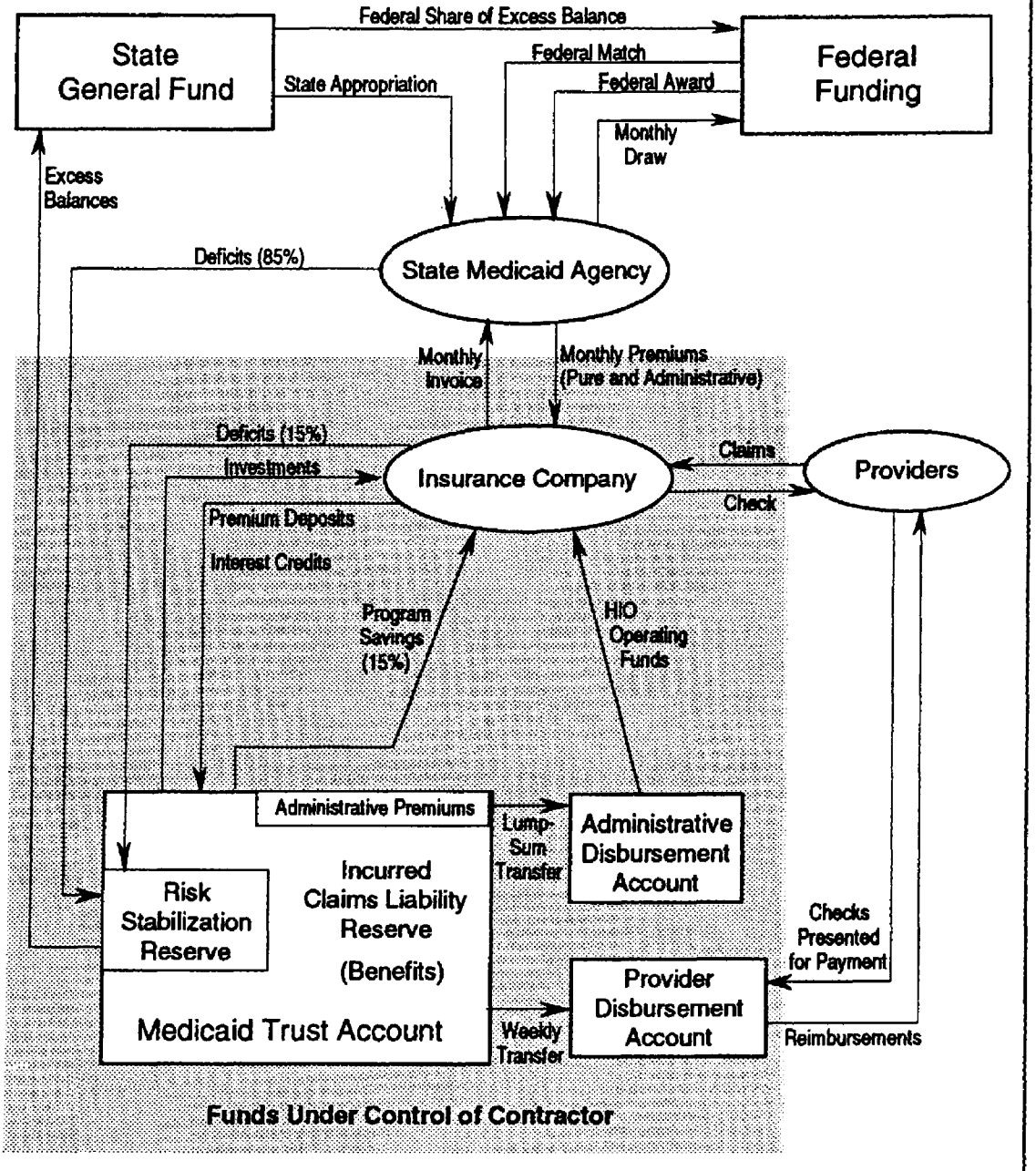
To receive payment for services provided to covered recipients, participating health care providers submit claims to the insurance company. The claims are processed by the company, and a transfer of funds is made from the Medicaid trust account to the provider disbursement account on a weekly basis. The funds transferred cover the amount of claims from providers processed for the week. The insurance company mails the reimbursement checks to the providers.

At the end of the coverage period any losses or operating surpluses of the Medicaid account are settled between the state and the insurance company according to the negotiated "quota share." The quota share is the proportion of any loss to be paid by the state and the contractor or any surplus to be apportioned.

Figure 4

Flow of Funds for the Medicaid Program Under the Health Insuring Organization Model

(Based on the Texas Process)



Note: Some portions of this structure have recently been modified by the state of Texas. This figure shows the structure which has been proposed for the Virginia program.

Source: JLARC staff analysis of Texas Title XIX Medicaid Contract.

Until very recently in Texas, for example, if incurred claims costs exceeded the pure premiums paid by the state, 85 percent of the loss was paid by the state (and the federal government by way of the normal program match) and 15 percent was paid from company funds. Texas has recently modified this approach, adopting a graduated schedule of proportions based on contractor performance. These amounts are deposited to the Medicaid trust account (to cover incurred claims costs). In Texas, the insurance company's potential risk of loss is capped at $6.5 million. Indiana also has established a quota share of 85 percent for the state and 15 percent for the contractor.

Operating surpluses are also divided among the state, federal government, and the insurance company in the same proportions as the quota share. There are limits on the total amount of excess to be distributed to the contractor similar to the limits on liability.

JLARC REVIEW

This review of risk-sharing/insured Medicaid was mandated by Item 13 of the 1991 Appropriation Act:

> *The Joint Legislative Audit and Review Commission, as part of its review of the Medicaid Program, shall consider whether contracting with a private firm for automation and management of the Medicaid Program under a risk sharing agreement would generate program savings while maintaining reimbursement for essential services under the program.*

To address the mandate, this report examines the potential benefits of a health insuring organization for the Virginia Medicaid program, and assesses the potential for program cost avoidances. The analysis included a comparison of the Virginia and Texas programs, because Texas has the only HIO program in continuous operation since the creation of the Medicaid program. Comparisons to Indiana are not as useful because of recent changes in the program.

A number of research activities were completed for this report. Interviews were conducted with the staffs of the Department of Medical Assistance Services, the State Treasurer's office, the SCC Bureau of Insurance, the current fiscal agent for the Virginia Medicaid program, the HIO contractor for the State of Texas, the Texas Department of Human Services, and the Texas Legislative Budget Board. JLARC staff reviewed reports from the U.S. General Accounting Office, the Health Care Financing Administration (HCFA), the Texas State Auditor, the Texas Research League, and the consulting firm of Lewin-ICF, as well as marketing materials from the companies which provide fiscal agent and HIO services. Staff also completed a detailed review of the Texas and Indiana HIO contracts and the Virginia fiscal agent contract. A comprehensive review of federal and state statutory and regulatory requirements was also conducted.

Financial and operational data for the Virginia and Texas Medicaid programs were analyzed to compare cost management performance across the two programs. This analysis included data provided by the contractors and state Medicaid agencies in both Virginia and Texas, as well as by HCFA.

REPORT ORGANIZATION

Chapter II outlines the findings of the research on the benefits of an HIO for the Virginia Medicaid program. The chapter focuses specifically on the advantages of HIOs cited in promotion of the arrangement and examines the actual experience of the HIO in achieving those benefits.

Chapter III presents the staff conclusions and recommendation related to the adoption of the HIO model for the Virginia Medicaid program.

II. Assessment of HIO Benefits

Health insuring organizations have been promoted as providing significant benefits for state Medicaid programs. These benefits are generally ascribed to the private nature of the insurance purchased through the HIO. Because program benefits for the Medicaid eligible population are managed by a private insurance company, private market incentives are said to be incorporated into the funding of the program. These incentives are said to reduce program costs, while improving access to health care for program recipients. The five benefits most often cited are: (1) the risk of benefit cost increases is transferred to the private insurance contractor, (2) private market incentives ensure that program costs are controlled, (3) state program costs are more stable from year to year, (4) federal funding is increased, and (5) the return from the investment of public funds is enhanced.

Modifying the Virginia Medicaid administrative structure to achieve these benefits could be a costly, difficult, and lengthy process. Therefore, it is essential that the State carefully consider the actual performance of health insuring organizations in achieving the administrative and program improvements cited in insurance company marketing materials before it attempts to implement such a major change. It is also necessary for the State to consider the performance of the existing administrative structure for Medicaid.

This chapter examines the performance of the HIO arrangement in achieving the potential benefits of that model. In addition, the chapter includes a comparison of the cost management performance of the Virginia Medicaid program with that of the Texas HIO.

Transfer of Risk

The health insuring organization model for the administration of Medicaid involves the purchase of prepaid health insurance for the Medicaid eligible population. With a fully-insured program, the purchase of insurance transfers the risk of loss from the purchaser to the insurer. To the extent that incurred claims costs exceed premiums, the insurer suffers a loss. On the other hand, should premiums paid be greater than incurred claims costs, the insurer enjoys a profit on operations.

The current HIO model, with its use of a quota share, however, does not constitute a fully-insured program. In fact, under the current HIO model, the state continues to self-fund all but a very small proportion of benefit costs. Little risk is actually transferred to the insurance company. This has important implications for the ability of the HIO administrative structure to provide the advantages cited by its proponents.

The Nature of Insurance for Public Benefit Programs. As an individual purchasing insurance it is often easy to see the nature of the risk against which the insurance is purchased. In the case of property insurance for example, the insurance guards against the partial or total loss of the property. The company offering the insurance can provide the protection against loss and make a reasonable profit because, under normal circumstances, only a small proportion of the property insured will be lost.

The purpose of insurance coverage for a publicly financed benefits program is quite different. The risk faced by the state is not a loss of use or value but rather an increase in costs for benefits paid. Funding a benefits program through an insurance arrangement is designed to transfer some of the risk of increased benefits costs from the state to the private insurance company to improve management of the program. The transfer of risk is to provide a market incentive for the company to closely manage benefit costs in order to keep costs at expected levels (as determined by actuarial analysis).

In a fully-insured program, the private company is liable for the full amount of any incurred claims costs greater than the premiums paid by the state (Figure 5a). For a benefits program as large as Medicaid, this could be a powerful incentive because the potential size of losses could be significant.

The state also is taking some risk in a fully-insured program. If the premiums paid are greater than the cost of benefits, a self-insured program would have resulted in lower costs (Figure 5b).

A fully-insured program would be attractive for a state at a time when benefit costs are growing and are difficult to predict. In fact, however, a fully-insured benefits program could not operate in the environment which would make it most attractive to states attempting to cope with growing Medicaid costs. Because there is no pool of other purchasers of insurance, any incurred claims costs in excess of premiums must be paid from company assets or from reserves built by the state.

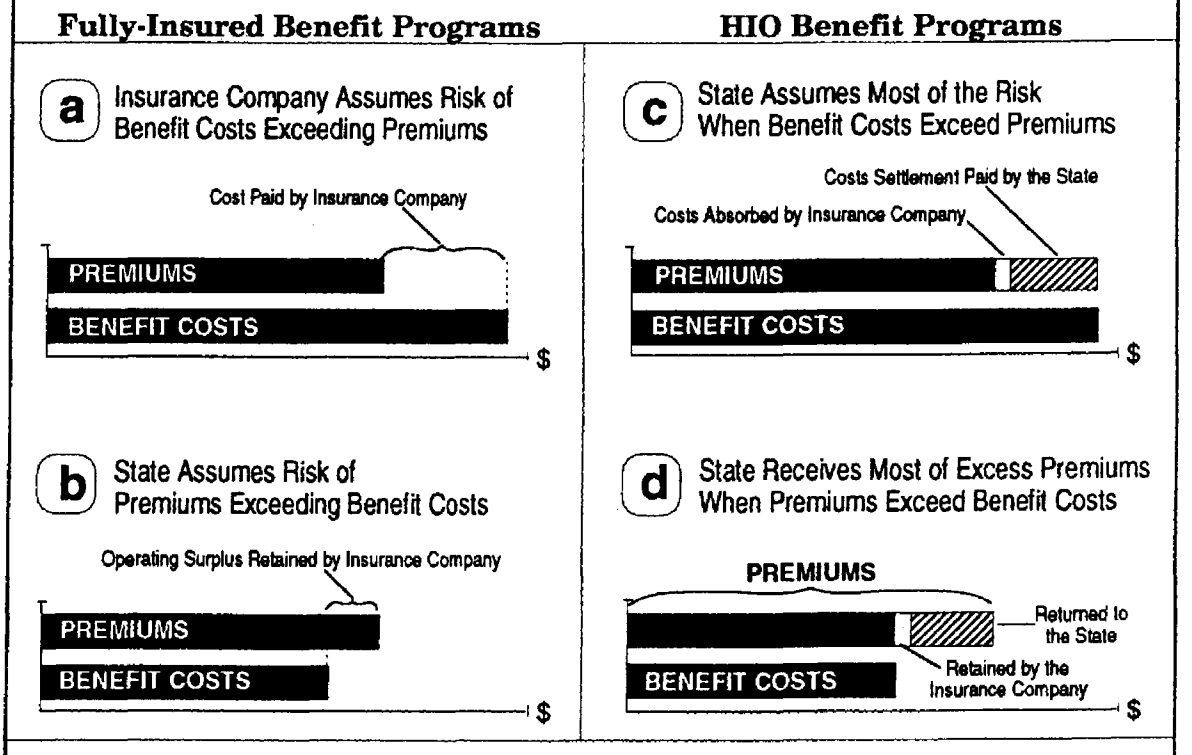
Both of these sources of funds for financing unanticipated claims costs are problematic. To fund excess claims costs from company assets could put at risk the financial viability of the contractor. No responsible insurer would likely accept such a risk. On the other hand, the use of reserves requires that premiums be increased to fund and maintain the reserve. This has the effect of increasing program costs for the state at a time when benefit costs are already increasing. The cost of building adequate reserves could be prohibitive.

The HIO model for administration of Medicaid reflects this difficulty of fully-insured programs in its use of a "quota share" provision. This mechanism introduces its own set of problems, and may make an insurance program of little value to the states.

The "Quota Share" Limits the Transfer of Risk. In the HIO model currently in use, a quota share provision is included in the insurance contract. It is the quota share which has led to HIO programs being called "risk-sharing" programs. The quota share specifies that benefit costs in excess of the premiums paid will be paid by the state and

Figure 5

Risks Associated with Insured Benefit Programs



Source: JLARC staff graphic.

the insurance company. That is, the quota share requires that the state and contractor share the risk.

In effect, the quota share modifies the insurance arrangement to provide for a cost settlement at the end of the coverage period (Figure 5c). Based on the quota share negotiated as a part of the contract, the state pays a portion of costs in excess of the premiums and the insurance company absorbs a portion of the costs. The quota share has traditionally been established as a fixed proportion of excess claims costs. In Indiana for example, the state pays 85 percent of excess claims costs and the insurance company pays 15 percent. This 85/15 split has also been proposed for Virginia.

In Texas, the quota share has recently been redesigned to replace the fixed 85/15 split with a graduated schedule of shares. The amount of risk or reward for the contractor depends on the size of the claims excess or savings. One interesting feature of the new Texas approach is that the insurance company has no liablity for the first two percent of costs in excess of premiums.

Since the insurance company does not assume the full risk of increased costs, it also does not enjoy the full benefit of operating surpluses. The quota share requires that a proportion of program savings be returned to the state and retained by the company (Figure 5d). This ability of the company to retain a portion of the program cost savings is the positive incentive for the company to manage costs.

In addition to the limitation of risk provided by the proportional shares, the insurance company is further protected from losses by a total dollar ceiling on liability. In Texas for example, the company's liability for benefit costs is capped at $6.5 million ($4.9 million prior to September 1, 1991). An analysis of the Texas program by the consulting firm Lewin-ICF found that as a result of the quota share the Texas program was almost completely self-funded. The Lewin-ICF report was a comprehensive review of the Texas HIO program commissioned by the Texas Legislative Budget Board. The report was completed in July 1991 and most of the recommendations have recently been implemented.

With regard to the Texas program, the consultants concluded that:

> Today, with the contractor being at risk for only $4 million in a program operating at a $2 billion level, it would not be inaccurate to characterize the present quota share arrangement as being 99.8 percent self-funded.

In response to this finding, Texas has recently increased the cap for the insurance company's liability to $6.5 million and has modified the quota share incentive structure.

The HIO program proposed for Virginia includes a quota share of 85 percent for the State and 15 percent for the contractor. No specific dollar cap has been proposed, but if established at a level comparable to that in Texas, the limitation of risk might be set at approximately $2-3 million. The effect of this limitation would be that the State would be purchasing only $2-3 million in insurance on a program with annual benefit costs in excess of $650 million (excluding pharmacy and long-term care benefits).

The HIO program as currently operated in Texas and Indiana — and proposed in Virginia — is not a fully-insured program. It transfers a small portion of the risk of increased benefit costs to the insurance company. Except for the quota share liability of the insurance company, the state remains liable for all benefit costs and administrative expenditures. Since the state purchases little insurance in an HIO arrangement, the key question becomes:

> Does the HIO arrangement improve the cost management of Medicaid benefits?

Market Incentives and Cost Management

The rapidly escalating costs of the Medicaid program have placed great pressure on state governments to find ways to better manage program costs while continuing to provide care to the eligible population. In recent years, approaches such as managed care have often been viewed as ways to reduce costs while making necessary health care services available to Medicaid recipients.

The health insuring organization has also been promoted as a tool to help states limit increases in benefits for Medicaid. The cost savings and avoidances generated by the HIO administrative model are supposed to be the result of private market incentives. As noted above, however, the limited amount of risk transferred to the contractor limits the nature of the incentives. In fact, the review of the Texas HIO by Lewin-ICF found that incentives may have actually increased the cost of premiums.

The promise of substantial savings was the impetus for a proposal that Virginia consider modifying its Medicaid program to adopt the HIO model of administration. One proposal for the Virginia program has promised savings of $35 million. This proposal has raised questions about the cost management performance of the current administrative structure for the Medicaid program.

These concerns about the HIO arrangement are addressed in this report in three issues:

(1) How do market incentives affect program costs in an HIO?

(2) Does the HIO administrative model provide any unique opportunities for cost management?

(3) How does the cost management performance of the Virginia Medicaid program compare to that of the Texas HIO?

The findings from these issues indicate that the HIO administrative model provides no particular advantage in cost management of benefits.

Market Incentives in the HIO. The health insuring organization model is promoted as a tool to control and even reduce program costs. The improved cost management of the HIO is supposed to be the result of direct financial incentives for the insurance contractor. In concept, the insured approach does appear to provide the types of positive and negative incentives that should result in improved management of the program. The contractor would benefit directly by reduced benefit costs: it would avoid a loss to be partially absorbed by the company and it would share in the program savings.

In fact, however, the incentive structure of the HIO may have another effect. In its review of the Texas HIO, Lewin-ICF found that:

> While the contractor retains incentives for cost control, positive performance can most easily be guaranteed by ensuring that premiums are set high enough to ensure a maximum quota share gain, i.e., the tendency to overestimate premiums may be structurally intrinsic to the quota share arrangement. The contractor has, in fact, earned a maximum gain since the inception of the program under the existing rules.

The consultants go on to say that:

> . . . normal principles of conservatism suggest that it would be irresponsible for the contractor, from the point of view of the contractor's fiduciary obligations to its shareholders, to negotiate premiums that placed the corporation at undue risk that overruns would need to be defrayed from [the contractor's] own funds. Hence, given the expected degree of estimating error in establishing premiums, the existing arrangement offers strong, logical incentives to persistently overestimate premiums.

It is impossible to tell whether funds returned to the state are from improved benefits management or are a result of intentionally overestimated premiums.

While the state receives a refund of a portion of the excess premiums, overestimating premiums is a serious problem for two reasons. First, the quota share arrangement provides for the state to receive only a portion of amounts in excess of benefit costs, and the contractor retains the remaining portion. While it is fair and reasonable for the contractor to share in savings resulting from efforts to better manage program benefits, it is not appropriate for the contractor to benefit as a result of premium overestimation. The quota share arrangement has no provisions for sorting the real program savings from the overestimated premiums. There is no effective means for the state to recover the full amount of any intentionally overestimated premiums.

Second, premium overestimation requires an unnecessary commitment of state general fund dollars. Because the settlement of program costs and premium payments occurs only at the end of the coverage period, premiums paid at the beginning of the coverage period could be unavailable for periods up to two years. This reduces the availability of general fund dollars for other critical programs.

In Texas, the incentive structure of the program has been modified in response to the Lewin-ICF report. The experience in Texas points to the difficulties of designing a private incentive structure for a publicly financed benefits program.

HIO Cost Management Techniques. The potential risk and profit of the HIO arrangement have been cited by HIO proponents as incentives for the contractor to "employ aggressive cost containment of benefit payments." Five specific types of cost management activities have been identified by the Texas HIO contractor as being key to the savings from the insured approach.

The five most important cost management techniques for an HIO are:

Utilization Review — Detection and prevention of fraud and abuse, identification and recoupment of overpayments, and provider educational visits.

Benefit Limitations — Review of the medical necessity of procedures based on the diagnosis and symptoms. Also considers the appropriateness of the setting for the procedure. This category includes those procedures that require prior authorization, manual pricing (because of the complexity or newness of the procedure), and all services that require the application of a limit.

Third Party Liability — Collection of monies owed the Medicaid program due to the identification of private insurance, tort, and liability.

Duplicate Auditing — Review and denial of services billed twice, and procedures billed on the same day without an indication of medical necessity.

Hospital Field Audit Recoveries — On-site hospital record reviews to identify when Medicaid funds have been inappropriately paid to hospitals.

A review of federal requirements and the cost management actions in use in Virginia, however, indicates that these five cost management actions are not unique to the HIO model. In fact, all are requirements of federal Medicaid regulations and are in place in Virginia and most other states.

Utilization review and benefit limitation activities are required by 42 CFR Part 455 and 42 CFR Part 456. These regulations are extensive and call for a wide range of cost management and program integrity actions on the part of the administering agency. Part 455 for example, requires that the state report fraud and abuse information to HCFA and have a method to verify that services were actually provided to recipients. Part 456 is more than 17 pages of the *Code of Federal Regulations*, and covers utilization review requirements in some detail for hospitals, mental hospitals, nursing facilities, psychiatric care, and the Medicaid program in general.

Recovery of Medicaid claims costs from responsible third party payors is required by 42 CFR Part 433 D. The regulations require that states obtain information about recipient insurance coverage at the time of initial application for Medicaid benefits and at each redetermination. States are also required to identify the liability of third parties and to seek recovery of certain claims that have already been paid by Medicaid (known as pay and chase).

For obvious reasons, federal regulations require that state MMIS systems contain automated checks for duplicate claims. This requirement is one of 35 which states must meet in order to receive maximum federal financial participation for administrative costs.

Finally, hospital field audit recoveries are related to the requirements of 42 CFR Part 456. The audits ensure that hospitals have complied with required utilization review activities.

All of these requirements apply generally to Medicaid programs in the states, and are not unique to the HIO administrative model. So the key components of HIO cost management are the activities which all states must use in order to compy with federal regulations. And in fact, all of these activities are used by DMAS and its fiscal agent to manage costs in Virginia.

Given that the HIO arrangement does not provide any unique methods for cost management, the important questions is: Does the HIO result in better performance of Medicaid cost management techniques? A comparison of the Virginia Medicaid program and the Texas HIO program seems to indicate that the HIO arrangement does not improve performance of cost management activities.

Cost Management Performance in Virginia and Texas. While all states are required by federal regulation to perform a core group of cost management activities, the states have some flexibility in how they implement the requirements. Thus, there is some variation in the performance of states in managing and controlling costs. The HIO administrative model has been promoted as providing improved performance in controlling costs because of market incentives.

To evaluate this claim, JLARC staff completed three research efforts related to the cost management performance of the HIO arrangement. First, the cost management performance of the Virginia Medicaid program was compared with that of the Texas HIO. In measuring cost avoidances, only the five techniques identified as an important part of the HIO arrangement were considered. Performance was measured by comparing benefit costs to the cost avoidances reported by the administrative agencies in each state for each of the last five fiscal years.

Second, JLARC staff evaluated the basis for the $35 million in potential savings which some have claimed could be achieved by converting the Virginia program to an HIO. Finally, staff reviewed the systems performance reviews prepared by HCFA for each of the two programs.

Over the period examined for this analysis, Medicaid benefit costs increased substantially in both Virginia and Texas. Benefit costs in Virginia increased almost 86 percent between FY 1987 and FY 1991. In Texas, benefit costs for the HIO program grew more than 181 percent over the same period (Table 1).

Table 1

Cost Management Performance in Virginia and Texas

State	Year	Program Costs	Cost Avoidances	Cost Management Ratio
Virginia	1987	$ 681,510,648	$152,340,543	22.35%
	1988	$ 783,740,343	$233,180,614	29.75%
	1989	$ 864,448,561	$271,440,741	31.40%
	1990	$ 972,268,899	$301,695,141	31.03%
	1991	$1,266,436,407	$431,173,264	34.05%
Texas	1987	$ 709,530,000	$242,300,000	34.15%
	1988	$ 811,487,000	$222,534,000	27.42%
	1989	$1,087,560,000	$297,436,000	27.35%
	1990	$1,430,859,000	$385,353,000	26.93%
	1991	$2,000,000,000	$523,200,000	26.16%

Source: Data repoted by HCFA, DMAS, Texas Department of Human Services and Texas HIO contractor.

Both programs also made extensive use of the cost management techniques which the Texas HIO contractor identified as critical to controlling program costs. In Texas, the insurance company reports cost avoidances of $523 million in FY 1991 alone. DMAS reports that cost avoidances for the Virginia program totalled $431 million for the same year.

In contrast to Texas, however, cost management performance in Virginia appears to have improved with the growth of program benefit expenditures. In Texas, increases in cost avoidances have not kept pace with increases in benefit costs. The ratio of cost avoidances to benefit costs rose from 22 percent in FY 1987 to 34 percent in FY 1991 for the Virginia program, while it decreased from 34 percent to 26 percent in Texas.

The review of the $35 million in potential savings found that the estimate was not based on any objective analysis of specific improvements which might be made in the administration of the Virginia Medicaid program. Rather, it appears to be a general projection of savings based on the experience in the Texas HIO program. It does not appear to account for the significant cost management efforts already underway in Virginia. Therefore, it should not be considered a valid estimate of the likely impact of implementing an HIO in Virginia.

Finally, HCFA's systems performance reviews of Medicaid management information systems in Virginia and Texas also show that both states are in compliance with

requirements for timely and accurate payment of claims. Many of the federal requirements for cost management are implemented in these automated systems. According to the HCFA reports no significant differences in performance can be seen between the Texas HIO system and the Virginia fiscal agent system.

These findings do not mean that the Virginia program cannot further improve the cost management techniques in use for the Medicaid program. In fact, Virginia and the other states continue to develop new and useful ways to improve the delivery of health benefits to their Medicaid eligible populations while better managing the costs. DMAS should continue to work with the General Assembly and the fiscal agent to implement new cost management initiatives.

These findings do indicate that adoption of the HIO administrative model should not be expected to automatically result in cost management improvements. Instead, it appears that the successful performance of any administrative structure in managing benefit costs depends on the specific techniques adopted by the state, and on how well the techniques are implemented by responsible state agencies and program contractors.

Stability of Costs

With an insured program, reserves are built up from premium payments in excess of benefit payouts and from the yields on investments. These reserves are intended to provide the insurance company with sufficient cash resources to fund unexpected fluctuations in incurred claims costs. According to the proponents of the HIO arrangement, the reserve helps to stabilize the premium costs in an insured program.

The HIO arrangement is funded from monthly premiums for each of the covered recipients in the Medicaid program. In Texas, the state paid a single premium amount for the entire Aid to Families with Dependent Children (AFDC) and AFDC-related group of recipients. Separate premium amounts are established for aged and Medicare-related recipients and for disabled and blind recipients.

The substantial increases in the Texas Medicaid caseload which occurred in recent years were primarily in the AFDC/AFDC-related group. The increases were for groups with which the program had little operating experience. This made it difficult to project claims costs and resulted in significant divergences between premiums and actual claims costs. Because a single premium amount was set for a very diverse group of recipients, the uncertainty about one subgroup meant that premiums were overestimated for the entire group. In combination with the quota share incentive structure, the misprojections of premiums makes the funding for the insured arrangement unpredictable. The program reserves do not appear to have insulated the Texas program from this problem.

Lewin-ICF reviewed the stability of funding and concluded that the current quota share arrangement was less predictable than self-funding:

> The structure of the insured arrangement, as it has evolved, amplifies the effects of misprojections [of premiums]. Since the contractor's risk is limited to plus or minus $4 million, the State bears 99.8% of the risk in the current $2 billion program, but continues to pay advance premiums subject to retrospective settlements. Since the magnitude of even normal estimating errors is now larger than the amount of "insurance" the State is effectively buying, the quota share arrangement has become substantially less predictable than self-funding of benefits.

The consultants note that this would not be the case in a fully-insured program.

This problem with the HIO administrative structure raises serious questions about the usefulness of this approach in the current Medicaid funding environment. Given the increases in costs and constantly changing mandates from the federal government, it is essential that the State have a method for program administration that provides for some stability of funding.

In response to the Lewin-ICF findings, Texas is attempting to stabilize premium costs by separating premiums for the AFDC/AFDC-related group into five subcategories. By making separate cost projections for each of these subgroups it is hoped that premium amounts will more accurately reflect actual claims cost experience. In addition, the quota share incentive structure is being modified. Because these changes have only recently been made, it is too early to determine how successful they will be in addressing the problems noted by the consultants.

Impact on Federal and State Funding

One of the advantages cited for the HIO arrangement is its maximization of the draw of federal funds. Because premiums are paid at the beginning of each month, federal funds are drawn monthly also. With the fiscal agent model, funds are disbursed to the contractor on a weekly basis, and federal funds are drawn in weekly amounts. Thus, the HIO makes federal funds available in larger amounts, earlier in each month. These funds can be invested, increasing the yield for the Medicaid trust fund.

One unintended consequence of the insured arrangement, however, is increased state budget outlays. This results from the need to build program reserves within the Medicaid trust fund. This is an integral part of any insurance based approach, and is seen in both of the HIO programs currently operating.

Based on their review of the Texas program, Lewin-ICF reported that:

> . . . in order to build up adequate program reserves in an insured arrangement, it is necessary for the state to make advance payments to the insurer, so that the insurer can use the expected lag between incurred services and ultimate service payment to build up a reserve

> sufficient to cushion against unexpected fluctuations in the level of incurred services. For any given period — whether it be a month, a fiscal year, or a budgetary biennium — it follows by definition that the amount paid out of the state treasury for premiums will always exceed the amount that would be paid out of the state treasury for that period if the state were carrying the risk for its own claims payment costs.

The consultants concluded that the state budget outlays for an insured program will always exceed the outlays for a self-funded program (fiscal agent or self-administered approaches).

In fact, it is this increase in state outlays that results in increased federal participation. Because the costs are higher for the insured program, the draw of federal dollars is increased. But this increased draw is not an offset to state funds — rather federal funding is increased only because state funding is increased to account for overall higher program costs.

Investment of Public Funds

The investment of funds in the various accounts used to manage the payment of Medicaid benefits is an important issue because of the amount of the funds involved. The HIO is cited as providing enhanced opportunities for investment earnings because of accelerated investment of federal and state funds in the trust account. However, there are questions about the performance of investments in the HIO model, and it is not clear whether the typical contractual arrangement for investments in an HIO would be legal in Virginia.

Performance of Investments in the HIO. With the HIO arrangement, the insurance company is responsible for the investment of funds in the Medicaid trust reserve. In Texas, the state has historically been guaranteed a return rate on investments equal to the 90-day Treasury Bill rate. Texas also received one-third of any yield in excess of the guaranteed rate. In Indiana, the guaranteed rate is equal to the 180-day Treasury Bill rate. Neither state has historically received any interest from investments of the daily balances in the provider disbursement account.

The experience in Texas seems to indicate that the investment of the reserve amounts does not provide the advantages often cited. The Lewin-ICF report found that:

> . . . the impact of contractor interest earnings on reserves is modest relative to the magnitude of the float, and provides only a negligible offset to program costs, since the great majority of interest earnings result in offsets to Federal matching payments. During the historical period we studied, in fact, [the contractor's] returns on the administrative portfolio in which reserve funds are held were consistently below the level that the State of Texas earned on its own invested funds.

As a result of this finding, Texas has recently revised the provisions of its HIO contract related to interest earnings. The new contract calls for the state to receive the guaranteed rate equal to the 90-day Treasury Bill rate plus one-half of the yield in excess of the guaranteed rate. The state will also begin to receive one-half of the interest from investments of the daily balances in the provider disbursement account.

In Virginia, the investments made by the State Treasurer have had consistently higher yields than the 90-day Treasury Bill rate. In FY 1991 for example, the average yield on investments managed by the Virginia State Treasurer was 8.01 percent. The average Treasury Bill rate for the year was 6.75 percent.

Investment of Public Funds in Virginia. Currently in Virginia, Medicaid funds are invested by the Treasurer as a part of other funds in the State's general account. Even after funds have been transferred to the Medicaid trust account, the daily balances are invested. The Medicaid fiscal agent is not in any way responsible for the management of funds in any of the program's accounts.

This arrangement is consistent with current law, which authorizes the Governor or the State Treasurer to invest all State funds (*Code of Virginia*, Section 2.1-185). There is no authorization for the Governor or Treasurer to delegate this responsibility to a private contractor.

While the HIO premiums paid to the insurance company might be viewed as payments to any other vendor, and therefore no longer constituting public funds in the control of the Commonwealth, the typical contractual arrangement for HIOs implies a continuing public interest in the funds managed by the insurance company. In both Texas and Indiana, the insuring contractor is legally obligated to return a portion of the investment earnings to the states, implying that the reserves remain public funds.

In Virginia, to the extent that premiums might be considered public funds even after payment to the contractor, investment of those funds by the contractor could require revisions to the statutory provisions for investment of State funds. Under the current law, it does not appear that the management of Medicaid trust fund investments by a private contractor would be permitted.

III. Conclusions and Recommendation

This review of the health insuring organization model for administration of the Medicaid program has focused on the benefits which that model can provide in the face of growing program costs. Based on the experience in Texas — the only state with a continuously operating HIO — the HIO arrangement does not appear to provide the significant benefits it has been claimed to provide. It is not clear how an insurance based program with cost settlements of the type associated with the HIO can offer any real benefit to the State. In fact, if the experience in Texas is any indicator, costs might actually be expected to increase with an HIO arrangement.

It is clear from an examination of the HIO in Texas and the proposal made for the Virginia Medicaid program that:

1. Because of provisions that substantially limit HIO liability for excess claims, the HIO actually assumes little risk and the State purchases little insurance.

2. The building of reserves in a new HIO would result in increased Medicaid costs for the State.

3. The market incentive in the HIO arrangement appears to work toward the overestimation of premiums. There is no way for the State to fully recover such excess costs.

4. The cost management techniques cited as critical methods used by the HIO to contain costs are all federally mandated cost management activities already in use in Virginia.

5. HIO cost management performance in Texas has been no better than the performance of the fiscal agent approach used in Virginia.

6. The yield on investments of public funds by the State Treasurer will not likely be improved by the HIO contractor.

These concerns raise serious doubts about the usefulness of the HIO as a means to better anage the Medicaid program in Virginia or to contain program costs. JLARC staff will assess the administrative costs of the Medicaid program in other reports in the series on Medicaid.

In conclusion, therefore, the HIO cannot be viewed as a quick fix for escalating Medicaid benefit costs. Further, the substantial costs and disruption to the program to implement an insurance arrangement appear unwarranted given the limited nature of

any benefits likely to be achieved. It does not appear appropriate for Virginia to consider modifying the basic administrative structure of Medicaid at this time.

Recommendation. **The State should retain the fiscal agent administrative structure for the Virginia Medical Assistance Program.**

Appendix A

Agency Responses

As part of an extensive data validation process, each State agency or other organization involved in a JLARC evaluation is given the opportunity to comment on an exposure draft of the report. This appendix contains comments from the Department of Medical Assistance Services, The Computer Company, and Electronic Data Systems Corporation.

DEC 1 2 1991

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

BRUCE U. KOZLOWSKI
DIRECTOR

PATRICIA A. GODBOUT
DEPUTY DIRECTOR-
ADMINISTRATION

JOSEPH M. TEEFEY
DEPUTY DIRECTOR-
OPERATIONS

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
804/225-4512 (Fax)
800/343-0634 (TDD)

December 12, 1991

Mr. Philip Leone
Director
Joint Legislative Audit and Review Commission
Suite 1100
General Assembly Building
Capitol Square
Richmond, Virginia 23219

Dear Mr. Leone:

We have reviewed the exposure draft of your report, Special Report: Evaluation of a Health Insuring Organization for the Administration of Medicaid in Virginia and have no comments to offer.

Thank you for the opportunity to review the report.

Sincerely,

Pat Godbout for

Bruce U. Kozlowski

BUK/tgj

Attachment

THE COMPUTER COMPANY

December 10, 1991

Mr. Glen S. Tittermary
Senior Division Chief
Joint Legislative Audit and Review Commission
Suite 1100
General Assembly Building
Capitol Square
Richmond, VA 23219

Dear Mr. Tittermary:

I have completed a review of an exposure draft of the JLARC special report, Evaluation of a Health Insuring Organization for the Administration of Medicaid in Virginia.

I found the report to be very thorough and objective and I believe the recommendation is appropriate for the Commonwealth.

The only correction I would suggest is to the price per claim on page 4 of the report. The price is $0.522 for State FY '92. The $0.498 price was for State FY '91.

Also, I noticed on the cover of the report that this is "the second report in a series on the Virginia Medicaid program". Since I have no knowledge of the "first" report, I would appreciate a copy for our file. I will be happy to pay for any copying costs.

If The Computer Company can be of any additional assistance to JLARC, as the study continues, please let me know.

Sincerely,

William F. Cozens, Jr.
Executive Account Manager, VMAP

WFC/bsh

cc: Ralph L. Axselle, Jr.
James B. Gooding

Corporate Office 4300 Cox Road Glen Allen, Virginia 23060 • P.O. Box 6987 • Richmond, Virginia 23230 (804) 965-7400 • Fax: (804) 965-7416

December 13, 1991

Mr. Philip A. Leone
Director
Joint Legislative Audit and Review Commission
Suite 1100 General Assembly Building, Capital Square
Richmond, Virginia 23219

Dear Mr. Leone:

I wish to thank the efforts made by your organization in studying the question of an insured arrangement for Medcaid in Virginia. I have included under separate attachment some general items you should consider in your analysis.

Again thank you and your staff for your efforts and if we can provide you with additional information please feel free to contact me at (804) 965-7000.

Sincerely,

John Fortuna

John Fortuna
Director
State Government Marketing

Provost Technical Support Center
4405 Cox Road, Suite 200
Glen Allen, Virginia 23060
(804) 965-7000
Fax: (804) 965-7199

The following are general comments on sections of the JLARC report.

The Transfer of Risk is Limited in an HIO:

* It appears to assume that the contractor must have 100% of the risk to have any incentive to contain costs.

No Apparent Improvement in Cost Management Performance:

* The benefits of the HIO are not in the existance of cost management functions but on how well these functions are performed. The incentive system of the HIO is intended to promote increased effectiveness in cost management. It is the cost management performance that needs to be compared and not the functional titles of departments.

Funding May Be Less Stable:

* A state has to project recipients and cost per client whether they self administor, have a fiscal agent or a HIO. The payment of a premium does not change the predictability of client months or costs per client.

Reserves Increase Budget Outlays:

* Outlays are not increased. Lewin report described a shifting forward of some costs and agreed that effective contractor incentives would reduce program outlays.

Investment Performance Weak and Contrary to Law:

* Lewin report disregarded the increase interest from early draw down of federal funds. Also Lewin report incorrectly calculated the interest earnings returned to the state so it appeared there was no benefit.

Genearal:

* The Lewin report that was used as a base for analysis had inaccuracies that were identified after publication. The state of Texas also did an analysis of the Lewin report which identified opportunities to fine tune the HIO and more quickly achieve program savings. It appears that this additional analysis was not taken into consideration in the JLARC report.

JLARC Staff

RESEARCH STAFF

Director

Philip A. Leone

Deputy Director

R. Kirk Jonas

Division Chief

● Glen S. Tittermary

Section Managers

John W. Long, Publications & Graphics
Gregory J. Rest, Research Methods

Project Team Leaders

Teresa A. Atkinson
Linda E. Bacon
Stephen A. Horan
Charlotte A. Kerr
Susan E. Massart
Robert B. Rotz
Wayne M. Turnage

Project Team Staff

James P. Bonevac
Craig M. Burns
Andrew D. Campbell
Julia B. Cole
Joseph K. Feaser
Stephen P. Fox
Joseph J. Hilbert
Lisa J. Lutz
Laura J. McCarty
Deborah L. Moore
Barbara W. Reese
Phoebe A. Roaf
E. Kim Snead

ADMINISTRATIVE STAFF

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Secretarial Services

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Betsy M. Jackson, Publications Assistant

Interns

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