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May 21, 2003 Joint Committee on Finance Paper #386

HMO Assessment and Payments
(DHFS -- Health Care Financing -- Payments, Services, and Eligibility)

[LFB 2003-05 Budget Summary: Page 211, #2]

CURRENT LAW

Wisconsin contracts with health maintenance organizations (HMOs) to provide comprehensive health care services to certain medical assistance (MA) and BadgerCare enrollees. HMOs use a managed care approach to encourage enrollees to use preventive and less costly services than they would otherwise use if they obtained services from independent providers on a "fee-for-service" basis. HMOs must provide all MA-covered services, with a few exceptions. As a condition of serving MA and BadgerCare enrollees, HMOs must be licensed by the Wisconsin Office of the Commissioner of Insurance (OCI) and meet MA standards for quality assurance, cultural competency, enrollment capacity, and coordination of care.

Currently, HMOs serve low-income families enrolled in MA and BadgerCare in 68 of Wisconsin's 72 counties. As of April, 2003, 13 HMOs were providing services to approximately 256,000 MA enrollees and approximately 77,000 BadgerCare enrollees. As a condition of serving low-income families enrolled in MA, HMOs must agree to also serve families enrolled in BadgerCare.

Capitation Payments. Under the MA and BadgerCare programs, the state provides a fixed monthly payment, or "capitation payment," to the HMO for each MA or BadgerCare beneficiary enrolled in the HMO to cover the cost of services the HMO provides to enrollees. The capitation amount varies, depending on where the beneficiary lives, the age and gender of the beneficiary, and for a woman, whether or not she is pregnant.

HMO capitation payments are established on a calendar year basis. The Department of Health and Family Services (DHFS) determines the total amount paid to HMOs for a calendar year period, based on negotiations with HMOs and the amount of funding budgeted in the MA benefits

appropriation for capitation payments. An HMO's willingness to participate in MA and BadgerCare frequently depends on an HMO's assessment of the feasibility of serving MA and BadgerCare beneficiaries under the terms of the contract and the level of capitation payments. In making this decision, HMOs determine whether the capitation payment represents an acceptable discount from the "fee-for-service equivalent." A "fee-for-service equivalent" is an actuarial calculation of what it would cost to serve MA and BadgerCare beneficiaries under a fee-for-service model. Payments are based on the expectation that, through the use of managed care, HMOs would be able to provide services at a discount to this fee-for-service equivalent estimate.

In calendar year 2003, HMO capitation payments are paid at an estimated average statewide discount of 9.3% for non-pregnant MA recipients, or 9.3% less than the fee-for-service equivalent for that population. The average statewide discount for pregnant women enrolled in MA is 22.6% and 14.6% for BadgerCare recipients. The actual discount varies significantly, depending on the region in which the HMO serves MA and BadgerCare participants. For example, the aggregated discount rate for low-income families in MA varies from 4.3% for HMOs participating in the La Crosse region to approximately 20.6% to HMOs serving the Green Bay region.

Provider Taxes. Federal MA rules define a health care-related tax as a licensing fee, assessment, or other mandatory payment that is related to health care items or services – meaning that at least 85% of the tax burden falls on health care providers. In general, health care-related taxes must be broad-based and applied uniformly to classes of providers in order for the revenue from the tax to be used as the state match for federal MA funds. In addition, the tax may not violate certain hold harmless provisions specified in the rule.

A provider tax is considered to be “broad-based” if it is imposed with respect to all items or services in the class determined by non-federal, non-public providers in the state or is imposed with respect to all non-federal, non-public providers in the class. For example, any such tax on inpatient hospital services could not exempt certain types of private hospitals from the tax, based on the location, characteristics, or mix of patients at these hospitals.

If a state implements a health care provider tax, it must impose it uniformly. A tax is not considered to be uniformly imposed if the state provides for any credits, exclusions, or deductions for providers that have as their intent to return all or a portion of the tax paid or provides for a “hold harmless” provision.

If a provider tax does not meet the standards established in rule for being “broad-based” or “uniformly imposed,” a state may seek a waiver from these requirements. However, if a state applies for such a waiver, it must demonstrate that the net effect of the tax and associated expenditures is redistributive in nature, and the amount of the tax is not directly correlated with MA payments. Further, states may seek a waiver to exempt rural and sole-community providers from a provider tax.

GOVERNOR

Increase MA and BadgerCare benefits funding by $47,222,900 (-$13,873,000 GPR, $23,630,600 FED, and $37,465,300 SEG) in 2003-04 and $58,514,800 (-$8,276,500 GPR, $27,078,100 FED, and $39,713,200 SEG) in 2004-05 to reflect the net effect of: (a) increasing capitation payments made to HMOs that serve MA and BadgerCare enrollees; (b) funding supplemental payments to HMOs; and (c) using a portion of the estimated revenue DHFS would collect from a new assessment on HMOs to replace GPR base funding for MA and BadgerCare benefits. Increase estimates of revenue to the MA trust fund by $37,465,300 in 2003-04 and by $39,713,200 in 2004-05.

HMO Assessment. For the privilege of doing business in this state, require each HMO to pay an annual assessment of one percent of the HMO's gross revenues for the immediately preceding calendar year to the state. Specify that the revenue from the assessment would be deposited in the MA trust fund. Require DHFS to determine the amount of each HMO's assessment, based on a statement that each HMO must file annually, by March 1, with the Office of the Commissioner of Insurance. Require each HMO to pay one-fourth of the total assessment by the end of each calendar year quarter.

Provide that these assessments would first apply to annual statements for 2002 that were due on March 1, 2003, and to assessments that are due on September 30, 2003.

Specify that current applicable statutory provisions regarding deficiency and refund determinations, interest and penalties, administrative provisions, and collection of delinquent taxes that apply to general use and sales taxes would also apply to the HMO assessment created under this provision. Require DHFS to levy, enforce, and collect the assessment and develop and distribute forms necessary for levying and collecting the assessment. Require DHFS to promulgate rules that establish procedures and requirements for levying the new assessment.

Authorize an affected HMO to contest an action by DHFS related to this assessment by submitting a written request for a hearing to DHFS within three days after the date of the DHFS action. Specify that any DHFS order or determination that results from such a hearing would be subject to judicial review under Chapter 227 of the statutes.

Payments to HMOs. Create a biennial, sum certain SEG appropriation from the MA trust fund to support supplemental payments to HMOs. Specify that all moneys received from the HMO assessment would be credited to this appropriation. Require DHFS to provide supplemental payments to HMOs from this new appropriation to assist the HMOs in meeting increasing costs and more intense utilization of services by MA and BadgerCare recipients and other reimbursement needs DHFS identifies.

DISCUSSION POINTS

Modification to the Bill

1. In a letter to the Co-chairs of the Joint Committee on Finance dated March 17, 2003, the DOA Secretary asked the Co-chairs to consider increasing funding in SB 44 related to this item. The letter indicates that, to accurately reflect the Governor's intent for funding for HMO payments under MA and BadgerCare, funding in the bill would need to be increased by $8,051,600 (-$6,737,000 GPR, $10,953,900 FED, and $3,834,700 SEG) in 2003-04 and $42,985,500 ($3,551,200 GPR, $35,369,500 FED, and $4,064,800 SEG) in 2004-05.

2. Under the Governor's recommendations, as modified, revenue from the assessment would be used to reduce base GPR support for MA and BadgerCare, increase HMO capitation payments, and provide supplemental payments to HMOs equal to 70% of the estimated revenue available from the assessment. The administration estimates that the discount rate under this proposal would total: (a) 8%, beginning in 2004 for low-income families in MA: (b) 16%, beginning in 2004, and 8%, beginning in 2005, for pregnant women enrolled under the Healthy Start criteria; and (c) 12%, beginning in 2004, and 8%, beginning in 2005, for BadgerCare enrollees.

3. Under the MA and BadgerCare base reestimates prepared by this office, payments to HMOs are expected to total approximately $469.8 million (all funds) in 2003-04 and $475.0 million (all funds) in 2004-05 for low-income families enrolled in MA and approximately $134.3 million (all funds) in 2003-04 and approximately $144.8 million (all funds) in 2004-05 for families enrolled in BadgerCare.

4. Based on the estimated cost to fund capitation payments based on current law, the cost to implement the revised proposal identified in DOA's March 17, 2003 letter has been reestimated. Based on this reestimate, revenue to the MA trust fund would increase by $41.9 million SEG-REV in 2003-04 and $44.0 million SEG-REV in 2004-05, which is $4,434,700 in 2003-04 and $4,286,800 in 2004-05 more than assumed in SB 44. The current estimate is based on more recent information about gross revenue collected by HMOs in 2002. The original estimates were based on 2001 revenue. This reestimate assumes that the assessment would apply to both health care and investment-related revenue.

5. In addition, the costs of providing reimbursement increases to HMOs, based on the administrations' revised proposal, have been reestimated. The following table summarizes the allocation of assessment revenue under the administration's revised proposal, which incorporates the MA and BadgerCare base reestimates.

Governor's Modified Proposal, as Reestimated
Use of HMO Assessment Revenue

	2003-04				2004-05			
	GPR	FED	SEG	Total	GPR	FED	SEG	Total
Base Funding	-$18,728,500	$0	$18,728,500	$0	-$9,664,700	$0	$9,664,700	$0
Capitation Payments	0	18,431,200	11,751,800	30,183,000	0	37,646,700	22,737,600	60,384,300
Supplemental Payments	0	17,910,300	11,419,700	29,330,000	0	19,202,300	11,597,700	30,800,000
Total	-$18,728,500	$36,341,500	$41,900,000	$59,513,000	-$9,664,700	$56,849,000	$44,000,000	$91,184,300

The administration indicates that the supplemental payments to HMOs under this proposal would be distributed proportionally to HMOs based on their MA and BadgerCare enrollment. However, federal regulations limit payments to HMOs at the managed care equivalent, or fee-for-service equivalent. Therefore, actual allocations may be modified to ensure that no HMO would receive a total payment that exceeds the managed care equivalent.

6. The purpose of the Governor's recommendations is to use revenue from the assessment to claim federal MA matching funds, which could be used to fund increased payments to HMOs. Under this proposal, funding to increase MA and BadgerCare payments would total $59,513,000 in 2003-04 and $91,184,300 in 2004-05.

7. The administration argues that without the revenue from the assessment, the state cannot afford to increase payments to HMOs under MA and BadgerCare and not providing increases in the capitation rates increases the risk that some HMOs may choose not to contract with DHFS to serve MA and BadgerCare enrollees. If changes in the fee-for-service equivalent are not funded, the discount rate at which HMOs serve MA and BadgerCare recipients would increase because the capitation rates would not keep up with changes in utilization. It is estimated that HMO capitation payments would need to be increased by 6.1% annually to maintain the current discount rates.

8. In negotiating with HMOs for the 2002 contract, CompCare, one HMO decided not to continue participating in MA and BadgerCare because the capitation payments would not support the HMOs' costs of providing services to these groups. As a result, in some areas of the state where CompCare had previously been one of only two HMOs serving that geographic area, MA and BadgerCare beneficiaries are no longer required to enroll in an HMO as a condition of receiving MA and BadgerCare benefits. In 2002 and 2003, additional HMOs withdrew services from certain geographic areas of the state.

Effect of HMO Assessment

9. Based on unaudited reports submitted by HMOs to OCI for calendar year 2002, it is estimated that revenue from the assessment under the Governor's proposal total $41.9 million in 2003-04 and $44.0 million in 2004-05. These estimates assume that gross HMO revenue would increase by 5% in calendar year 2003 and an additional 5% in calendar year 2004.

10. Under this proposal, all licensed HMOs in Wisconsin would be required to pay the assessment, but only those HMOs that participate in MA and BadgerCare would benefit by receiving increased payments under these programs. Currently, 13 of the state's 20 licensed HMOs participate in MA and BadgerCare. The remaining seven HMOs would pay the assessment and not benefit from the increased MA and BadgerCare payments.

11. Under federal law, any permissible provider tax will create "winners" and "losers." Those HMOs where revenue from MA and BadgerCare represents a smaller portion of their gross revenue compared with revenue from commercial plans would likely end up paying more in the assessment than they receive back in increased payments. Those HMOs with a large share of revenue from MA and BadgerCare relative to gross revenue would fare better under an assessment. Attachment 1 to this paper identifies, for each HMO, 2002 gross revenue and net income, as reported by OCI, and projected 2003 MA and BadgerCare payments.

12. In 2002, HMOs reported net income of approximately $63.8 million, which represents gross revenue, less expenses. While this net income is sufficient as a whole to absorb the amount of the assessment under the bill without increasing premiums for other payers, it is not clear that 2002 net income would be indicative of future revenue. In 2001, net income for all HMOs was approximately $10.0 million. In 2000, HMOs reported net income of $3.0 million. The distribution of net income across the HMOs varies significantly, as seen in Attachment 1. Some HMOs may have sufficient income to absorb the assessment, others may not.

13. Additionally, some HMOs may pass along an assessment in the form of premium increases for commercial payers, regardless of their reported net income. Those HMOs that receive increased MA and BadgerCare payments under the Governor’s proposal could use those increased payments to increase payments to the HMOs’ providers, reduce premiums for other payers, or offset any reductions in net income.

14. It has been argued that an assessment on HMOs would place HMOs at a competitive disadvantage with other types of insurers in Wisconsin, risking HMOs participation in the Wisconsin health care coverage market. It is not known to what extent this would occur. Meeting market demands, controlling outside patient referral expenses, and maintaining enrollment growth appear to be the significant factors that allow HMOs to stay in a market.

15. HMOs have been losing market share to other types of plans available to employers, such as preferred provider organizations and point-of-service health plans. Data from the Kaiser Family Foundation and Health Research and Education Trust indicates that, nationally, the share of

covered workers enrolled in an HMO decreased from a high of 31% in 1996 to 26% in 2002, while the share of workers that were enrolled in a preferred provider organization plan increased from 28% to 52% over that same period.

16. Some HMOs may continue to operate with net losses, regardless of whether the state creates the assessment. For example, according to quarterly financial reports filed with OCI, Humana, which had over 86,000 enrollees in 2002, had a net loss of approximately $15.2 million in 2001 and $6.4 million in 2002. Humana does not participate in MA and BadgerCare and therefore, would not benefit from increased payments under MA and BadgerCare.

17. Therefore, if an HMO exits the market after the creation of an assessment, this decision would be based on a variety of factors, including the HMOs own business situation, as well as the new assessment.

18. Alternatively, an assessment on HMOs could provide an incentive for HMOs to increase participation in MA and BadgerCare as a way of recouping more of the assessment revenue paid by an HMO. However, it is unclear how effective this incentive might be, since a federally-permissible provider tax would have distributional effects on all HMOs.

Distribution of the Assessment Revenue

19. Any provider assessment and the distribution of payments from the revenue of that assessment would require approval by the Centers for Medicare and Medicaid Services (CMS). In considering approval of a provider tax, CMS officials would review the way in which the assessment would be levied and the distribution of payments from the revenue to ensure that it conforms with federal laws and regulations on the provider tax issue and payments to managed care organizations. The administration indicates that the HMO assessment created under the bill must be applied to non-MA and BadgerCare HMOs if the revenue from new assessment would be used to claim federal MA matching funds.

20. However, the state of Michigan recently received approval from CMS to assess its MA HMOs equal to an amount that would provide a 5% increase in capitation payments to HMOs serving the state's MA population. HMOs that do not participate in Michigan's MA program are not subject to the assessment. There are currently 26 licensed HMOs in Michigan, of which 18 participate in the state's MA program. The amount paid by each HMO is proportional based on each HMO's premium revenue from all sources other than Medicare.

21. Based on conversations with staff from Michigan's MA program, in approving Michigan's state plan amendment, CMS officials wanted to ensure that the distribution of revenue under the Michigan proposal was not based proportionately on the amount paid by each HMO. Specifically, to receive CMS approval, the payment of the assessment and its distribution had to produce "winners" and "losers," meaning some HMOs had to pay more than they received and others had to receive more than they paid. Michigan officials indicated that the state had to make several modifications to its payment formula to meet CMS requirements for approval.

22. If the Committee wanted to create an HMO assessment to fund rate increases to HMOs, and minimize the number of HMOs that would not benefit by increased MA and BadgerCare payments, it could limit the assessment to only those HMOs that participate in MA and BadgerCare. In this way, the seven HMOs that currently do not participate in MA and BadgerCare would not be subject to the assessment. Based on the Michigan experience, it appears that such an assessment could be approved by CMS.

The estimated amount of revenue available from a 1% assessment on just those HMOs that currently participate in MA and BadgerCare would generate $30.8 million in 2003-04 and $32.4 million in 2004-05. This would represent a decrease to the estimated SEG revenue in the bill of $6,665,300 in 2003-04 and $7,313,200 in 2004-05. Under this alternative, if the same amount of funding was allocated to reduce base GPR costs in MA and BadgerCare as provided in the reestimate of the modified Governor's recommendations, then the total increase in capitation payments would be $53,811,800 in 2003-04 and $60,776,800 FED in 2004-05.

23. Alternatively, the Committee could reduce the amount of the assessment to 0.5% of gross revenue to minimize the impact on HMOs. Under this proposal, estimated SEG revenue would decrease by $16,565,300 in 2003-04 and $17,713,200 in 2004-05, compared with the amounts in the bill. Under this alternative, if the same amount of funding is allocated to reduce base GPR costs in MA and BadgerCare, as provided in the reestimate of the revised Governor's recommendations, then the total increase in capitation payments would be $34,011,800 in 2003-04 and $39,976,800 in 2004-05.

24. Under any of these alternatives, the administration would have to determine how to distribute the additional funding between increasing capitation payments to maintain the current discount rates, address disparities in the regional discount rates, and fund supplemental payments in a manner that would meet CMS approval under a state plan amendment. The appropriation created in the bill for supplemental payments to HMOs is a biennial appropriation. Therefore, DHFS would have flexibility to allocate the funding between fiscal years since HMO contracts are negotiated on a calendar year basis.

25. Finally, the Committee could delete the Governor's provisions and provide $13,873,000 GPR in 2003-04 and $8,276,500 GPR in 2004-05 to restore base MA funding that would have been supported with revenue from the assessment under the bill. If the Committee chooses to delete the Governor's recommendation, no funding would be provided to support increased reimbursement to HMOs in the 2003-05 biennium. Capitation payments would be maintained at calendar year 2003 levels and would not be adjusted for changes in utilization of services by HMO enrollees.

ALTERNATIVES

1. Approve the Governor's revised recommendations, as described in DOA's March 17, 2003, letter, as reestimated and identified in Attachment 2.

Alternative 1	GPR	FED	SEG	TOTAL
2003-05 REVENUE (Change to Bill)	$0	$0	$8,721,500	$8,721,500
2003-05 FUNDING (Change to Bill)	- $6,243,700	$42,481,800	$8,721,500	$44,959,600

2. Modify the Governor's recommendations to specify that the assessment would only apply to those HMOs that participate in MA and BadgerCare and modify the amounts in the bill, as indicated in Attachment 2.

Alternative 2	GPR	FED	SEG	TOTAL
2003-05 REVENUE (Change to Bill)	$0	$0	- $13,978,500	- $13,978,500
2003-05 FUNDING (Change to Bill)	- $6,243,700	$29,073,100	- $13,978,500	$8,850,900

3. Modify the Governor's recommendations to specify that the HMO assessment would be 0.5% of an HMOs' gross revenue, rather than 1.0%, and would apply to all HMOs, as recommended by the Governor. Modify the amounts in the bill, as indicated in Attachment 2.

Alternative 3	GPR	FED	SEG	TOTAL
2003-05 REVENUE (Change to Bill)	$0	$0	- $34,278,500	- $34,278,500
2003-05 FUNDING (Change to Bill)	- $6,243,700	$8,773,100	- $34,278,500	- $31,749,100

4. Delete provision.

Alternative 4	GPR	FED	SEG	TOTAL
2003-05 REVENUE (Change to Bill)	$0	$0	- $77,178,500	- $77,178,500
2003-05 FUNDING (Change to Bill)	$22,149,500	- $50,708,700	- $77,178,500	- $105,737,700

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Attachment

ATTACHMENT 1

2002 Revenue and Net Income, and 2003 MA/BadgerCare Payments by HMO

	2002 Revenue*	2002 Net Income*	Estimated 2003 Payments MA/BadgerCare**
United Health Care of WI	$714,473,701	$14,043,091	$126,419,081
Dean Health Plan, Inc.	529,037,022	2,212,761	16,516,664
Compcare Health Services Insurance Corp.	383,344,832	811,903	0
Touchpoint Health Plan, Inc.	303,070,576	3,310,794	24,323,689
Security Health Plan, Inc.	285,800,680	7,348,086	40,863,874
Humana WI Health Organization Insurance Corp.	246,295,333	-6,446,754	0
Physicians Plus Insurance Corp.	233,702,675	9,173,262	0
Network Health Plan, Inc.	232,130,180	5,887,890	44,580,853
Managed Health Services Insurance Corp.	200,441,793	6,030,662	154,404,040
Unity Health Plans Insurance Corp.	197,043,026	4,360,968	5,345,536
Group Health Cooperative of South Central WI	130,954,837	10,578,234	3,713,807
Gundersen Lutheran Health Plan, Inc.	110,595,879	1,607,563	0
Group Health Cooperative of Eau Claire	98,209,083	459,366	21,162,227
Valley Health Plan, Inc.	88,089,390	1,066,305	1,463,269
Atrium Health Plan, Inc.	76,876,503	1,680,623	42,074,230
MercyCare Insurance Co.	67,212,417	436,730	10,985,018
Health Tradition	66,942,741	430,244	7,847,952
PHP Health Plans Inc./Previa Health Plans, Inc.	63,862,513	1,194,325	0
Medical Associates Clinic Health Plan of WI	17,230,068	27,707	0
Medica Health Plans of WI	10,541,902	-427,519	0
TOTAL	$4,055,855,151	$63,786,241	$499,525,221

*As reported by the Office of the Commissioner of Insurance
**Determined by DHFS

ATTACHMENT 2

Summary of Alternatives

Alternative	Revenue to the Trust Fund 2003-04	Revenue to the Trust Fund 2004-05	2003-04 GPR	2003-04 FED	2003-04 SEG	2003-04 Total	2004-05 GPR	2004-05 FED	2004-05 SEG	2004-05 Total
Funding in SB 44	$37,465,300	$37,913,200	-$13,873,000	$23,630,600	$37,465,300	$47,222,900	-$8,276,500	$27,078,100	$39,713,200	$58,514,800
Alternative 1										
Governor's Recommendations, as modified	$41,900,000	$44,000,000	-$18,728,500	$36,341,500	$41,900,000	$59,513,000	-$9,664,700	$56,849,000	$44,000,000	$91,184,300
Change to Bill	4,434,700	4,286,800	-4,855,500	12,710,900	4,434,700	12,290,100	-1,388,200	29,770,900	4,286,800	32,669,500
Alternative 2										
1% Assessment on MA/BC HMOs only	$30,800,000	$32,400,000	-$18,728,500	$41,740,300	$30,800,000	$53,811,800	-$9,664,700	$38,041,500	$32,400,000	$60,776,800
Change to Bill	-6,665,300	-7,313,200	-4,855,500	18,109,700	-6,665,300	6,588,900	-1,388,200	10,963,400	-7,313,200	2,262,000
Alternative 3										
0.5% Assessment on All HMOs	$20,900,000	$22,000,000	-$18,728,500	$31,840,300	$20,900,000	$34,011,800	-$9,664,700	$27,641,500	$22,000,000	$39,976,800
Change to Bill	-16,565,300	-17,713,200	-4,855,500	8,209,700	-16,565,300	-13,211,100	-1,388,200	563,400	-17,713,200	-18,538,000
Alternative 4										
Delete Provision	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Change to Bill	-37,465,300	-37,913,200	13,873,000	-23,630,600	-37,465,300	-47,222,900	8,276,500	-27,078,100	-37,913,200	-56,714,800

*Assuming that funding is distributed on a calendar year basis.