Senator Charles E Grassley

Testimony

House Committee on Oversight and Government Reform

April 25, 2012

Thank you for inviting me to testify at this hearing today. With your permission, I'll give a brief version of a much longer statement I would like to enter into the record.

Mr. Chairman and members of the Committee, over the next 10 years the federal and state governments will spend roughly 7 TRILLION in combined dollars to run the Medicaid program.

A very significant percentage of the Medicaid program will be run through what most of us call managed care.

Essentially, the states will take the federal dollars they receive merged with their own dollars and hand them over to a third party, a managed care company, to provide services for Medicaid beneficiaries.

The federal government has encouraged states to do so and certainly the current trend is for more and more managed care.

It is also federal policy that states are supposed to impart some due diligence and oversight by knowing where Medicaid dollars are being spent and CMS, likewise, is supposed to confirm that states are properly overseeing where their Medicaid dollars are being disbursed.

In August 2010, the Government Accountability Office issued a report that highlighted the inconsistency of CMS's oversight of state rate-setting.

Mr. Chairman and members of the Committee, my ongoing investigation into federal and state oversight of managed care contracting leaves me gravely concerned that accountability is severely lacking in a program that is spending 7 TRILLION combined federal and state taxpayer dollars.

Today, this hearing will focus largely on what has occurred in the state of Minnesota.

There are allegations that the state systematically overpaid managed care companies to cover Medicaid beneficiaries while under paying the same plans for coverage of individuals paid for with state-only dollars.

This appears to be another example of the old game of states pushing the bounds to maximize federal dollars received while minimizing state dollars spent.

If that isn't bad enough, when one of the plans tried to return the overpayment, documents show that the state schemed to keep the federal government from receiving its share of the overpayment to one specific company, UCare. [1]

My investigation has turned up troubling questions that I am very pleased your committee will be able to explore further with relevant witnesses today.

Lucinda Jesson of the State of Minnesota has very difficult questions to answer such as …

> Was the state systematically overpaying managed care plans on Medicaid while underpaying the same plans to provide care for individuals covered with state-only dollars?
>
> Documents show that at least once before a managed care company returned funds in 2003. How long has systematic overpayment been occurring in Minnesota? [2]
>
> Documents from the four plans in Minnesota prove that each one consistently showed excess revenues derived from Medicaid while showing losses on the state-only plans. Was the state aware of this disparity? [3]
>
> And while the state now trumpets the fact that they collect repayments for excess revenue over 1%, does the state have any auditing mechanism in place to confirm that the amounts reported by the managed care companies are accurate?

Cindy Mann, of CMS, also has some very difficult question to answer.

> In 2010, the GAO raised significant questions about CMS's oversight of rate setting. What have you done to assure beneficiaries and taxpayers that rates are being appropriately set?
>
> In your March 21, 2011 letter to the state of Minnesota, you asked if "the state included reserve fund requirements in calculating actuarially sound managed care rates"? Isn't that your job to know the answer?
>
> What assurance can you give us that what has gone on in Minnesota hasn't gone on all over the country?

Mr. Chairman, my investigation should not be interpreted as questioning the role of managed care in Medicaid.

To the contrary, I think having a risk-based, outcome-driven role for managed care in Medicaid has tremendous potential to produce high quality care for Medicaid beneficiaries.

However, for this to happen, CMS and the states have to live up to their responsibilities in overseeing contracts with managed care.

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[1] Emails provided by the State of Minnesota (Attachment 1).
[2] 11-3-2003 Medica Talking Points provided by the State of Minnesota (Attachment 2).
[3] Data provided by HealthPartners Inc, Medica, and UCare (Attachment 3).

In closing Mr. Chairman, while my investigation is ongoing, one specific solution is becoming fairly clear to me.

States should be required to know the medical-loss ratio of every managed care company they contract with specific to the Medicaid beneficiaries they serve.

That medical-loss ratio should be clearly defined by CMS and consistently implemented across every state that uses managed care.

That medical-loss ratio should be based on independently audited, verifiable encounter data and expense data.

That medical-loss ratio should make clear what administrative expenses are related to the provision of Medicaid benefits and what administrative expenses are not.

That medical-loss ratio should be transparent for CMS, the states, and the public to see.

Let me be clear, I do not support a federally defined, minimum threshold for medical-loss ratio that requires all plans below a certain threshold to refund dollars.

Instead, I believe that purchasers, in this case states, using transparent information about how their dollars are being spent are best suited to make decisions about the value provided from managed care companies.

We have legitimate disagreements about many issues in Congress, but on this issue, there can be no disagreement. We must have a better understanding of where 7 TRILLION dollars will be spent by the Medicaid program.

Attachment 1

Leitz, Scott D (DHS)

From: Golden, James I (DHS)
Sent: Wednesday, February 08, 2012 1:09 PM
To: Leitz, Scott D (DHS)
Subject: Fw: UCARE donation - Account 512606

From: Cammack, Martin L (DHS)
Sent: Wednesday, February 08, 2012 12:45 PM
To: Johnson, Charles E (DHS); Golden, James I (DHS); Berg, Ann M (DHS); Vogt, Angela (MMB)
Subject: FW: UCARE donation - Account 512606

Just a heads up, Cecil Ferkul (Deputy Legislative Auditor) voiced concerns about the UCare donation at a meeting I had with her today. The meeting was for other topics, but she brought this topic up at the end. In particular, she is concerned about the wording contained in a UCare letter sent to the State. I wasn't familiar with the letter she showed me. While I referred her to the policy staff at DHS, at her request, I provided her the information in the e-mail(s) below. At the end of our meeting, she indicated she will likely be doing more follow-up within DHS.

From: Cammack, Martin L (DHS)
Sent: Wednesday, February 08, 2012 12:16 PM
To: Cecile.Ferkul@state.mn.us
Cc: Ricker, Christopher M (DHS)
Subject: RE: UCARE donation - Account 512606

Cecile,

Here's what I found. The UCare donation is addressed in the Laws Of 2011, 1st Special Session, Chapter 9, Article 10, Section 13.
MMB received the UCare donation this past Fall; DHS is now preparing to report the donation on the Q.E. 12-31-11 CMS-64 federal report. DHS Health Care and Federal Relations is providing legal guidance to FOD on how to report the donation. Our understanding is that this reporting is informational only, similar to how the MinnesotaCare tax revenue is reported on the CMS-64.

With regard to the accounting, the UCare payment (estimated receipt) was not budgeted in FY 2011 MAPS by either DHS or MMB. Because the End of Session 2011 budget tracking documents assigned the UCare donation to DHS, the amount was initially budgeted by DHS in FY 2012 SWIFT (standard agency post-session procedure). As confirmed by the first e-mail below, this budget has since been removed from SWIFT by DHS upon the direction of MMB.

I will give Ann Berg (Federal Relations), Jim Golden, Chuck Johnson and MMB a heads up that you or your staff may have additional questions.

Thanks,
Marty

From: Ricker, Christopher M (DHS)
Sent: Wednesday, February 08, 2012 11:59 AM
To: Cammack, Martin L (DHS)
Subject: RE: UCARE donation - Account 512606

The check was received by MMB this fall. MMB contacted our federal relations division on 11/7/11 confirming receipt. I've been coordinating with Fed Relations on this since this summer due to the implications on CMS64 reporting and potential impacts on our MA award.

This was not budgeted in SFY11.

Let me know if you have any other questions.

From: Cammack, Martin L (DHS)
Sent: Wednesday, February 08, 2012 10:19 AM
To: Ricker, Christopher M (DHS)
Subject: FW: UCARE donation - Account 512606

Chris, remind me, has this donation already been received by MMB? The OLA is looking into this payment as a part of their FY 2011 Single Audit. Was this payment ever budgeted in FY 2011 MAPS as a DHS estimated revenue?

From: Ricker, Christopher M (DHS)
Sent: Wednesday, February 01, 2012 10:28 AM
To: Cammack, Martin L (DHS); Raiolo, Rob R (DHS)
Subject: UCARE donation - Account 512606

I spoke with Angela yesterday about the above. She agreed we (DHS) should not be booking or reflecting any revenue related to this. In fact, we do not want to give any appearances that the money might be coming to DHS (bolsters our argument with CMS that this wasn't a provider return and therefore doesn't need to be shared with them).

Rob, per our convo yesterday, I understand the budget has been already been reduced in SWIFT. I will complete the non-ded rev forecast file for this account to be consistent with the budget reduction.

Chris

Attachment 2

Medica Talking Points

November 3, 2003

Message #1:

Medica will announce a "premium holiday" for all customers for one-half of the month in December. Medica will be returning approximately $80 million to its customers; some $19 million will be returned to the state for its public health care programs.

- We applaud Medica for returning the overpayment to its customers. For the Department of Human Services, this translates to an approximate 4% refund, the equivalent of 1/24th of our total payment to Medica in 2002.

Message #2:

Medica is distributing overpayments to both its public and commercial customers based on 2003 earnings. The state will be getting back the same rate as Medica's other customers.

- Medica had reserved $11 million in '02, expecting '03 to be a year of high costs. Medica thought the overall trend would be a 12% increase – but so far the health care increase for 2003 is at 8%.
- Medica is claiming 4.4% in retained earnings (profits) on public program business in 2002; other health care plans were at or near 1.1% retained earnings.
- State program spending contributed to 33% of Medica's total revenue in '02 and 56% of the company's total profit.

Message #3

We will want to explore if there are long-term implications on health care cost trends, including any implications on current public and private payment rates.

- The actual rates for 2003 will not be released by the health plans until next April. We will review the numbers and determine at that time if we need to adjust our rates with the plans.

Message #4

A portion of the overpayment the state receives from Medica will be shared with the federal government since it pays a portion of the enrollee health care coverage. The state portion of the overpayment will go toward reducing our future health care costs.

- The Medica overpayment will be left in the State General Fund where the legislature will determine its future use.

Message #5

We will be interested to learn if the reduction in Medica's cost trend will be experienced shared by other HMO providers.

- Other plans may not have overpayments to return to their customers. Health care experts were predicting that the trend toward increased health costs in '03 would continue.

Medica's experience of a reduction in cost growth from 12% to 8% is very good news, but an 8% growth is neither affordable nor sustainable.

While audited statements of the health plans will not be released until next April, we may ask to meet with plan officials in the interim to determine if we need to adjust our rates.

UCare Dollar Value and Profit Margins Attachment 5 - Revised

(Source: Minnesota Supplement #1 Statement of Revenue, Expenses and Net Income)

For the Year Ending December 31,	2006	2007	2008	2009	2010	2011
Minnesota Medicaid						
Net Underwriting Gain Percentage	1.52%	2.06%	1.65%	6.75%	6.77%	1.02%
General Assistance Medical Care						
Total Revenues						
Net Underwriting Gain (Loss)						
Net Underwriting Gain Percentage						
Other Non-MN Medicaid - General Assistance, Medicare Advantage, Dual Eligible and Other Non-Commercial Products						
Net Underwriting Gain Percentage	2.44%	1.09%	-0.61%	-0.15%	0.95%	0.95%
UCare Total						
Net Underwriting Gain Percentage	2.17%	1.38%	0.07%	1.91%	2.90%	0.97%

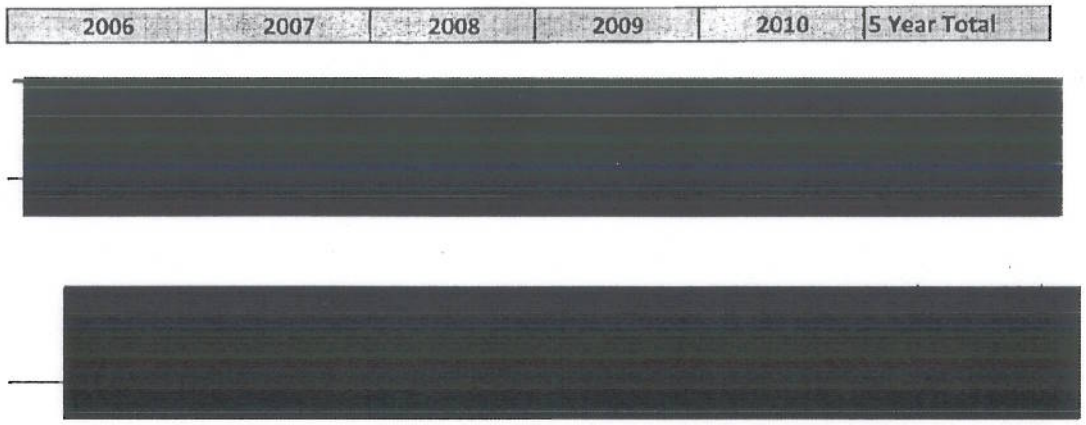
Attachment 3

HealthPartners, Inc Participation is required in all three programs by MN State law

Medicaid Data Request from Charles Grassley

Question number 4.

MN Medicaid Net Income 5 Year Summary (Data Source: MN Supplemental Report)



	2006	2007	2008	2009	2010	5 Year Total
Revenue						
GAMC						
PMAP						
MN Care						
Total Medicaid						
Net Income						
GAMC						
PMAP						
MN Care						
Total Medicaid						
Net Income %						
GAMC	-10.1%	-17.9%	-16.9%	-12.5%	2.5%	-12.6%
PMAP	-8.4%	0.5%	11.4%	7.3%	8.7%	4.7%
MN Care	4.0%	-2.6%	-11.8%	-4.6%	-0.4%	-3.1%
Total Medicaid	-6.0%	-2.6%	1.9%	1.5%	5.6%	0.6%

* Note: HealthPartners does not have any non-Minnesota Medicaid to compare to as requested

Revenue & Profit Margins (Rounded to nearest 1,000)	2006	2007	2008	2009	2010	Avg
MHP Medicaid (PMAP)						
[redacted]						
Margin %	-9.1%	5.5%	7.4%	9.3%	10.7%	5.8%
MHP Medicaid (MNCare)						
[redacted]						
Margin%	-1.2%	-4.6%	-4.3%	-0.2%	-21.7%	-7.8%
MHP Medicaid (combined PMAP and MNCare)						
[redacted]						
Margin %	-7.3%	3.3%	5.0%	7.1%	2.6%	2.7%
MHP GAMC[10]						
[redacted]						
Margin %	-13.1%	-18.2%	-11.5%	-13.9%	-14.2%	-14.0%
MHP Dual Eligibles						
[redacted]						
Margin %	5.5%	6.4%	3.0%	0.7%	-4.9%	1.6%

[9] "Margin" is identified as "Underwriting Gain or (Loss)" in *NAIC Supplement Number 1*.

[10] For the time periods noted in this table, Minnesota health plans were required to participate in General Assistance Medical Care ("GAMC") (which was dissolved effective March 31, 2010), regardless of losses in the program. In accordance with Minnesota HMO law, Minn. Stat. § 62D.04, Subd. 5, as a requirement for licensure, health maintenance organizations were required to participate in the medical assistance, GAMC, and MinnesotaCare programs. Additionally, Minnesota Medicaid law, Minn. Stat. § 256B.0644, required health maintenance organizations to participate in the medical assistance program, GAMC, and MinnesotaCare as a condition of participating in: (a) the state employees health insurance plan; (b) the public employees insurance program for plans offered to local or home rule charter city, county and school district employees; (c) the workers' compensation system; and (d) the Minnesota Comprehensive Health Association (Minnesota's high risk insurer). With the exception of GAMC, the above law is still relevant.

BCBS Profit/Loss Margins

	2006	2007	2008	2009	2010
GAMC	-20.5%	-33.4%	-26.7%	-19.5%	-6.8%
MNCare	-20.5%	-33.4%	-26.7%	-19.5%	-6.8%
PMAP	-11.6%	-6.1%	5.5%	6.6%	10.9%