DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date FEB 26 1997

From June Gibbs Brown
Inspector General

Subject State of Wisconsin's Medicaid Managed Care Program Financial Safeguards
(A-05-95-OO060)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

This memorandum is to alert you to the issuance on February 28, 1997 of our final report. A copy is attached.

The objective of our review was to assess whether the profits earned by health maintenance organizations (HMO) from the Medicaid managed care program were considered in establishing Medicaid cavitation rates. To meet our objective, we examined in detail the financial data submitted by the largest of the nine Medicaid contracting HMOS in the State of Wisconsin to determine the amount and reasonableness of profits earned under its Medicaid contract.

The State of Wisconsin sets the cavitation rate based on an actuarial study, and does not consider the contractors' financial data, specifically Medicaid profit margins, when establishing or adjusting the rate.

Based on our financial review of the selected contracting HMO, we determined that during the 3-year period from January 1, 1992 to December 31, 1994 the contractor's profit from the Medicaid managed care program exceeded our benchmark for reasonableness by $4 million. The excessive profits were due to the inflated costs of related party transactions which resulted in the contractor's Medicaid profits presented on the financial statements to be understated by $8.9 million. During this period, the contracting HMO benefitted from three increases in the Medicaid cavitation rate.

In our opinion, if the State had formulated the excess profits from the audited HMO into the calculation of the cavitation rate, they could have experienced an additional $4 million ($2.4 million Federal share) in Medicaid cost savings from just this one HMO.

We are recommending that the Wisconsin Department of Health and Social Services (DHSS):

- Establish policies and procedures with the State's Office of the Commissioner of Insurance (OCI) to monitor the financial status of Medicaid managed care HMOs.

- Meet regularly with the OCI to review HMO financial data related to Medicaid HMOS.

- Use the contractors' financial information, specifically data relative to profit margins, along with the actuarial reports, when setting or adjusting cavitation payment rates.

In their response to our draft report, the DHSS did not dispute the specific findings regarding the HMO we reviewed, however, they disagreed with the general conclusions contained in the audit report based on just one review. However, the State is concerned about the cost effectiveness of their HMO initiative and presented an action plan that they intend to implement which will address many of the concerns we have.

We considered the State's comments and revised our report to be more specific to the HMO we reviewed and the related effects on their HMO initiative statewide.

For further information, contact:

Paul P. Swanson
Regional Inspector General
for Audit Services, Region V
(312) 353-2618

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

STATE OF WISCONSIN'S MEDICAID MANAGED CARE PROGRAM FINANCIAL SAFEGUARDS

JUNE GIBBS BROWN
Inspector General

FEBRUARY 1997
A-05-95-OO060

DEPARTMENTOF HEALTH AND HUMAN SERVICES
REGION V
105 W ADA MS ST
CHICAGO. ILLINOIS 60603-6201

OFFICE OF
INSPECTOR GENERAL

Common Identification Number: A-05-95-00060

Peggy L. Bartels, Director
Bureau of Health Care Financing
1 West Wilson Street
P. o. Box 309
Madison, Wisconsin 53701-0309

Dear Ms. Bartels:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' report entitled, "State of Wisconsin's Medicaid Managed Care Program Financial Safeguards." The audit covered the period from January 1, 1992 through December 31, 1994. A copy of this report will be forwarded to the action official noted below for their review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), HHS/OIG reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5.)

To facilitate identification, please refer to Common Identification Number A-05-95-00060 in all correspondence relating to this report.

Sincerely,

Paul Swanson

Paul Swanson
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:
David DuPre, Associate Regional Administrator
Division of Medicaid
Health Care Financing Administration
105 West Adams, 14th Floor
Chicago, Illinois 60603

EXECUTIVE SUMMARY

OBJECTIVE

The objective of our review was to assess whether the profits earned by health maintenance organizations (HMO) from the Medicaid managed care program were considered in establishing Medicaid cavitation rates.

FINDINGS

The State of Wisconsin could make its Medicaid managed care program more cost effective. Although the State required contractors to submit financial data on their operations, the State does not analyze or consider the financial data, particularly profit margins, when establishing cavitation rates.

Based on our financial review of one contracting HMO, we determined that during a 3-year period the contractor's Profit from the Medicaid managed care program exceeded our benchmark for reasonableness by $4 million. Due to inflated costs of related party transactions, the contractor's Medicaid profits presented on the financial statements were understated by $8.9 million. During this period, the contracting HMO benefitted from three increases in the Medicaid cavitation rate.

The State sets the cavitation rate based on an actuarial study, and does not consider the contractors' financial data, specifically Medicaid profit margins, when establishing or adjusting the rate. Consequently, although the contractors were required to submit financial data concerning their Medicaid managed care programs, the State had no incentive to ensure the data was collected or analyzed when it was received.

In our opinion, if the State had formulated the excess profits from the audited HMO into the calculation of the cavitation rate, they could have experienced an additional $4 million in Medicaid cost savings from just the one HMO.

RECOMMENDATIONS

We recommend that Department of Health and Social Services (DHSS):

- Establish policies and procedures with the State's Office of the Commissioner of Insurance (OCI) to monitor the financial status of Medicaid managed care HMOS.

- Meet regularly with the OCI to review HMO financial data related to Medicaid HMOs.

- Use the contractor's financial information, specifically data relative to profit margins, along with the actuarial reports, when setting or adjusting cavitation payment rates.

In their response to our draft report, the DHSS did not dispute the specific findings regarding the HMO we reviewed, however, they disagreed with the general conclusions contained in the audit report based on just one review. The State is concerned about the cost effectiveness of their HMO initiative and presented an action plan that they intend to implement.

We considered the State's comments and revised our report to be more specific to the HMO we reviewed and the related effects on their HMO initiative statewide.

The State's response is presented in its entirety in APPENDIX B.

TABLE OF CONTENTS

BACKGROUND

Federal and state governments are increasingly looking to managed care programs as a way to contain costs while providing greater access to care and improving quality of care. Wisconsin (WI) has operated a primary care case management program supported by a waiver from Section 1915(b) of the Social Security Act, since August 1984. As of January 1994, the WI Department of Health and Social Services (DHSS) had risk contracts with nine health maintenance organizations (HMO) in three counties within the State. Starting October 1, 1996, the DHSS is committed to expanding the Medicaid managed care program to all Wisconsin counties, where access to a primary care physician can be assured.

Under the Section 1915(b) waiver, the Medicaid recipients must obtain medical services from an HMO which contracts with the WI DHSS . Contracting HMOS assume the financial risk of providing all covered medical services to eligible enrollees for a negotiated fixed monthly payment known as the cavitation payment. The DHSS sets the cavitation rate based on an actuarial study.

In a prior Office of Audit Services (OAS) survey of the WI Medicaid managed care program (May 1995) , we determined that the WI DHSS had established administrative procedures to monitor Medicaid managed care contracts. The DHSS had procedures to select HMOS, contract with them, and monitor the quality of care provided to Medicaid enrollees. The State indicated that the Medicaid program only contracts with HMOS licensed by the Office of the Commissioner of Insurance (OCI) . Additionally, DHSS relies on the OCI for financial regulation, instead of monitoring the financial aspects of the Medicaid HMOs.

The OCI is primarily concerned with the solvency of the HMO and its ability to meet financial reserve requirements. In that regard, all HMOS are required to submit annual financial reports of their business operations. While these reports disclose related parties with whom an HMO does business, OCI only looks at the HMO's operations in total. Neither OCI or DHSS are concerned with the profits earned by any particular line of business.

To expand our survey, a financial related audit at a Milwaukee County Medicaid HMO (MA-HMO) was initiated. The MA-HMO selected, the largest of nine Wisconsin MA-HMOs, had: (1) financial records in sufficient detail to quantify revenue and expenses related to the Medicaid managed care contract, (2) a variety of related party contracts, and (3) profits during the audit period.

OBJECTIVE, SCOPE & METHODOLOGY

The objective of our review was to assess whether the profits earned by HMOS from the Medicaid managed care program were considered in establishing Medicaid cavitation rates.

To meet our objectives, we selected the largest of the nine MA-HMOS for a review of financial records during the period January 1, 1992 through December 3i, 1994. Since the objectives of this review did not require an assessment of the selected MA-HMO's internal control structure, we limited the analysis to a review of the financial information being considered by the State agency. Our evaluation included such tests of the accounting records as were considered necessary under the circumstances. Accordingly, we do not express an opinion on the internal controls.

To accomplish our objective, we determined: (1) the amount of Medicaid cavitation revenue used for medical services; (2) the amount and reasonableness of transactions between the selected MA-HMO and its related parties; and (3) the level and reasonableness of profits earned under the Medicaid managed care program. We generally obtained and reviewed documentation, including Medicaid managed care contracts, financial statements, accounting records, and related party agreements, applicable to our review objectives. To quantify the Medicaid pre-tax profit, management fee and reinsurance premium, we considered the HMOS methodology.

We conducted our field work at the selected MA-HMO located in Milwaukee, WI. We completed our review work in the Madison Field Office.

Our evaluation was made in accordance with generally accepted government auditing standards applicable to our objective.

FINDING IN DETAIL

The State of Wisconsin could make its Medicaid managed care program more cost effective. Although the State required contractors to submit financial data on their operations, the State does not analyze or consider the financial data, particularly profit margins, when establishing cavitation rates. Based on our financial review of one HMO, we determined that it is possible for contractors to earn unreasonable profits from the Medicaid managed care program, obscure these profits in their financial reporting, and concurrently receive increases in their Medicaid cavitation rates.

CRITERIA

The DHSS Medicaid managed care contract with participating HMOS states that the HMO will provide an annual audit report with financial statements "... presented in a form specified by the Department that clearly shows the financial position of the HMO in each enrollment area. . . . " It goes on to state the HMO agrees to provide either: 1) a clear indication of total costs related to enrollees, as part of the annual audit, or 2) estimates based on generally accepted accounting principles and supporting working papers of those total costs. This has not occurred.

CONDITION

We determined that, during the period of January 1, 1992 through December 31, 1994 the selected MA-HMO experienced an estimated $22.9 million profit from the Medicaid managed care program which exceeded our benchmark for reasonableness by $4 million. However, the MA-HMO reported Medicaid pre-tax earnings of only $14 million on their financial statements. The understatement of earnings was attributable to the inflated costs of related party transactions for reinsurance and management fees amounting to $2.9 million and $6.0 million, respectively. The MA-HMO profit of **$22.9** million, rather than the $14 million reported on their financial statements, is presented below.

YEAR	PRE - TAX INCOME	NET REINSURANCE	MANAGEMENT FEE (Income Portion)	TOTAL
1992	$2,700,000	$1,000,000	$1,300,000	$5,000,000
1993	4,100,000	1,000,000	1,800,000	6,900,000
1994	7,200,000	900,000	2,900,000	11,000,000
TOTAL	$14,000,000	$2,900,000	$6,000,000	$22,900,000

To establish a benchmark for the reasonableness of the $22.9 million profit, we used: (1) a profit margin guideline of 5 percent of premium revenues, established by the Pennsylvania Department of Insurance for the managed care industry in that State, and (2) the minimum surplus requirements for WI contractors, established by WI's OCI based on the contractor's HMO premiums earned. This benchmark allows at least a 9 percent profit margin on revenue. See Appendix A for calculations. We determined the MA-HMO's Medicaid profit exceeded our benchmark during 1993 and 1994, by $4 million, as indicated below.

EXCESS EARNINGS			
YEAR	PRE-TAX INCOME	OIG BENCHMARK	EXCESS PRE-TAX PROFIT
1992	$5,000,000	$6,250,000	N/A
1993	6,900,000	6,750,000	$150,000
1994	11,000,000	7,150,000	3,850,000
TOTAL	$22,900,000		$4,000,000

We were able to identify the understated income by analyzing the financial data that the MA-HMO was required to submit to the DHSS . Our review of this data and supporting documentation disclosed that the reinsurance and management fee expenses resulted from less than arms length transactions and were inflated. Details are presented below.

Reinsurance Coverage. The Medicaid managed care contract is a "risk" contract. An individual HMO is at risk of experiencing a loss attributable to the enrollees cost of services exceeding the

[1] WI, like most States, has not established profit margin guidelines for the managed care industry. The 5 percent of premium revenue benchmark is based on prior OAS reviews and we believe it is a reasonable basis.

cavitation revenue. Under a reinsurance contract, stop-loss coverage shifts the financial liability from the HMO to the insurer, in this case the affiliate, for any enrollee whose costs exceed a certain level within a contract period. In exchange for assuming the financial risk, the HMO makes a per member per month reinsurance payment to the affiliate.

To evaluate the reasonableness of the reinsurance expense, we computed a recovery rate. This rate is a comparison of the recoveries to the reinsurance payments. We used the per member per month reinsurance rate and monthly Medicaid enrollment information supplied by the MA-HMO to estimate reinsurance payments. We quantified reinsurance expense, net of recoveries, from the financial statements. As shown below, our analysis found that the reinsurance payments greatly exceeded recoveries.

YEAR	REINSURANCE PAYMENTS (total expense)	RECOVERIES	REINSURANCE EXPENSE NET OF RECOVERIES	RECOVERY RATE
1992	$1,001,000	$12,000	$989,000	1.20%
1993	1,009,000	28,000	981,000	2.78%
1994	1,010,000	60,000	950,000	5.94%
TOTAL	$3,020,000	$100,000	$2,920,000	3.31%

In addition to the minimal recoveries, the per member per month cost increased dramatically as the MA-HMO switched coverage from an unaffiliated insurer to the related party during 1991. An OCI review for the 3-year period ending December 31, 1992 reported almost a 560 percent increase in cost between 1990 and 1991, with another 94 percent cost increase from 1991 to 1992.

We also compared the MA-HMO's reinsurance expenses, net of recoveries, to total premium revenues and found that for the 3-year period, the Medicaid reinsurance rates were, at a minimum, nine times larger than the national average. We concluded the $2.9 million reinsurance expense, net of recoveries, is an inflated unreasonable expense that would not have been incurred if the reinsurance agreement had been with an unaffiliated entity.

Management Fees. In 1991, the MA-HMO entered into a management service agreement with its parent company. The agreement is comprised of two management service fee components: the premium portion and the income portion. The contract agreement states that the MA-HMO shall pay the parent company a monthly management fee of 1.85 percent of gross revenues, excluding interest income-, plus 25 percent of pre-tax profit (after deducting the premium portion of the management fee) for that month. The management fee expense for Medicaid includes:

MANAGEMENT SERVICES FEE			
YEAR	PREMIUM PORTION (1.85% of REVENUES)	INCOME PORTION (25% of PRE-TAX PROFITS)	TOTAL
1992	$1,300,000	$1,300,000	$2,600,000
1993	1,400,000	1,800,000	3,200,000
1994	1,500,000	2,900,000	4,400,000
TOTAL	$4,200,000	$6,000,000	$10,200,000

While the premium portion of $4.2 million may appear reasonable, the income portion of $6.0 million is essentially a profit sharing plan with the parent company that is an unreasonable charge to Medicaid.

ROOT CAUSE

The DHSS sets the cavitation rate based on an actuarial study and does not consider the contractors' financial data, specifically Medicaid profit margins, when establishing or adjusting the rate. Consequently, although the contractors were required to submit financial data concerning their Medicaid managed care programs, the DHSS did not ensure that the data was collected and analyzed and did not use this financial information to set or adjust its rates. During the review period, the State enacted three Medicaid cavitation rate increases, while the selected HMOS earnings surpassed the OAS benchmark for reasonableness. Additional details regarding the Medicaid cavitation rate increases are located in an EXHIBIT following the report.

Since DHSS officials did not review the financial aspects of the HMOS , they were unaware of the HMOs' levels of profitability. Although DHSS officials did not believe HMOS were making excessive profits, this assumption had never been verified through audit. Rather than conducting financial audits of participating HMOS, the DHSS is concerned that the HMOS meet the expectations of providing medically necessary and appropriate services to Medicaid enrollees. The DHSS has relegated the responsibility for determining the financial viability and solvency of HMOS to the OCI. Since the OCI does not perform audits of the contractors' financial reports to assess the reasonableness of contractor's Medicaid profits, financial data is not considered when the State sets or adjusts the Medicaid cavitation payment rates.

EFFECT

In our opinion, if the DHSS had adjusted the cavitation rate based on the excess profits noted at our selected HMO, the State could have realized additional savings of at least $4 million in the Medicaid managed care program. Details are, as follows:

ESTIMATED SAVINGS - Selected HMO		
	1993	1994
Savings per Member Month	$0.23	$5.83
MA-HMO Member Months*	660,000	660,000
Medicaid Excess Pre-tax Profit	$150,000	$3,850,000
ESTIMATED TOTAL SAVINGS	$4,000,000	

Factors contributing to the significant increase in pre-tax profit between 1993-and 1994 include: (1) Medicaid cavitation rate increases, *(2)* increased efficiency, and (3) inflated related party transactions.

Both the State and Federal programs would benefit from reducing Medicaid program expenses.

RECOMMENDAT IONS

As the Medicaid managed care program expands, the actuarial data currently used for the cavitation rates will erode. To ensure program savings, other alternatives will be needed to set the cavitation rates. Monitoring the financial status of Medicaid HMOS and using the information in the rate setting process could have resulted in additional Medicaid savings of at least $4 million ($2.4 million Federal share) during 1993 and 1994. We believe it is crucial to the success of the program that DHSS improve its oversight function of the financial performance of Medicaid managed care contractors.

We recommend that DHSS:

- Establish policies and procedures with the State's OCI to monitor the financial status of Medicaid managed care HMOs.
- Meet regularly with the OCI to review HMO financial data related to Medicaid HMOS.

---

[2] Member months are rounded to the nearest 10,000.

- Use the contractor's financial information, specifically data relative to profit margins, along with the actuarial reports, when setting or adjusting cavitation payment rates.

Subsequent to the audit period, the State discontinued the contract provision requiring HMOS to submit cost reports. Consequently, two of the recommendations proposed in the draft of this report were eliminated and replaced with the suggestion to work with OCI to regulate, review,-and monitor HMO financial information.

On November 6, 1996, DHSS responded to a draft of this report. We reviewed the response and have made some changes to this report . The DHSS response is included in its entirety as Appendix B.

AUDITEE COMMENTS

The DHSS does not dispute the specific findings regarding the HMO we reviewed, however, they disagree with the general conclusions contained in the audit report based on just one review. The State also disagrees with the implied position of the report regarding setting or adjusting the HMO rates based on individual HMO profit margins. The DHSS is concerned about the cost effectiveness of their HMO initiative and intends to implement the following action:

1. Establish a work group comprised of staff from the HMO policy and rate setting unit and the OCI to meet regularly to review HMO financial data related to Medicaid HMOs, with the possibility of establishing threshold indicators.

2. Identify Medicaid programs in other states which utilize profit-related adjustments and assess their effectiveness.

3. Re-examine the current WI HMO rate setting methodology for effectiveness and determine whether profit-related adjustment may be warranted.

OFFICE OF AUDIT SERVICES RESPONSE

Based on the State's objections to some of the general conclusions in our draft report we revised those conclusions to be more specific to the entity we reviewed and to demonstrate the effects that the results from just one entity may have on the HMO initiative statewide. Accordingly, we revised our estimated cost savings amount.

In our opinion, the State's proposed action plan is an aggressive response to our recommendations regarding the cavitation payment

rates . We believe the key to this plan is that DHSS work with OCI to assure adequate regulation.

Currently, the Medicaid cavitation rate is set solely based on a fee-for-service equivalent developed from an actuarial study. As the State expands the managed care program statewide, the actuarial data will change and may no longer be statistically representative of the Medicaid population. While we believe the State does go to great lengths to set the cavitation rates using actuarial data, the current methodology, which does not utilize HMO profit information, will need to be revised as the fee-for-service base erodes. In our opinion, utilizing HMOS' financial status in rate setting may be the most economically viable option available.

EXHIBIT

AND

APPENDICES

EXHIBIT

STATE OF WISCONSIN'S
MEDICAID WAGED CARE PROGRAM
Medicaid Cavitation Rates

The Medicaid cavitation rates, applicable to the selected HMO, for the 3-year period of our review are as follows:

CAVITATION RATES[1]	1992	1993		i994
		Jan-Jun	Jul -Dee	
AFDC[2] & Healthy Start - Children	$105.75	$110.27	$113.19	$118.03
Healthy Start - Pregnant Women	$334.67	446.93	452.38	479.67

Rates provided in the table reflect the per member per month rates . The cavitation rate can vary for each contracting HMO due to the discount rate and optional benefits, like dental and chiropractic . During 1993 & 1994, there were three rate increases . The 1993 rate increases were effective January 1 and July 1. The 1994 rate increase occurred after contract negotiations, but was retroactively applied to the beginning of the year. The rate differential and percentage of Medicaid cavitation rate increases during the 3-year period of our review are as follows:

MEI :CAID CAVITATION RATE INCREASE				
	1992 to Jan 1993	Jan to July 1993	July 1993 to 1994	TOTAL
AFDC & Healthy Start - Children	$4.52	$2.92	$4.84	$12.28
Increase:	***4.27%***	***2.65%***	***4.28%***	N/A[3]
Healthy Start - Pregnant Women	$112.26	$5.45	$27.29	$145.00
Increase:	33.54%	1.22%	6.03%	N/A

Our calculations and comparisons are based on the HMO selected for review. Changes and percentages may vary due to the discount rate and optional benefits.

---

[1] Cavitation rates are per member per month.

[2] AFDC - Aid to Families with Dependent Children.

[3] N/A - not applicable.

STATE OF WISCONSIN'S
MEDICAID MANAGED CARE PROGRAM
Earnings Guidelines

PRE-TAX PROFIT CALCULATION		
YEAR	MEDICAID PREMIUM REVENUES	PRE-TAX PROFITS (5% of premiums)
1992	$69,000,000	$3,450,000
1993	75,000,000	3,750,000
1994	79,000,000	3,950,000
TOTAL	***$223,000,000***	$11,150,000

SURPLUS CALCULATION'				
YEAR	PREMIUMS EARNED	COMPULSORY SURPLUS (3%)	SECURITY SURPLUS*	REQUIRED SURPLUS
1992	$69,000,000	$2,070,000	$2,794,500	$2,800,000
1993	75,000,000	2,250,000	3,015,000	3,000,000
1 9 9 4	79,000,000	2,370,000	3,152,100	3,200,000
TOTAL	$223,000,000	$6,690,000	$8,961,600	$9,000,000

GUIDELINES			
YEAR	SURPLUS	PRE-TAX PROFITS	TOTAL
1992	$2,800,000	$3,450,000	$6,250,000
1993	3,000,000	3,750,000	6,750,000
1994	3,200,000	3,950,000	7,150,000
TOTAL	$9,000,000	$11,150,000	$20,150,000

[1] Compulsory surplus is 3 percent of premiums earned (net of reinsurance expense incurred) for the HMO Business operation in WI. The security surplus is between 110 and 140 percent of the compulsory surplus depending on the premiums earned.

[2] Security Surplus Factor is 135, 134 and 133 percent for 1992, 1993 and 1994, respectively.

Tommy G. Thompson
Governor

Joe Leean
Secretary

State of Wisconsin
Department of Health and Social Services

DIVISION OF HEALTH
1 WEST WILSON STREET
P.O. BOX 309
MADISON WI 53701-0309

November 6, 1996

Paul Swanson, Regional Inspector General
Department of Health and Human Services
Region V
105 W. Adams Street
Chicago, IL 60603-6201

Dear Mr. Swanson:

Thank you for the opportunity to review the draft Office of the Inspector General (OIG) audit report "State of Wisconsin's Medicaid Managed Care Program Financial Safeguards" (identification number A-05-95-OO060). I am responding to your letter to Kevin Piper, now Division of Health Administrator.

The objective of the report was to "assess whether the profits earned by Health Maintenance Organizations (HMOs) from the Medicaid managed care program were considered in adjusting Medicaid cavitation rates." The Wisconsin Medicaid program does not use profit margin as a factor in calculating HMO cavitation rates. This fact was made clear to the field auditors at the time the audit was begun. However, we viewed the audit as an opportunity to view HMO operations from a different perspective and assess our current methodology of setting Medicaid HMO cavitation rates based on actual Medicaid costs.

The Wisconsin Medicaid program prides itself on administering an effective and responsive HMO program - a program that has saved both the state and federal government tens of millions of dollars, while dramatically improving recipient access to quality health care services. Consequently, we were concerned when suggestions contained in the draft audit report implied that Wisconsin operates an inefficient program. While we do not dispute the specific findings regarding the HMO in question. we believe that the general conclusions contained in the audit report are inappropriate due to generalizations that are not entirely accurate.

We also recognize that, as we move away from our Medicaid fee-f or-service (FFS) base, we need to monitor the issue of "profit" more closely. Therefore, we have begun a series of actions intended to more closely examine the status of our HMO rate-setting and reinsurance policies. Following are several comments regarding major findings contained in the audit report and an action plan intended to address the recommendations of the audit report.

Excessive **Profit Margins**

The audit report concluded that "excessive profits" were being earned by all HMOS contracting with the Wisconsin Medicaid program. While we concur that the HMO **in question earned high profits, data from the Office of** Commissioner of Insurance (OCI)

(Attachments and 2) show that the entire HMO industry was in an "up-cycle" during the year under audit. The data indicate that profit margins as a percent of premiums began rising steadily in 1988. Net income for Wisconsin HMOs peaked in 1992, dropped slightly in 1993 and rose again sharply in 1994. During this time period, HMO profits were high for both Medicaid and commercial products.

We **believe that the high profit levels symbolize** industry trends toward **greater administrative efficiencies and improved utilization control.** As indicated in the attachments, the market has begun **to self-correct and profits are on the decline. In support of the attachments, preliminary indications are that profit** levels **through the** second **quarter of 1996 continue the decline begun in 1995.**

We also note that the report concluded all Wisconsin Medicaid HMOs were earning profits of the same magnitude **as** the t-MO under audit. However, the OCI data indicate that the report's generalization of across-the-board profits was likely overstated. An examination of medical loss ratios for Medicaid HMOS reveals that no HMO had a medical loss ratio as low as the HMO under audit. Indeed, one Medicaid HMO had a medical loss ratio greater than one. While we believe that most HMOS earned a profit from the Wisconsin Medicaid program, we believe the draft audit report overstates the magnitude of that profit.

Stop Loss Insurance

The audit report concluded that the HMO paid excessive amounts in stop loss payments to a related party. The report seems to imply that this is an indication of "excess profits." It is, in fact, a business decision made by the HMO that may reflect prudent management.

The net cost of reinsurance offered to Medicaid HMOs by the State of Wisconsin would have cost the HMO in question much more than was actually paid in the year under audit. We also note that comparisons between what was paid to the related party and what may have been paid under the State reinsurance program are difficult due to differences in the insurance thresholds and related premiums. However, we will ask our contracted actuary to investigate the current methodology for setting reinsurance rates and to compare our Medicaid insurance rates to commercial rates.

Use of profit margins to set or adjust rates

Given our current rate setting methodology, we disagree with the (implied) position of the report that HMO rates should be set or adjusted based on individual HMO profit margins.

Reliance upon profit margins to set cavitation rates would penalize profitable HMOs that are administered efficiently while holding inefficient HMOS harmless. The method currently used by Wisconsin and other states, and approved by the federal Health Care Financing Administration, establishes cavitation rates by discounting the Medicaid per member'per month FFS equivalent cost based on actual Medicaid costs, projected forward to the rate year. Savings are based on actual Medicaid costs. However, as the FFS base continues to erode, we have begun to examine other rate setting methodologies which may have utility in the future, some of which may require collecting more Medicaid-specific HMO cost information.

Financial reports required under the HMO **contract**

The report suggests we should require financial reports in our HMO contract.

We discontinued our past HMO contract provision requiring HMOS to submit cost reports to us. We can easily obtain them from the OCI. The OCI, as the state licensing agency, has a statutory responsibility to monitor HMO financial stability and performance. It is important for your report to clarify that we contract only with **HMOS licensed by the** OCI. **We work together with the** OCI **to assure adequate, but not duplicative, regulation.**

We monitor HMO service performance, focusing on service-related performance benchmarks that will demonstrate that recipients have access to medically necessary services, Medicaid HMOS are held to the stringent quality assurance standards contained in the HMO contract.

We continue to have access to HMO financial reports submitted to the OCI, and review them on an as-needed basis.

Summary

In conclusion, we do not dispute your findings that the HMO in question recorded high profits during the year under audit. However, for the reasons noted above, we do object to 1) your generalization that all Medicaid HMOS have in the past made (and continue to **make) excessive profits; and 2) that the Wisconsin Medicaid program is unconcerned about profits earned by Medicaid-contracted** HMOs.

The Wisconsin Medicaid program goes to great lengths to assure that the cavitation rates **paid by the Wisconsin Medicaid program are set at an appropriate level. We firmly** believe that information gleaned from one audit of one HMO does not provide sufficient grounds for making general statements regarding the status of the entire Wisconsin Medicaid HMO managed care program. Consequently, based on the information presented above, we **respectfully request that the draft audit report be modified by removing general statements regarding the efficacy of the Wisconsin Medicaid program.**

Action Plan

The Wisconsin Medicaid program is, of course, concerned about the cost effectiveness of our HMO initiative. As a result, we will implement the following action plan:

1. Establish a work group comprised of staff from the HMO policy and rate setting unit and the OCI to meet regularly to review HMO financial data related to Medicaid HMOs. This group will examine the need for establishing threshold indicators for medical loss ratios and net income for Medicaid HMOs. This may allow us to focus on HMOS that exceed the established thresholds to ascertain whether the outliers are reasonable.

2. Instruct our contracted actuary, Milliman and Robertson, Inc. (M&R), to take the OIG audit report to the next level. M&R will be instructed to conduct a survey of other state Medicaid programs to identify which states currently utilize profit-related adjustments and assess their eff activeness. We will also ask them to determine the reasonableness of our state's reinsurance rates compared to other states.

3. Re-examine the current Wisconsin HMO rate setting methodology for' effectiveness and determine whether profit-related rate adjustments may be warranted, as HMO expansion results in a significant reduction in the FFS base.

Thank you, again, for the opportunity to review the report.

Sincerely,

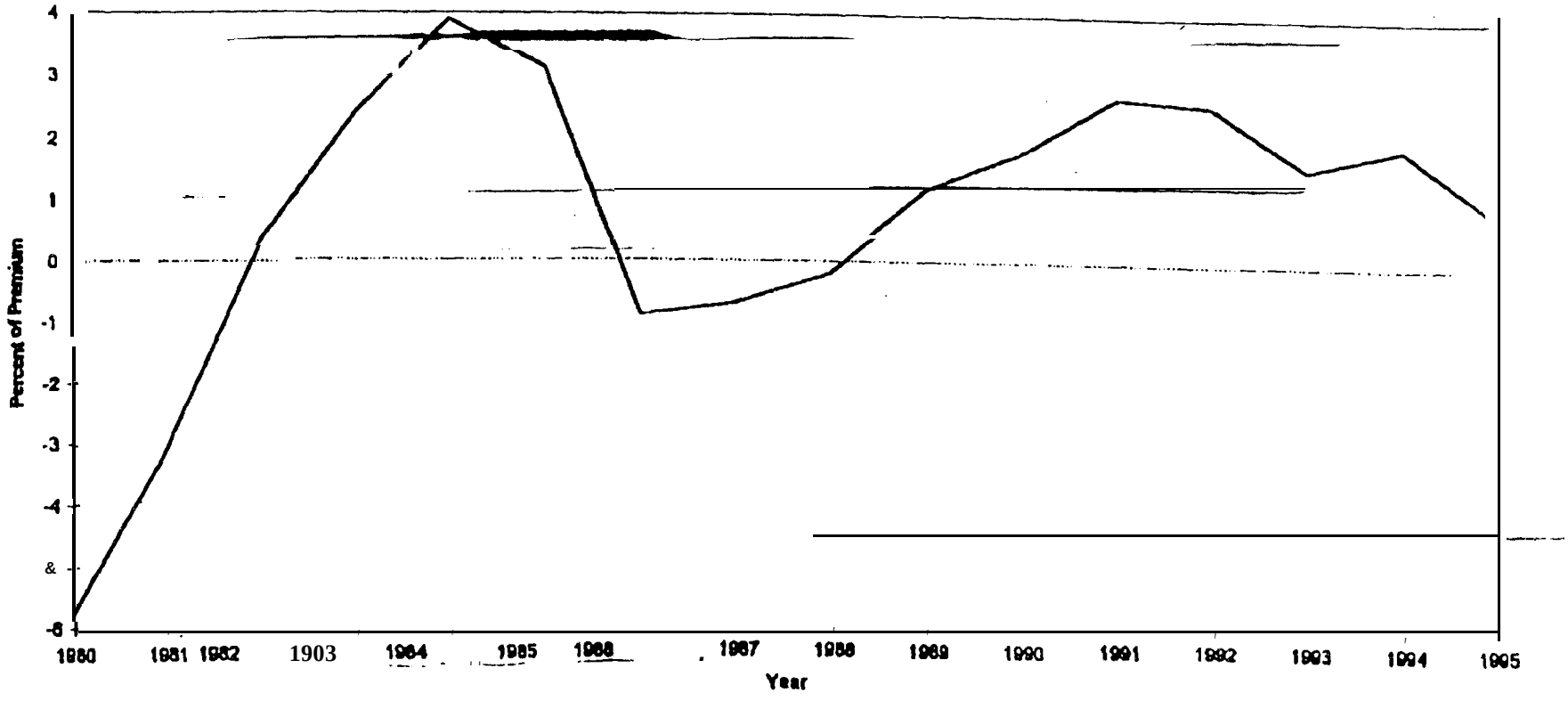
Peggy **L.** Bartels, **Director**
Bureau of Health Care Financing

PLB:my
MC09136.AC
96-P-09-026A

Attachments

cc: Kevin B. Piper
Pris A. Boroniec
Angela Dombrowicki
Michael Fox

Licensed Domestic HMO Profit Margin



Licensed Domestic HMO Net Income