

RESTRUCTURING MEDICARE FOR THE LONG TERM PROJECT

Final Report of the Study Panel on
Capitation and Choice

Structuring Medicare Choices

April 1998

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The project received financial support from The Robert Wood Johnson Foundation, The Pew Charitable Trusts, and the Kaiser Family Foundation.

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Foreword

This report is the final product of the Study Panel on Capitation and Choice convened by the National Academy of Social Insurance (NASI) as a part of its *Restructuring Medicare for the Long Term* project. The Study Panel's assignment has been to analyze options for restructuring Medicare's capitated health plan options for the next century. Other Academy study panels are examining Medicare's fee-for-service program, Medicare's larger social roles, and options for long-term program financing. A Steering Committee of additional Medicare experts provided charges to each of the Study Panels and will synthesize their results in policy-relevant reports of their own.

The Study Panel on Capitation and Choice includes experts drawn from medicine, economics, public policy, law, consumer organizations, and industry. In a series of meetings, commissioned papers, and writing by individual Study Panel members and Academy staff over a 20-month period, the Study Panel on Medicare Capitation and Choice analyzed the steps that need to be taken to improve competition among Medicare health plan options.

Although just under 13 percent of Medicare beneficiaries were enrolled in capitated health care plans in 1997, this figure is increasing rapidly, and more than a quarter of all enrollees are expected to be in capitated managed care plans by the year 2002. The Balanced Budget Act of 1997 (P.L. 105-33) opened up new opportunities for managed care arrangements that hold out the promise, if they are organized and reimbursed appropriately, to both serve the needs of beneficiaries and help reduce the rate of growth in Medicare expenditures.

The Panel's analysis of options for structuring systems in which health plans compete for Medicare enrollees was detailed and at some points highly technical. Designing a system that will promote improved quality of care, access to care, and efficiency involves questions about criteria for plan and provider participation in competitive systems, payment methods, oversight and accountability, and beneficiary protection. The report reflects the complexity of the issues involved. Based on its review, however, the Panel has concluded that the technical issues that could determine the success or failure of structured choice in Medicare can and should be the focus of a comprehensive program of research, demonstrations and evaluation.

After analyzing current models operating in the public and private sectors, the Panel has developed the framework for a structured model it believes should be tested in the Medicare program. In the model proposed for study by the Panel, beneficiaries would pay more for health plans that are more expensive due to variations in plan efficiency or practice style. For such a system to work well for beneficiaries, the Panel proposes that the current Medicare benefit package be expanded to approximate more closely the benefits generally included in employer-sponsored insurance (including coverage of prescription drugs), and that Medicare payments to health plans be adjusted to reflect the health of individual enrollees. The Panel also believes that while administration of structured choice systems needs to be done on a regional or local basis, there need to be national standards for all Medicare participating plans, including standards for access, quality of care, oversight activities, data collection and reporting, and consumer education. The Panel calls for expanded support for local entities that can provide specialized, personal assistance to beneficiaries who need to understand plan and provider options.

In addition, the Panel calls for systematic research to determine if partial capitation methods can reduce incentives to under-serve beneficiaries without unacceptable losses in treatment effectiveness and efficiency; to assess the benefits of standardized benefits options, in terms of beneficiary understanding, effects on duplicative coverage, and out-of-pockets costs; and to examine the utility of other options for refining payments, such as reinsurance, stop-loss protection, or carve-outs of high-cost conditions.

Finally, the Panel has developed a recommendation for a major, multi-year demonstration which would go beyond projects already being planned, to implement Medicare choice models in which fee-for-service (with expanded benefits) and managed care plan options are offered in a competitively-bid “premium support” system. While recognizing the technical and political challenges that this would entail, the Panel believes that a real-world demonstration is essential for identifying the feasibility and desirability of such a system and refining the policies and methods required for managing a restructured Medicare program.

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Executive Summary

Medicare is a national health care program serving over 39 million elderly and disabled people. It represents almost one fifth of the nation's health care spending, and over 12 percent of federal budgetary outlays. About 13 percent of Medicare beneficiaries were enrolled in capitated managed care options in 1997; this is expected to increase to almost 30 percent by 2002. The Medicare provisions of the Balanced Budget Act of 1997 (P.L. 105 - 33) opened up new opportunities for organizing managed care plans that can serve the needs of the Medicare population. These changes, however, may only be a first step. More fundamental restructuring is likely to be needed to meet the needs of future generations of Medicare beneficiaries.

The National Academy of Social Insurance project, *Restructuring Medicare for the Long Term*, was initiated in 1995 to provide analyses of the most important questions facing the nation's leaders who will decide the future of the Medicare program. The project's Steering Committee and four study panels, focused on fee-for-service modernization, Medicare capitation and beneficiary choice, Medicare's larger social roles, and long-term financing, are considering policy questions for Medicare's future. The Study Panel on Medicare Capitation and Choice is chaired by Joseph Newhouse, the John D. MacArthur Professor of Health Policy and Management, Harvard University. Panel members are listed in the front of this report. The Panel was formed to identify steps that should be taken in improving Medicare's capitated payment options and to examine in particular how health care plans can compete for enrollees based on their ability to control costs and offer quality services.

The Study Panel on Medicare Capitation and Choice believes that the basic goal in a system offering choice among health care plans should be to create a publicly accountable system that is flexible enough to take advantage of local market opportunities while maintaining the standards of a national entitlement program. The Panel also believes that reforms should be designed to preserve basic Medicare benefits for all beneficiaries, and that beneficiaries should be protected against cost sharing that would undermine their ability to gain affordable access to plans and providers of their choice. Fostering competition on quality and costs of care should serve the needs of Medicare beneficiaries, by leading to more cost-effective delivery of services.

Policies to restructure Medicare should balance the need to control Medicare program costs with the need to protect beneficiaries' statutory entitlement to necessary and appropriate health care. This should be based on thorough analysis of (1) the strengths and weaknesses of market-based competition among health plans; (2) methods for paying for services equitably, given the health care needs of Medicare beneficiaries; and (3) approaches to ensuring beneficiaries' access to quality health care. This report presents the Panel's findings, conclusions and recommendations in these areas.

Based on its analysis of systems offering choice among health plans, the Panel believes that a structured choice model that includes elements of some of the existing systems could be incorporated into a framework that might work well for beneficiaries and the Medicare program. Some systems such as the

Federal Employees Health Benefits Plan (FEHBP) and the California Public Employees' Retirement System (CalPERS) have been successful in holding down the rate of premium growth while retaining a large number of plans from which to choose, and maintaining high levels of consumer satisfaction. Structured choice systems use a range of methods, including review of contract proposals and bids, formal negotiation over price, establishment of standards for plan participation and benefits design, disclosure of price and quality information, and innovative ways of developing and presenting information to facilitate consumer choice. These systems also demonstrate that it is possible to design competitive models that include national health plans in addition to regional and local plans, making it possible to offer enrollees managed care and fee-for-service options virtually anywhere in the United States. The Panel believes that continuing to study the existing systems that offer choice among competing health plans will yield important insights for future Medicare reforms.

The Medicare market, however, differs from other health insurance markets. There is a high level of medical risk to be covered, fee-for-service is the dominant type of coverage, and supplemental insurance appears to dilute the out-of-pocket cost incentives to use health care services efficiently. The use of Medicare-covered services reflects a variety of factors. These include higher rates of functional impairment, repeated hospitalizations associated with certain serious medical conditions, and extended periods of illness prior to death that occur among the elderly and people unable to work due to disability.

There are also two other important differences between Medicare and the private markets in which structured choice systems have succeeded. First, the Medicare benefits package is not adequate in comparison to the protection available in the commercial employer-based insurance market or to beneficiaries' needs. Coverage of prescription drugs and lack of a cap on out-of-pocket liability are major deficiencies in the Medicare benefits package. Most beneficiaries have some form of supplemental coverage, either through employer-based retiree plans, Medigap policies, or from Medicaid. This makes the beneficiary health care market more complicated in terms of benefits design and financial incentives for providers and consumers. Second, there has been a serious problem of biased selection in the Medicare managed care market, with healthier beneficiaries disproportionately enrolling in capitated managed care plans, and beneficiaries with greater health care needs opting for fee-for-service. This has led to overpayment of capitated plans. The payment structure has allowed managed care plans in some areas to offer a richer benefits package at little or no additional cost to beneficiaries, while Medicare has failed to achieve any savings from managed care.

The Panel concluded from its review that expanding the current Medicare benefits package, particularly with respect to coverage of prescription drugs and catastrophic costs, would foster competition among Medicare fee-for-service and managed care options. And while administration of structured choice systems needs to be done on a regional or local basis, the Panel concluded that there should be national standards for all Medicare participating plans, including stan-

dards for access, quality of care, oversight activities, data collection and reporting, and consumer education. The Panel also believes that all beneficiaries should have meaningful choice among health plans and providers, and that current protections for low-income beneficiaries should be maintained or expanded.

As more Medicare options are made available to beneficiaries, the Panel concluded that there needs to be expanded support for local consumer education services to provide individual counseling to beneficiaries. The Panel also proposes that Medicare coordinate its annual open enrollment and information periods with those for Medicaid, other federal health care programs and Medigap policies. This will make health plan “shopping” and care coordination easier for those enrollees with dual eligibility or supplemental policies.

The core of the report recommendations centers on the need for a program of research, demonstrations, and evaluations to inform decisions about structuring choice in Medicare. Systematic research to address specific technical issues is essential to the success of structured competition among plans serving Medicare beneficiaries. The recommendations focus on the need to:

- move ahead with an aggressive program to develop and implement risk adjustment methods based on beneficiary health to be used in capitation payments to Medicare plans;
- determine if partial capitation methods, in which payment is based in part on actual use of services rather than solely based on a fixed per capita payment for each plan enrollee, can reduce incentives to under-serve beneficiaries without

unacceptable losses in treatment effectiveness and efficiency;

- assess the benefits of standardized benefits options, in terms of beneficiary understanding, effects on duplicative coverage, and out-of-pockets costs;
- build on existing demonstrations to examine other options for refining payments, such as reinsurance, stop-loss protection, or carve-outs of high-cost conditions; and
- develop, in collaboration with other public and private health care organizations, a broad-based Medicare research and evaluation program that uses the health status and health risk data to examine issues of cost effectiveness, outcomes, and quality of health care.

In the closing chapter of the report, the Panel recommends that the Health Care Financing Administration (HCFA) develop a program of research and demonstrations focused on the design and evaluation of a “premium support system” for Medicare. The report presents a framework for a major, multi-site demonstration project in which the panel believes this model should be tested. In this demonstration project, traditional Medicare, with enhanced benefits, would be an option.

In the demonstration proposed by the Panel, a wide range of capitated plans and Medicare fee-for-service options offering a statutorily defined benefit package and meeting national performance standards would compete on price and quality. The federal Medicare contribution would be a fixed proportion of the cost of competitively bid premiums in local markets. Beneficiaries would pay more for a higher-priced plan; all beneficiaries enrolled in a given plan would pay this same premium. The Panel concluded, however, that

incidence and distribution of health care problems in the Medicare population require that Medicare payments to health plans be adjusted to reflect the health of individual enrollees, using the best available methods. The Panel believes that a real-world demonstration is essential for identifying issues and detecting problems before imple-

menting changes that will affect the lives of tens of millions of Medicare beneficiaries and their families.

The full text of the recommendations presented at the end of each chapter is included as Appendix C.

Chapter 1

Report Overview

The National Academy of Social Insurance project, *Restructuring Medicare for the Long Term*, was initiated in 1995 to provide analyses of the most important questions facing the nation's leaders who will decide the future of the Medicare program. The project's Study Panels consist of experts in fields including economics, medicine, history, finance, law and public policy, geriatrics, public health, and sociology. The project's Steering Committee is chaired by Robert Reischauer, Senior Fellow at the Brookings Institution. The Steering Committee and four Study Panels, focused on fee-for-service modernization, Medicare capitation and beneficiary choice, Medicare's larger social roles, and long-term financing, are considering policy questions for Medicare's future.

The Study Panel on Medicare Capitation and Choice is chaired by Joseph Newhouse, the John D. MacArthur Professor of Health Policy and Management, Harvard University. Panel members are listed at the front of this report. The Panel was formed to identify steps that should be taken in improving Medicare's capitated payment options and to examine in particular how health care plans can compete for enrollees based on their ability to control costs and offer quality services. In its charge to the Panel, the Steering Committee asked that it examine models for increasing choice among capitated health care plans participating in Medicare. The Panel was asked to analyze a range of issues that might affect how well these models could work for the Medicare population. Among the specific topics the Panel reviewed in detail were alternative approaches for organizing competition, capitation payment and

risk-sharing methods, the implications of benefits design and risk segmentation in health care markets, and methods for facilitating informed beneficiary choice among health plans. Approaches to expanding options for insurance coverage beyond models in which health plans accept risk for Medicare-covered services under capitated payment arrangements, such as medical savings accounts or direct contracting outside of the Medicare program, were not addressed by the Panel in any detail.

As the Panel's work proceeded, major changes in Medicare began to take shape. The Medicare provisions of the Balanced Budget Act of 1997 (P.L. 105-33) opened up new opportunities for organizing managed care plans that can serve the needs of the Medicare population. Medicare is a national program serving 39 million elderly or disabled people. It represents almost one fifth of the nation's health care spending, and 12 percent of federal budgetary outlays (72, 121). About 13 percent of Medicare beneficiaries were enrolled in capitated managed care options in 1997 (141); this is expected to increase to over 27 percent by 2002 (121). Expanded choices for beneficiaries, however, also creates greater needs for information and oversight.

Balancing the need to control Medicare program costs with the need to protect beneficiaries' statutory entitlement to necessary and appropriate health care will require understanding the options for reform in terms of how Medicare can be structured to take greater advantage of efficiencies that may be available in the health care markets it serves;

how services can be paid for equitably, given the health care needs of Medicare beneficiaries; and how beneficiaries' access to quality health care can be ensured.

In the Panel's view, the basic features of a restructured Medicare system warranting focused study would include:

- **capitation or partial capitation** operating in close coordination with fee-for-service Medicare, in which a fixed amount, adjusted for the health risk of beneficiaries, is paid to a wide range of health care organizations for all covered services needed in a specified period of time; and
- **a choice among health care organizations** which will offer enrollees a range of plan and providers, including fee-for-service options. Participating plans would offer an appropriate benefits package defined in statute and would meet nationally consistent performance standards. The goal is to stimulate competition among health plans and across managed care and fee-for-service options in order to promote improved quality of care, access to care, efficiency in the delivery of care, and to slow the growth of health care costs.

Any decision to restructure a program affecting tens of millions of Americans should be preceded by an aggressive, focused research and demonstration program so that adequate information is available regarding the consequences (intended and unintended) that result. The Panel therefore believes that a demonstration should be conducted to test a premium support model in which the government's contribution toward the cost of Medicare would be sufficient to assure the availability of high-quality, accessible health care for all Medicare beneficiaries, reflecting

the cost of health care in the markets where beneficiaries live. Such a demonstration would evaluate a model in which:

- Medicare's financial contribution is a fixed proportion of the cost of a Medicare benefit package that is defined in statute and offered by competing entities,
- beneficiaries and health care providers are made more financially accountable for their health care decisions, and
- affordable access for all beneficiaries to a choice of health care plan and provider options is ensured.

The Medicare provisions of the Balanced Budget Act of 1997 (P.L. 105-33) open up new opportunities for organizing managed care plans that can serve the needs of the Medicare population. Expanded choices for beneficiaries, however, also create greater needs for information and oversight. As new systems for structuring choice among health plan alternatives evolve and more beneficiaries enroll in managed care organizations, the Medicare program will need to be able to monitor access, quality, and costs of care, including costs to beneficiaries. Medicare beneficiaries will need enough information about plan alternatives to make good choices in an increasingly complex marketplace. This report focuses on the long-term issues and options for developing an accountable infrastructure that can support the market-based system of health care for beneficiaries envisioned in the Balanced Budget Act reforms.

The report is organized as follows: Chapter 2 provides an overview of health plan options in Medicare, focusing in particular on the evolution of Medicare managed care, and the particular program characteristics and market

dynamics that need to be considered in the longer-term restructuring efforts.

Chapter 3 discusses the Panel's findings and recommendations regarding options for government to equitably and efficiently structure beneficiaries' greater choice of health plans. The chapter reviews the basic aspects of the design and operation of structured choice models, including benefits design, plan participation, administration and management, payments methods, and accountability, and briefly reviews how a set of structured choice systems operating the public and private sectors work. The chapter then presents the Panel's conclusions regarding the broad lessons that can be drawn from these programs and recommendations regarding the Medicare benefits package and open enrollment policy, and recommendations for additional research that needs to be done to inform policy, including research on the standardization of benefits.

Chapter 4 examines in detail a range of issues involved in devising mechanisms for paying providers equitably, including approaches to implementing and managing systems to avert market-based incentives for capitated health plans to avoid, or underserve, patients with costly health care problems. The chapter is divided into four sections that review methods for direct adjustment of capitation rates to reflect risk (risk adjustment); combining risk adjustment with other financing and

reinsurance mechanisms (risk-sharing); the potential for developing special approaches to delivering services or paying for particular types of medical care (carve-outs); and capitation and partial capitation of providers within health care plans. The chapter's recommendations address one specific policy concern, capitation payments to individual providers within health plans, and identify two research areas, partial capitation methods and research using data on health risk and use of health services that the panel believes could be particularly useful.

Chapter 5 reviews issues in protecting beneficiaries from potential abuses in the managed care marketplace and mechanisms for helping them make well-informed choices among options for health care. The recommendations address two broad policy issues: expanded support for local consumer counseling and information services, and consistent national standards for plans serving Medicare beneficiaries.

The final chapter brings many of the issues and recommendations discussed in the earlier chapters together in recommendations for building on current Medicare demonstrations to address key issues in the design of benefits and payment systems, and for conducting a live test of structured choice model that would include Medicare managed care and fee-for-service health plan options.

Chapter 2

Medicare and Managed Care

While Medicare has served as a laboratory for many types of innovation in health care financing and delivery, managed care has not yet come to play the same dominant role in the health care market for Medicare beneficiaries as it has for employer-based health insurance. The unprecedented growth of Medicare managed care in the past few years now holds out the promise of significant restructuring to improve program effectiveness and control costs. Managed care enrollment appears to reflect changes in both the demand for managed care and in expanded interest in the Medicare market on the part of the managed care industry. The goal of expanding managed care in Medicare is to provide a mechanism for delivering better coordinated care more cost-effectively. Participation in Medicare managed care however has been biased by the way that Medicare's managed care options are structured and reimbursed. The result has been that increasing managed care enrollment has not produced expected savings, and variations in payment rates have resulted in serious inequalities in program benefits across regions of the nation.

The balanced budget agreement and Medicare reforms passed in 1997 have made basic changes in Medicare's managed care program. Some are designed to address short-term technical problems; others may catalyze structural changes to the Medicare marketplace. This chapter reviews the basic structure of Medicare managed care at the end of 1997. Trends and problems in managed care enrollment, benefits structure, financing, beneficiary protection, and pro-

gram accountability point to issues that need to be addressed in the long-term restructuring of Medicare.

TYPES OF MEDICARE MANAGED CARE

Managed care options have always been available in the Medicare program. But it was the implementation, in 1985, of legislative changes enacted in the 1982 Tax Equity and Fiscal Responsibility Act (TEFRA, P.L. 98-21) that introduced the first program-wide, full-risk managed care capitation option in Medicare (136). Through 1997 managed care could provide benefits through three different types of Medicare contracts: risk (the most common), cost, and health care prepayment plans.

Risk plans have been paid a per capita premium, currently set at 95 percent of the actuarially-adjusted projected average expenses for fee-for-service beneficiaries in each county. Risk plans assume full financial risk for enrolled beneficiaries. The plans must provide all Medicare-covered services, and may offer additional services. Except for emergency and out-of-area urgent care, members of risk plans must receive all of their care through the plan. Risk plans may, however, provide an out-of-network option that allows beneficiaries to go to providers who are not in the managed care plan.

Cost plans, first authorized in 1972, were paid a pre-determined monthly amount per beneficiary based on a total estimated budget tied to the plan's costs. These plans provided

all Medicare-covered services, and could provide the additional services in return for premiums charged to beneficiaries. Medicare beneficiaries in cost plans could obtain Medicare-covered services outside the plan with no limitations. When they obtained care outside the plan, Medicare paid its traditional share of the costs, and the beneficiary paid Medicare coinsurance and deductibles (to the extent that they were not covered under additional benefits provided by the plan).

Health Care Prepayment Plans are the oldest type of Medicare managed care entities which were authorized in the original Medicare statute. Few of these arrangements were still operating in the 1990s. They were paid in a manner much like cost plans, but they did not cover Medicare Part A services (inpatient hospital care, skilled nursing, hospice, and some home health care). Some did, however, arrange for these services for members, and some filed claims for their members as well (134).

The 1997 Medicare reforms introduced new forms of risk contracts to Medicare, and provided for the phased termination of the cost plan and prepayment options. The new program of choices has been named Medicare+Choice. It provides for a range of coordinated health care plans within Medicare, including HMOs previously participating in the risk program (with and without point-of-service options in which enrollees can elect to use out-of-network provider if they are willing to incur higher costs); preferred provider organizations (fee-for-service plans with incentives for patients to use net-

work providers); provider-sponsored health care organizations (PSOs), and medical savings accounts (MSAs) linked to high-deductible plans. A new option for private fee-for-service arrangements is also established in the legislation. All beneficiaries enrolled in both Part A and Part B can enroll in Medicare+Choice plans, except for those in the End Stage Renal Disease (ESRD) program who are not already in a choice plan at the time of their diagnosis.

Prior to the implementation of the 1997 reforms, all Medicare managed care plans provided at least a 30-day open enrollment period each year, but many have allowed for enrollment throughout the year. Plans enrolled all beneficiaries eligible for Part B benefits on a first come, first served basis (except for those with ESRD or those who elect hospice care), until they have met their enrollment capacity. Beneficiaries were permitted to disenroll from any of these plans for any reason at the end of each month. New enrollment policies establishing an open enrollment season and limiting disenrollment options will be phased in beginning in 2002 (see below).

Medicare risk plans assume full risk for the services they cover. If they offer optional uncovered services, they are permitted to collect additional amounts, in the form of co-payments or deductibles, from enrollees.¹ The Medicare program rules have also limited the profit that risk contracting plans may earn to the level of profit they earn in their commercial business. If Medicare payments exceeded plan costs, these savings (i.e., the

1 Except for fee-for-service and MSA plans, total cost sharing and premiums charged to Medicare enrollees are not allowed to exceed the expected cost of the additional benefits beyond those required to cover the savings, plus the national average amount of cost-sharing for Medicare-covered services in the traditional Medicare program (144)

difference between projected costs and expected revenues computed according to Medicare payment formulae) must either be returned to the Medicare program or used to pay for additional benefits for Medicare enrollees. Although plans are not allowed to return excess Medicare payments to enrollees as cash rebates, they may use the revenue to reduce or entirely waive beneficiary cost-sharing.

Until the 1997 reforms, all risk contractors were required to have no more than 50 percent of plan enrollees in Medicare and Medicaid (the “50-50 rule”), and have a minimum of 5,000 commercial members in urban areas or 1,500 commercial members in rural areas. Under the provisions of the Balanced Budget Act, enrollment requirements for the new Provider-Sponsored Organizations (PSOs) are modified to require a minimum enrollment of 1,500 beneficiaries, or 500 in rural areas. The 1997 legislation also eliminated the 50-50 rule for contracts beginning on or after January 1, 1999, and allows the Secretary of the Department of Health and Human Services (HHS), to waive the rule for existing contracts. A number of provisions designed to prevent discrimination and protect beneficiaries have also been put in place. For example, Medicare policy requires plans to submit written plan information on benefits and cost-sharing provisions that plans provide to beneficiaries to the Health Care Financing Administration (HCFA) for review, and limits the value of promotional gifts to a “nominal” value of \$10.00 or less. HCFA

regulations and legislative provisions of the Balanced Budget Act also placed restrictions on plan policies that limit providers’ communication with patients regarding treatment options (so-called “gag rules”). The 1997 legislation incorporated much of the regulation designed to address perceived problems with physician payment incentives and the beneficiary appeals process into law (see Chapter 5).

Perhaps the most significant refinement of the risk program in the mid 1990s was the introduction of point-of-service (POS) options, which allow enrollees to use out-of-plan providers at some additional cost. In 1995, HCFA clarified its position that contractors were in fact permitted to offer these as optional benefits. The ability to see specific providers, and to obtain care when traveling out of the HMO area could increase the attractiveness of managed care for some beneficiaries (149). As of January 1, 1997, about 30 risk plans (of 276 plans with risk contracts) were offering POS options. The specifics of the POS benefits are left to individual plans, including which services are included, whether the out-of-plan benefits will be subject to precertification (formal prospective approval), and if the plan will limit the annual dollar amount for the services beneficiaries use out-of-plan.² HCFA has required, however, that plans continue to offer all Medicare covered benefits to enrollees (within the plan) and HCFA must approve the co-payments and deductibles for POS options (149). Setting these payment levels is important: for beneficiaries, it deter-

2 There appears to be considerable variation in the way that POS options have been implemented by Medicare risk contractors. PPRC reported, in 1997, that most plans limited the amount of out-of-network benefits covered, with annual limits ranging from \$1,500 to \$50,000 or more; most charge coinsurance of 20 percent, and impose an annual deductible, that might range anywhere from \$100 to \$1,000; and additional premiums generally ranged from \$15 to \$60 per month. (147).

mines the attractiveness of the option. From the perspective of the plans, the option could result in net plan savings if the deductibles are larger than the costs of equivalent services that would have been provided by the network.

Before the 1997 reforms, the law and regulations governing Medicare restricted the development of managed care options to a fairly narrow set of arrangements. Managed care risk plans contracting with HCFA have been required to be federally-qualified Health Maintenance Organizations (HMOs) as defined in the HMO Act of 1973 (P.L. 93-222), or competitive medical plans (meeting similar requirements set out in regulation). The requirements have included meeting financial and solvency requirements, demonstrating the ability to furnish the services available under fee-for service Medicare in the same area, and maintaining a quality assurance program. These legal requirements limited participation in Medicare managed care to plans which are organized as HMOs. Other forms of managed care, such as the preferred provider organization options that are common in the health care market for working adults were not available to Medicare beneficiaries, except in a number of demonstrations being conducted by HCFA.

The Medicare Choices demonstration, initiated before the 1997 reforms, is continuing to offer Medicare beneficiaries a variety of managed care delivery options (e.g., Preferred Provider Organizations (PPOs) and Provider Sponsored Networks) currently not available to Medicare beneficiaries as their primary source of coverage. As of August, 1997, 17 plans were participating in the demonstration. Nine plans were in operation, and the remaining eight were continuing develop-

mental activities (77). Eleven were provider-sponsored networks, generally organized by hospitals entering into agreements with local groups of physicians. Others include provider-owned HMOs, providers with HMO partners, and other managed care arrangements (91). The demonstration projects will include a variety of payment arrangements, including the capitation payment currently used for Medicare HMOs and capitation payments incorporating new methods for adjusting payments to reflect medical risk. The demonstration project will also test different payment methods (e.g., blended rates and partial capitation; see Chapter 4). Many of the managed care plans chosen to participate in the demonstration project are located in market areas that currently have limited enrollment in risk contracts. HCFA's Center for Health Plans and Providers, Division of Demonstration Programs, expects it to last from three to five years. Some, but not all, of the demonstration programs are expected to continue to operate after the demonstration ends, under the new Medicare+Choice system (77).

A second Medicare demonstration, Medicare SELECT, offers supplementary benefits (so-called Medigap benefits; see below) in a managed care structure. The goal is to encourage the development of efficient provider networks that can provide standardized packages of supplemental benefits at lower cost than traditional supplementary insurance. The first 15 state-wide Medicare SELECT demonstrations began in 1992, and in 1995 the program was extended to all 50 states.

The Balanced Budget Act of 1997 (P.L. 105-33) was designed to offer beneficiaries a broad choice of health care plans. Like

Medicare risk HMOs, all Medicare+Choice organizations agree to provide the basic package of Medicare Part A and B services and are paid on a prospective capitated basis and assume full financial risk. The organizations must be organized and licensed under state law as risk-bearing entities eligible to offer health insurance in each state where they offer a Medicare+Choice plan.³ The Balanced Budget Act of 1997 (P.L. 105-33) also establishes that federal standards regarding financial solvency, benefits requirements, requirements relating to inclusion or treatment of providers, and coverage determinations, including appeals and grievances related to coverage and benefits, preempt state law or regulations that are not consis-

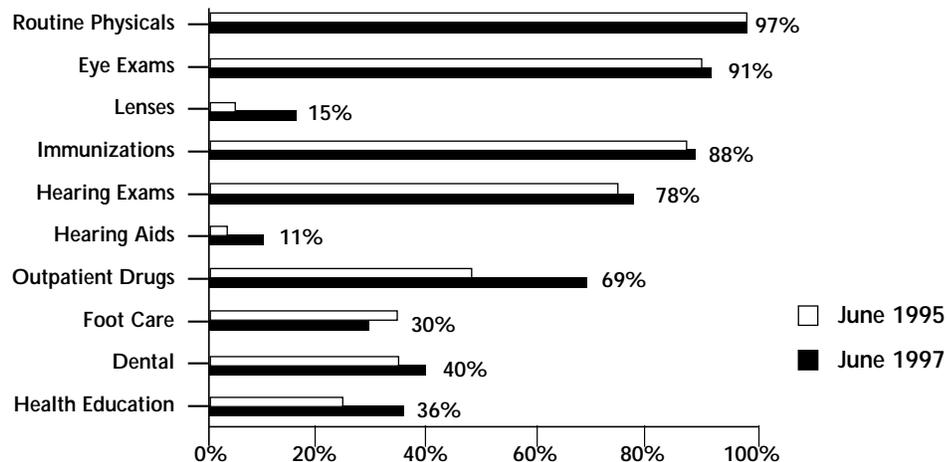
tent with federal standards for all Medicare+Choice plans.

Issues raised by these options are discussed in later sections of this report.

BENEFITS AND COST-SHARING

Almost all Medicare risk plans offer some benefits beyond those covered under standard Medicare fee-for-service insurance. Most provide routine physical examinations, eye and hearing exams, immunizations, and some type of coverage for outpatient prescription drugs (Figure 2-1). The provision of additional services has increased over time. Prescription drug coverage has been a particularly attractive benefit. In June 1995, 48 percent of risk plans offered a drug benefit,

Figure 2-1. Percentage of Medicare Risk Plans Offering Additional Benefits in Their Basic Option Package, June 1995-June 1997



Source: Physician Payment Review Commission analysis of Medicare Managed Care Contract Reports, June 1995 and June 1997

³ Special conditions for Provider Sponsored Organizations (PSOs), which are generally defined as “public or private [entities] established or organized and operated by a health care provider, or group of affiliated health care providers.” (137). Because many PSOs encompass a variety of organizational configurations and because there has been wide variety in the ways in which states regulated these entities (90); (see Chapter 5), the statute allows PSOs that can meet federal requirements, but are not able to obtain state licenses solely because they cannot meet financial solvency requirements for risk-bearing entities, to seek a waiver from the Secretary of DHHS to allow them to participate in Medicare+Choice for three years.

and by June 1997, this had increased to 69 percent (141).

While the range of additional benefits offered by risk plans has expanded, the premiums that HMOs charge beneficiaries for additional services have been reduced. Between June 1995 and June 1997, the percentage of Medicare risk HMOs charging no additional premium at all for expanded benefits rose from 50.7 to 67.46 percent. Only about 11 percent of risk plans charged premiums of more than \$40 per month for the enriched benefits(141).

Additional benefits provided by Medicare HMOs have offered an alternative to supplemental insurance purchased by beneficiaries, employers, or provided by the government through Medicaid. Beneficiaries have been able to obtain most or all of the benefits provided in supplemental insurance — or even more generous benefits, such as preventive services which may not be covered in supplemental plans — at little or no cost. This has been particularly important for beneficiaries who do not receive adequate retiree health benefits (and who have incomes too high to qualify for Medicaid). About one third of all beneficiaries pay for supplemental (Medigap) insurance — which costs about \$1,200 per

year — out-of-pocket because they believe this additional coverage is needed (149).⁴

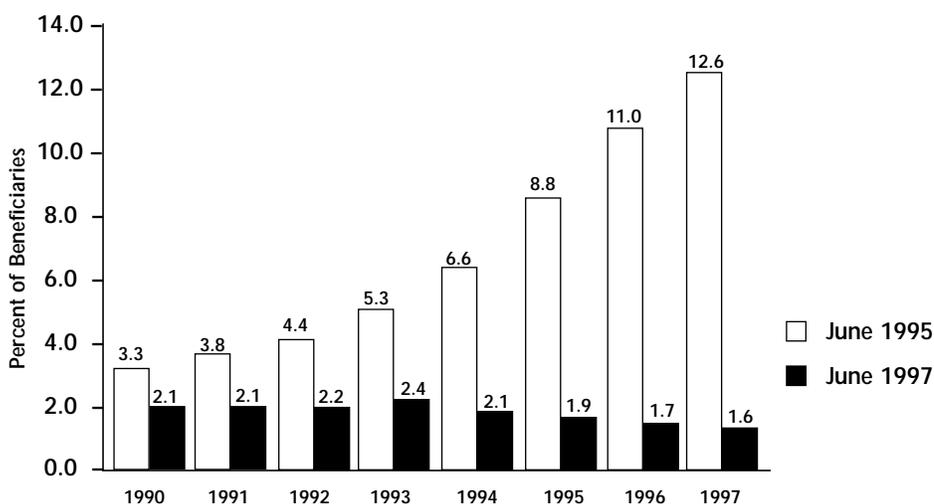
Supplemental Medicare insurance provided by employers, employers plus Medigap, Medicaid, plus other forms of supplemental insurance cover 51 percent of the population, leaving only 13 percent with Medicare as the only form of health insurance (149).

ENROLLMENT TRENDS

At the beginning of 1997, more than 4.9 million Medicare beneficiaries (over 13 percent) were enrolled in a total of 336 managed care plans. About 80,000 beneficiaries per month were voluntarily enrolling in risk-bearing HMOs throughout 1996, and the rate appeared to be increasing. Virtually all of this growth has been in risk plan enrollment (see Figure 2-2); about 86 percent of beneficiaries in managed care were in risk plans. As of January 1, 1997, 248 of the 350 managed care plans participating in Medicare were risk plans (134). Plan participation in the risk contracting program has also been accelerating rapidly. Between December 1996 and June 1997, the number of risk plans participating in Medicare rose by over 17 percent (141).

4 A particular sticking point with regard to Medigap coverage is the fact that prior to the 1997 Balanced Budget Act, beneficiaries who dropped Medigap policies because they enrolled in Medicare HMOs sometimes were unable to obtain new policies if they decided to return to fee-for-service Medicare. Medigap insurers were legally permitted to invoke pre-existing condition restrictions on beneficiaries seeking "replacement" Medigap coverage. A number of bills were introduced in the 105th Congress to address this issue. The Medicare provisions of the Balanced Budget Act of 1997 (PL 105-33) provide some additional protection to beneficiaries who lose supplemental coverage because their employer-provided policies are discontinued, or they are dropped from coverage they had through the discontinuation of a demonstration program or because of the failure of a supplemental carrier through insolvency or bankruptcy. Beneficiaries who enroll in Medicare+Choice plans when they turn 65, then disenroll from the plan within 12 months are also provided with guaranteed issue protections. Individuals who voluntarily drop Medigap protection after continuous enrollment (for more than a year) in a risk plan are not, however, covered by any guaranteed issue provisions for Medigap if they want to return to fee-for-service. Guaranteed issue does not, moreover, prevent insurers from charging high premiums to persons considered to be potentially costly medical risks.

Figure 2-2. Percent of Medicare Beneficiaries Enrolled in Risk and Cost Plans, 1990-1997



Source: Physician Payment Review Commission analysis of Medicare Managed Care Contract Reports. All data are for December, except that 1997 data are from June.

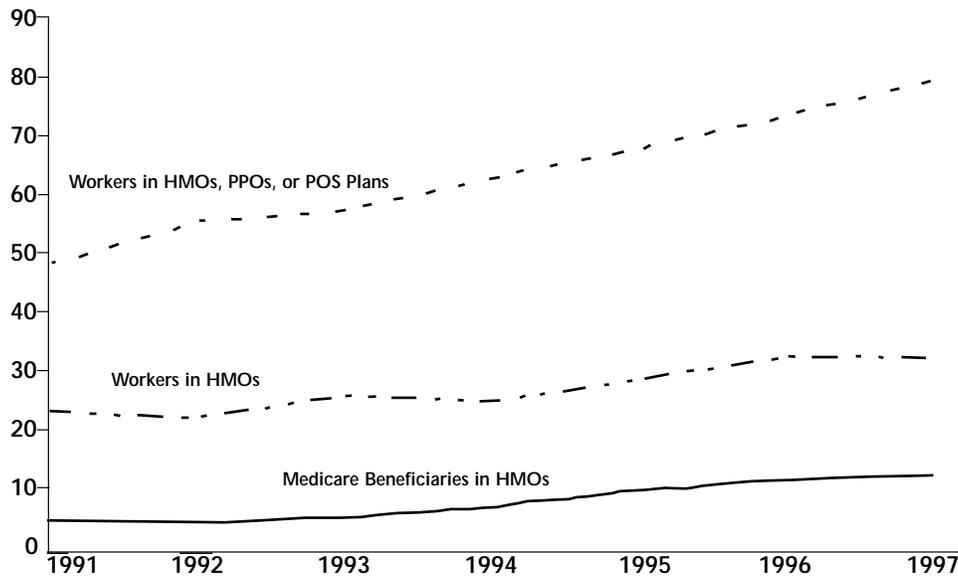
Since 1989, Medicare risk enrollment annual rates of growth have exceeded enrollment growth in managed care in the non-Medicare population (137). Medicare managed care enrollment levels, however, trailed far behind enrollment in managed care among the working population. Figure 2-3 demonstrates that the influx into managed care among the working population is largely the result of movement into PPOs and POS plans, rather than HMOs. While there are no available data on how many Medicare beneficiaries have joined HMOs because of the introduction of POS options, nor on how many actually use this option, the Physician Payment Review Commission estimated that about 500,000 beneficiaries (about 10 percent of risk enrollees) were in plans with POS options in 1996 (149).

Participation in Medicare managed care varies widely across the country. There are far more HMOs participating in Medicare in urban than rural areas, and enrollment rates

are about twice as high among beneficiaries living in core metropolitan areas (about 21 percent in 1996) compared to those in smaller outlying urban areas. HMO enrollment among those eligible for Medicare due to disability is also low; in 1997, only 5.8 percent of disabled Medicare beneficiaries were enrolled in HMOs (141). Less than one percent of beneficiaries in rural areas were enrolled in Medicare risk plans in 1996, although the numbers were increasing (149); many rural areas had no participating risk plans for beneficiaries to join (144). Enrollment in the risk program has also been highly concentrated in a relatively low number of states. In June 1997, six states made up over 70 percent of overall enrollment, with California alone comprising 37 percent of enrollment. Conversely, many states have very little or no enrollment in risk contracts (141), (Figure 2-4).

Historically, enrollment was highly concentrated in a relatively small number of large

Figure 2-3. Trends in Managed-care Enrollment, 1991-1997



Source: Physician Payment Review Commission and KPMG Peat Marwick, July 1997

HMOs (168). There are some indications, however, that enrollment in Medicare HMOs has been diversifying. An analysis conducted by PPRC in 1996 found that new enrollees reside in a somewhat different mix of states than those where enrollment has always been relatively high (149). Between 1995 and 1996, with 50 new plans entering the Medicare risk program, the proportion of beneficiaries concentrated in the eight largest plans fell from 46 percent to 34 percent of all enrollment in Medicare HMOs (74).

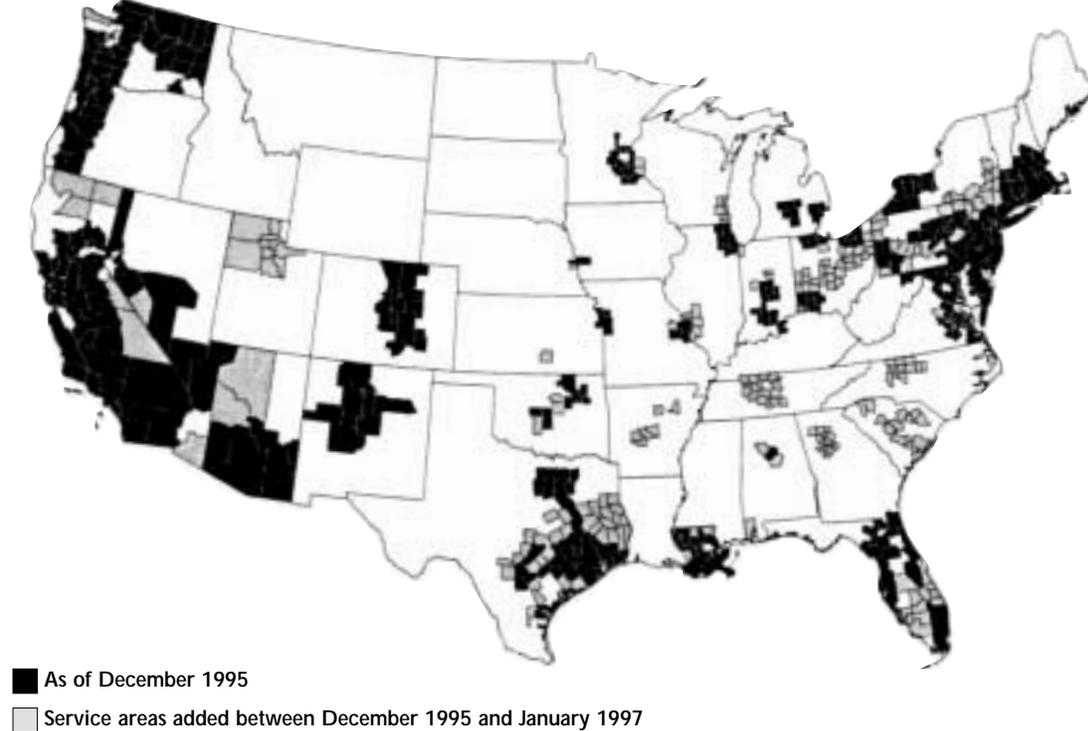
MARKET DYNAMICS

Enrollment in Medicare managed care reflects several underlying dynamics. First, as HMOs have moved into many major market areas, Medicare beneficiaries become an attractive potential market. If much of the working population is already enrolled in

managed care, the potential for market expansion may shift to Medicare beneficiaries (74). People aging into Medicare are increasingly likely to have been enrolled in managed care during their work lives. Managed care organizations have also had over a decade of experience with Medicare risk enrollees, and the some of the older managed care plans have been delivering care to Medicare beneficiaries for an entire generation. Both beneficiaries and plans have had the opportunity to learn how to work with each other to manage the varied and complex health care needs that come with aging and chronic illness.

Second, the proportion of employers offering supplemental retiree health benefits has declined significantly since the 1980s. In 1984, an estimated 67 percent of large and mid-sized employers offered retiree health

Figure 2-4. Medicare Risk Plan Service Area, 1995 and 1997



Source: Health Care Financing Administration, Office of Managed Care

benefits; data from KPMG Peat Marwick surveys indicate that this dropped to the 40-45 percent range in the 1992-1995 period. The proportion of these same employers paying for health coverage for family members of retirees declined rapidly as well, from 42 percent in 1984 to 14 percent in 1995 (48). Reductions in the proportion of large employers providing retiree coverage were also reported in a 1997 study by Hewlett Associates (59).

There are strong financial incentives for employers as well as beneficiaries to opt for Medicare managed care when planning their retiree benefits strategies.⁵ Medicare risk

plans are estimated to expose employers to 50 percent less liability than other arrangements (48). Consequently, more and more employers are offering, or limiting retirees to, managed care options. The percentage of retirees who could choose an HMO option grew from 42 percent in 1988 to 63 percent in 1995; PPO options grew from 19 to 25 percent in this same period, and the option of joining a POS plan grew from 14 percent in 1993 to 30 percent in just two years, from 1993 to 1995 (48).

Although the percentage of non-institutionalized retired elderly having employer-based retiree coverage actually increased steadily

5 In addition to current premium costs, the Financial Accounting Standards Board has required, beginning with fiscal years after December 15, 1992, that companies record unfunded retiree health insurance liabilities on their financial statements. This greatly increases reportable liabilities, which "has caused many employers to reexamine their role in providing benefits for current and future retirees" (33).

throughout the period 1977 (19.5 percent) to 1993 (39.4 percent) (48), it appears to have leveled off, and may actually be falling. In 1995, data from the Medicare Current Beneficiary file (the same survey data used in the KPMG Peat Marwick analysis for 1993) indicated that about 37 percent of Medicare beneficiaries in fee-for-service had some form of employer-paid supplemental health insurance (including those who had employer coverage plus their own privately-purchased supplemental insurance.) (149).⁶

The third dynamic driving enrollment patterns is the uneven, and in important instances relatively high, reimbursement rates for health plans in certain areas of the United States that result from unanticipated consequences of the payment formula for risk plans. This formula was set in statute, and administered centrally by HCFA. As with other administrative pricing approaches, the link between prices and the market costs of services can become distorted (21).

Through 1997, the formula set out in Medicare statute⁷ for paying risk plans stipulated that the capitation rates be set at 95 percent of the costs Medicare would have expected to incur had the beneficiary remained in fee-for-service. Each year HCFA calculates national trends in inflation and uti-

lization patterns, and in changes in Medicare program provisions. The payment for HMOs has been based on the calculation of Adjusted Average Per Capita Costs (AAPCC). This method is supposed to estimate the amount a Medicare enrollee would have spent had she or he enrolled in the Medicare fee-for-service program within the same county. Medicare adjusts payments for enrollee age, gender, Medicaid status, institutional status, and employment (working aged) status.⁸

The capitation rate for each HMO enrollee is calculated by applying these risk adjusters to the county rate, in order to predict how the expected costs for each beneficiary is likely to differ from that of an average beneficiary (124). HCFA calculates separate rates for Part A and Part B services, and for beneficiaries over age 65, beneficiaries eligible for Medicare because of disability, and for those with End Stage Renal Disease. These adjusters result in large variations in capitation payments for different individuals, reflecting the average costs for people in each group. For example, in one county in California where the average monthly payment for Medicare beneficiaries was \$622.55 in 1996, an HMO would have been paid \$1,205.51 per month for an 87 year old, non-working, non-institutionalized female

6 Gabel et al.,(48) explain the seeming paradox of decreasing employer coverage of retirees coinciding with increasing rates of elderly Medicare beneficiaries having employer-based supplemental coverage (prior to 1995) as a cohort effect: retiree coverage reflects the mix of companies and their retirement patterns at the time they retire. Once they have retired, beneficiaries with employer-based coverage have an additional life expectancy of about fifteen years. Each new class of seniors entering Medicare affects the margin and alters the average. Many retirees may be able to retain the level of employer-based coverage available when they retired, even though new retirees from the same firms may not have such benefits available. Beneficiaries may also have worked in organizations other than the one where they worked when they retire, and they may receive benefits from that employer. It is also possible that more women with work experience are retiring with their own retirement benefits, rather than those of their spouses (75).

7 Section 1876 (a)(4) of the Social Security Act.

8 For more detailed information on the calculation of the AAPCC, please see PPRC Basics No. 4, Medicare Managed Care: Premiums and Benefits, (Washington, DC: revised September, 1997).

beneficiary not eligible for Medicaid. The monthly payment for a 68 year old, non-working, non-institutionalized male was \$487.47 (149).

The problems with the Medicare capitation formula are well known to HCFA, providers, beneficiaries, and policymakers. In 1997, the average AAPCC, when weighted to reflect the number of beneficiaries living in each county was \$468 per month (\$395 unweighted). But because fee-for service costs vary widely, the AAPCC rates have differed substantially across counties, and across areas of the nation (124). With the formula adjustments, the AAPCC for counties in 1997 ranged from \$221 (Arthur County, Nebraska) to \$767 (Richmond County [Staten Island], New York). Large variations occur even within the same metropolitan areas: in Philadelphia County, the AAPCC was \$704, while the AAPCC in adjoining Montgomery County, Pennsylvania was \$516 (124). The AAPCC has tended to be higher in areas where utilization of services is high, such as larger urban areas where more health services are available. Per capita spending on health care in rural areas is generally lower than in more urbanized areas, leading to lower average AAPCCs among rural counties, although there has been considerable variation even among these (143).

Overall, areas with higher AAPCCs have more Medicare risk plans than areas with low AAPCCs (68). According to PPRC, "Plans competing in the same market areas may receive substantially different payments for beneficiaries who live on opposite sides of a county boundary. These differing payment

levels appear to have an effect on plan participation and enrollment" (143). The disparity in payments stymied the growth of Medicare managed care in many rural areas. From the providers' perspective it also appears to penalize managed care organizations operating in areas where medical care utilization and costs have traditionally been low, including areas where practice patterns may reflect more efficient and appropriate use of services (40).⁹ From the perspective of beneficiaries, the variation in payment rates translates into real inequalities in Medicare benefits and out-of-pocket costs: beneficiaries in areas with high AAPCCs and many HMOs from which to choose may be able to enroll in a plan offering many additional benefits at no additional cost to the beneficiary, while those in some areas, including entire states, have no access to risk plans at all.

Equally important, research has shown that these adjusters are only weakly related to beneficiaries' expected fee-for-service costs and to their actual utilization of services. In part, this is due to the inability of the limited set of risk adjusters used in the current payment calculation to accurately predict an individual's health care needs (see Chapter 4). In addition, the small size of the beneficiary population in many counties leads to volatility in the AAPCC calculations from year to year. (149). There is, however, convincing evidence that Medicare risk HMOs as a whole have enrolled a healthier population on average than Medicare FFS. In its 1996 Report to Congress (149), PPRC presented evidence that, for the six months before enrolling in managed care plans, beneficiaries incurred costs 37 percent below those for

9 Conversely, however, increasing payment rates low-cost areas, such as the payment floors established in the 1997 Balanced Budget Act, mean that HMOs will be paid at rates significantly higher than would be predicted based on utilization and costs those areas.

beneficiaries in fee-for-service. They also found that when beneficiaries disenrolled, their costs rose 60 percent above fee-for-service levels in the six months after returning to fee-for-service.¹⁰ Because use of services before or after enrollment in an HMO cannot be directly compared to the use of services when the beneficiaries were enrolled in the HMOs, there are still unanswered questions about these findings. However, it is reasonable to assume that failing to adjust for the comparatively better health status of managed care enrollees resulted in over-paying HMOs for the expected health care needs of enrollees. In 1997, PPRC estimated that paying HMOs 95 percent of the AAPCC cost Medicare about \$1 billion (24).

There is some research that suggests that favorable selection into Medicare risk plans is in some part a reflection of the recent entry of new plans and populations into managed care. One study found that among continuously enrolled beneficiaries, after several years in which AAPCC payment results in net losses to Medicare, Medicare begins to save money under capitation compared to what it would have had to reimburse providers through fee-for-service (74). Analysis completed by PPRC in 1997 found that predicted costs¹¹ approached fee-for-service averages

only for beneficiaries who had been enrolled in HMOs for eight or more years (145). It is also reasonable to speculate that as more people who become eligible for Medicare are already enrolled in managed care plans, more beneficiaries, including those with health problems, will continue in managed care. Over time, this is likely to result in a broader, more representative Medicare managed care population base.¹² A more “mature” market, however, does not eliminate the problem of Medicare’s AAPCC capitation payment formula not accurately reflecting the costs that plans incur from providing appropriate levels of care to Medicare patients.

The Balanced Budget Act of 1997 (P.L. 105-33) instituted a set of changes designed to address the problems associated with the AAPCC payment system. The revised system phases in a system which provides a payment floor that increases payment to low payment areas;¹³ provides for minimum annual updates of 2 percent (i.e., an increase of two percent in plans’ county payment level); blends national and local payment rates to reduce the wide gaps (moving to 50 percent national/local blend by 2003; and requires the introduction of a new risk adjustment methodology that accounts for variations in

10 Brown et al., (19) found that Medicare spent 5.7 percent more for Medicare risk enrollees than if they had remained in fee-for-service. This analysis modeled costs using an adjustment for health status (rather than measuring actual costs) to estimate expected differences in use of services related to differences in practice styles in fee-for-service versus HMO practice. Riley et al., recently found that the average costs for HMO enrollees are 12 percent less than that for FFS enrollees, so that after the five percent discounting of the AAPCC rate, Medicare experiences financial losses of about 7 percent, on average, for each beneficiary choosing HMOs over FFS (98).

11 The data did not allow for measurement of actual costs.

12 Analysis of the Minneapolis-St. Paul market, where nearly 50 percent of Medicare beneficiaries are in managed care, found no evidence of favorable selection; in fact, there was some indication that Medicare beneficiaries in managed care in that market had health care needs equal to or greater than the fee-for-service population (29). However, three of the five Medicare risk HMOs in the area subsequently dropped their risk plans (74).

13 The minimum payment amount of \$367 was set for 1998, with annual updates set at the growth rate in Medicare fee-for-service spending minus .8 percentage points in 1998 and minus .5 percentage points for 1999-2002. Special rates of 150 percent of their 1997 payment rate were set areas outside of the United States (139).

per capita costs based on health status by January 2000 (see chapter 4).¹⁴

ISSUES FOR THE LONG TERM

Understanding the reasons for the growth of Medicare managed care in the 1990s should help guide the policy changes that will be needed to secure Medicare for the next generations. Unfortunately, some of the lessons to be learned are difficult ones.

The goal of increasing enrollment in Medicare managed care is to foster competition in the health care market, leading to more cost-effective delivery of health services. The evidence regarding managed care's success in this regard has been mixed. A growing body of literature is emerging on the effects of Medicare managed care on access to and quality of health care.¹⁵

Overall, there appears to be support for the view that managed care can lead to more effective and efficient delivery of health care to beneficiary populations, and that it can work well for many beneficiaries. There are, however, areas of concern, particularly with regard to access to appropriate specialty care, and for beneficiaries with chronic and serious health care problems (149, 158, 87).

With respect to cost savings, there is agreement that in its first dozen years, Medicare's

risk program failed to yield direct savings to the Medicare program.¹⁶ As will be discussed in later chapters, there are other examples where structured choice among health care plans and insurers appears to have had more success.

Balancing the need to control Medicare program costs with the need to protect beneficiaries' statutory entitlement to necessary and appropriate health care will require a detailed understanding of the technical and political details of the models being considered. To assess whether structured choice could work for Medicare, the Panel reviewed the evidence from existing and specially-commissioned research and policy studies in terms of:

- how Medicare might be structured to take greater advantage of efficiencies that may be available in the health care markets it serves;
- how services can be paid for equitably, given the health care needs of Medicare beneficiaries; and
- what needs to be done to help beneficiaries make informed choices in the Medicare marketplace.

In the following sections, these issues are discussed in turn.

14 Because the payment formula takes into account HCFA's projection of Medicare growth rates and the minimum floor and minimum update factors, there is little margin available for regional payment adjustments in the first year the new system will take effect. For 1998, all plans will receive either the floor payment or the two percent update. In effect, the blend was superseded by the floor and minimum update provisions of the payment formula, so that the objective of narrowing geographic differences by blending national and local rates was not realized. In future years, the formula may permit more geographic adjustment, but PPRC projections suggested that the narrowing of the geographic differences will remain modest except for raising rates in the lowest paid areas to the floor (141).

15 A comprehensive review of this research is presented in Langwell and Esslinger (73); also see Miller and Luft (80).

16 A range of studies indicate that increased penetration of Medicare managed care may be associated with some savings in Medicare fee-for-service costs. There are, however, a variety of factors that could account for this association, including other competitive forces in the non-Medicare markets. If, as Langwell and Esslinger point out, there is some spillover from managed care to fee-for-service practice patterns, this "would alleviate much of the concern about favorable selection and excess payments to Medicare HMOs" (73).

Chapter 3

Structuring Medicare Markets

There is a consensus among the Study Panel that structured, or managed, competition can provide incentives that help to expand consumer choice, control health care costs and promote quality improvements. Applying the concept of structured competition to Medicare managed care would mean developing a system that works in local markets for structuring choice among alternative plans while maintaining national standards for covered services and beneficiary protection. For the market to work efficiently, there would have to be a system in place that provides clear incentives for health care plans to increase the effectiveness and quality of health care services, reduces plan incentives to selectively recruit good insurance risks to negligible levels, and allows beneficiaries to make informed choices among plans. Structuring a market approach that can accommodate both managed care and Medicare fee-for-service options is particularly challenging.

Medicare is a national social insurance program, funded from a payroll tax, general revenues and beneficiary premiums. In 1995, Medicare accounted for \$187 billion, or 18.9 percent of national health care spending (151).¹ About 97 percent of Americans aged 65 and older (more than 33 million people) are enrolled in Medicare, along with about 5 million disabled persons and 210,000 people with end-stage renal disease (130). As beneficiaries live longer, they are vulnerable to an increasing risk of chronic disease (60). Surveys of the Medicare population indicate

that about one fourth of the elderly population and more than half of the disabled beneficiaries rate their own health status as “fair” or “poor.” Most beneficiaries have limited incomes. In 1993, 72 percent of elderly beneficiaries reported annual incomes of less than \$25,000; about 13 percent are eligible for Medicaid (137). Ensuring access to appropriate health services for the Medicare population presents problems unlike those affecting the working population.

The experience to date indicates that the market for Medicare managed care options has not worked well from a program cost perspective, and has not developed in some areas of the United States at all (see Chapter 2). To be accountable to beneficiaries and to taxpayers, Medicare would need to devise systems that maximize competition among health plans while maintaining access to appropriate care for beneficiaries. This involves consideration of:

- what types of benefits packages plans can offer;
- which plans will be allowed to participate in Medicare managed care;
- how choice among plans will be administered;
- how the products will be paid for (including cost-sharing);
- how fiscal, administrative, and quality oversight will be structured to protect Medicare beneficiaries, health care providers, and the public; and

¹ The national spending figure does not include beneficiary cost-sharing, i.e., payment for Medicare co-payments and deductibles.

- how Medicare fee-for-service fits into the system for structuring choice.

This chapter begins with an overview of the broad issues raised by these questions. These issues will be central to the design of a demonstration of competitive bidding among alternative health plans included in the 1997 Medicare reforms of the Balanced Budget Act, as well as to more far-reaching reforms will be considered for preserving Medicare as the Baby Boom generation reaches retirement age. The Panel has looked at a variety of systems for managing competition among health plans in the public and private sectors. The systems described later in this chapter represent some of the larger and/or most innovative models. Drawing on the experiences of these systems from the perspective of Medicare provides insights for designing a more competitive and efficient system for administering beneficiary choice among health care plans.

ISSUES IN STRUCTURING MEDICARE CHOICE

Managed Care Benefits

While Medicare benefits are defined in statute and regulation, there has always been some variation in coverage policies resulting from regional variations in medical practice and utilization review policies (80). Variation in capitation rates for risk programs (see Chapter 2) has increased the variation among plans, and across regions, in the types of services included in Medicare-financed care.

In competitive markets, it makes economic sense to allow plans to compete for members by offering a variety of optional benefits. Beneficiaries have different needs and preferences for health services. How variation

affects the ability of markets to serve beneficiary needs, however, is subject to debate.

On the one hand, a vast array of optional benefits, each defined by individual plans, makes it very difficult for consumers to compare benefits and service options. If drug benefits vary according to the size of the deductible and/or copayment, whether drugs must be prescribed from a restricted formulary, whether specific drugs must be purchased through the plan pharmacy, and so forth, beneficiaries may find it very difficult to calculate how each plan will work for their particular needs. If each of the supplementary benefits varies across a range of cost and utilization criteria, the alternatives expand geometrically. For beneficiaries (or couples both on Medicare) with extensive or chronic health care needs, the attractiveness of the options can become extremely difficult to sort out. On the other hand, limiting the variety of benefit options also means limiting beneficiaries' ability to pick benefits that match their needs and could discourage innovation by plans that have to meet regulatory requirements.

Second, it is possible that optional benefits, when included in "basic" benefits packages marketed by health plans, can contribute to biased selection. The popular example is plans offering health club memberships to attract younger, healthier Medicare beneficiaries. It is also possible, however, that if plans are properly reimbursed, some that elect to focus on groups with certain characteristics or care needs may be more efficient.

Third, some have argued that if it is not possible to sort out "standard" Medicare benefits from optional benefits, Medicare can end up paying for a better benefit package for some beneficiaries than others. The Medicare

reforms introduced in 1997 do not require standardization of plans benefits or supplemental benefits. In theory, allowing competition among plan options within a market area, including fee-for-service, should result in greater program efficiency. If plans can provide a richer package of benefits, then their competitors will have to provide comparable service to avoid losing enrollees. Medicare will, in effect, be able to provide more without increasing outlays. Equity in a national insurance program financed by a national payroll tax and general tax revenues is, however, politically and ethically complicated. In effect, it comes down to, from one perspective, whether beneficiaries who live in areas where it is possible to get “a better deal” on health care should get as large a Medicare “subsidy” on “core” health insurance as those living in less competitive or higher-cost areas.² Conversely, it could be argued that the market should be allowed to “work” even if it works better some places than others.

Benefits package issues are further complicated by the basic limitations of the Medicare “basic benefit package” itself, and the intricacies of supplemental insurance — employer-

sponsored retiree insurance, Medigap, and Medicaid — that have developed to fill some of the holes in beneficiaries’ insurance coverage. Supplemental plans provide protection against catastrophic costs, and can help pay for a variety of services that Medicare does not cover, such as prescription drugs, dental services, comprehensive mental health services, and “extended care facility” services. Flexibility in designing supplemental benefits also encourages innovation; plans and providers have room to experiment with alternative ways of meeting the needs of different beneficiaries. Coordinating benefits among these options in managed care programs can, however, raise a range of complications. Enrollment and disenrollment policies differ for Medicare and Medicaid,³ and supplemental coverage of copayment and/or deductible costs may dilute beneficiary incentives to choose more cost-effective health plans (106).

Participating in the Medicare Market

In the Medicare traditional fee-for-service market, participation in Medicare has been open to all licensed or certified providers; in Medicare managed care, participation has been restricted to federally qualified health

2 In a paper commissioned by the Study Panel, Feldman and Dowd discuss a range of options for dealing with variations in benefit packages in a competitive pricing system. They argue that even if plans develop “basic” benefit packages, there may be market incentives to include supplementary benefits in these packages, resulting in Medicare paying for benefits it did not wish to buy. Different approaches to structuring competitive bidding arrangements for Medicare contracts, as well as regulatory issues, are also discussed in the paper (39).

3 Beneficiaries may be enrolled in the same plan for Medicare and for Medicaid, if the plan has both Medicare and Medicaid contracts, but the benefits are administered separately under different administrative requirements. While Medicare is the primary coverage for non-institutionalized beneficiaries (and remains the primary coverage for hospital and physician costs for individuals confined to long-term care institutions), individuals living in the community might be enrolled in traditional Medicare and a Medicaid HMO, or fee-for service Medicaid and a Medicare HMO. If a beneficiary enrolls in a Medicare HMO and is also eligible for Medicaid, the HMO is the primary payer and Medicaid pays only for services that the HMO does not cover. This can become confusing with regard to HMO benefits with different copayment and deductible restrictions on benefits such as prescription drugs. An enrollee might also have two different primary care physicians, or have a fee-for-service physician providing specialty services when he or she is hospitalized, while the Medicaid HMO tries to coordinate prescription drug benefits post-discharge (106).

plans. Medicare reforms enacted by the 105th Congress included opening up Medicare to a wider range of provider organizations, including preferred provider organizations (PPOs) and provider sponsored organizations (PSOs). The specific requirements for an entity qualified to participate in Medicare managed care will be spelled out in new regulations, most likely at both the state and federal levels, since plans must conform to state law to be licensed as well as meet Medicare requirements.

Determining which organizations should be allowed to compete as Medicare managed care organizations involves trade-offs. On the one hand, open competition among all health plans in an area, in theory, should provide maximum choice to consumers and maximize competitive pressure, leading to greater value (in terms of price and quality of services, assuming valid performance measures are available). In theory, plans that are too expensive or which do not live up to enrollee satisfaction will not survive. In addition, more participating plans provide alternatives to consumers (should one of the other participating plans fail) and increases system capacity overall (39). Plans might develop specialty “niches” designed to meet the needs and preferences of particular communities.

In a program as large as Medicare, restricting participation in managed care contracting could have serious economic and political consequences. Its dominance can actually limit Medicare’s ability to use its market power. Loss of Medicare patients could seriously damage a plan’s viability. Restricting participation could create barriers to the entry of new plans into the market. The elimination of the requirement that managed

care plans limit total enrollment to less than 50 percent Medicare enrollees increases the likelihood that some plans, particularly new entrants to the Medicare market such as PSOs, may be particularly dependent on Medicare enrollees. Instability in plan participation triggered by Medicare policy could, over time, undermine the development of efficient markets; the exit of even one major plan could destabilize remaining plan options.

On the other hand, there are arguments for limiting the number of plans in a given market. Having to compete not only for enrollees, but also to be a “qualified” Medicare provider organization would add a second tier of competition. Limiting the number of participating plans could also reduce the problem of biased selection. With only a few plans operating in an area, segmenting the market by designing specialized benefit packages to attract low-risk beneficiaries might be a less attractive business strategy (39). Informed consumer choice might be easier in a less “cluttered” market. More broadly, the ability to restrict plan participation in Medicare managed care could be viewed as an important tool for quality improvement and consumer protection.

Organizing Competition Among Health Plans

In the private marketplace, there are no formally mandated or externally defined geographic boundaries for managed care markets. The service areas of commercial markets can overlap, with competitive plans providing services across county or state lines. Different types of managed care plans also vary in their ability to provide services across geographic areas. Staff or group model HMOs may operate from a set of clinics or

group offices, while independent practice associations (IPAs), or PPOs may include large networks of physicians dispersed widely throughout a region. Employer-based systems may also include fee-for-service plans that provide largely unrestricted access to all providers. In the employer-based market, people generally choose among the plans selected by their employers. The options among managed care plans are therefore generally those located in the areas where the employer is located. Employees pick among the plans selected by the employer that provide services in the area where the employee lives. In Medicare risk contracting, plans describe the areas, by counties and zip codes within county, from which they will accept Medicare enrollees (147). The Health Care Financing Administration (HCFA) reviews the HMO proposal and can require changes in the areas covered. Provisions of the Balanced Budget Act of 1997 (P.L. 105-33) provide flexibility in defining areas other than counties for setting payment rates for competing plans. At the request of a state's governor, HCFA could adjust payment areas to be statewide or to conform to metropolitan area definitions.⁴ The functioning service areas of the participating plans would, however, be initially set by the plans.

Creating fixed boundaries for Medicare markets would inevitably result in artificial break-up of some markets that have evolved over time, and might require considerable adjustment on the part of health care plans. Some areas might not develop stable competitive markets at all, because of low population or

geographic dispersion. Established Medicare market areas would, however, make it easier to administer Medicare contracts and to develop and disseminate comparative information on plan options, costs, and quality to beneficiaries. If plans were required to offer services to beneficiaries throughout the defined market area, plans could not avoid areas with particularly high rates of service utilization, or market selectively in areas with lower average costs (96), although it would still be possible that enrollees' selection of particular providers could result in de facto differences within market areas. In larger markets, it would still be possible for plans to provide "niche" or specialized delivery options in particular communities, as long as the basic benefits package were offered area-wide.

The administration of the process for selecting among health care plans has been the responsibility of HCFA. As Medicare options in each market area become more complicated, options for managing competition for enrollees need to be considered. One way of organizing the possibilities is to use the experiences of public and private sector health insurance purchasing alliances. In work commissioned for the Panel, Robinson and Powers (103) compare three general approaches: continuing HCFA's role as sole sponsor for beneficiaries (with greater involvement of regional offices); certifying large firms and purchasing alliances to sponsor their own retirees' selection of plans, with HCFA remaining as sponsor for Medicare beneficiaries without employment-based

4 Areas could be metropolitan statistical areas or, in the case of consolidated metropolitan statistical areas, each primary metropolitan area within the consolidated area (e.g., Milwaukee as one area, Racine as a separate area within the larger consolidated area), or the non-contiguous areas within each state that are made up of all the areas that are not in metropolitan statistical areas (rural areas). There are 255 metropolitan statistical areas and 73 primary statistical areas within the consolidated areas in the United States Census Department (120).

retiree health insurance; or a system with multiple certified sponsor organizations, which could include organizations such as labor unions and retiree/consumer organizations.⁵ These certified organizations would be responsible for providing beneficiaries with the information they need to make informed choices among plans, and for administering the competitive pricing system that is used to determine which plans are available to Medicare beneficiaries, and how much these plans are paid.

These approaches appear to offer different advantages and disadvantages related to financing, administration, and beneficiary protection. The single sponsor has the ability to pool risk and cross-subsidize plans, or areas, that serve beneficiaries with greater health care needs. A single sponsor also has greater leverage in the market. Multiple sponsors would likely permit diversity and innovation among plans. The disadvantages, however, are compelling. Consistent enforcement of Medicare program standards and beneficiary protections would be very difficult. Multiple sponsors could, in addition, lead to increased administrative costs, because there would still need to be federal oversight of the sponsoring organizations, and it could also contribute to increased opportunities for biased selection associated with large numbers of competing plans.

Setting up rules for beneficiary enrollment in and disenrollment from plans also has important implications for the way that competition will work. As discussed in Chapter 2, Medicare has (until recent changes in Medicare statute) allowed disenrollment from risk plans on a monthly basis. This pro-

vides beneficiaries with a “safety valve,” allowing them to leave plans they find unsatisfactory. It also may contribute to biased selection. As is discussed in Chapter 2, analysis of disenrollees conducted by The Physician Payment Review Commission (PPRC) showed that use of services among beneficiaries who disenrolled from HMOs were 60 percent above the fee-for-service average (149). Although the overall rate of disenrollment from Medicare HMOs to fee-for-service is low, switching between fee-for-service and HMOs and among HMOs is administratively burdensome for plans and supplemental insurers, and for HCFA data management systems. More important, movement in and out of plans weakens HMOs’ ability to focus on preventive care and care management.

Options for periodic “open enrollment” seasons for selecting plans, and for “lock-in” to plans for a fixed period after enrollment, like all other aspects of structuring Medicare choices, present trade-offs. A single open enrollment season, as is common in employer-based health insurance plans where choice among plans is offered, provides an opportunity to apply a “full court press” to focus Medicare consumer education programs and media information campaigns, and to disseminate comparative plan data. It would also greatly facilitate the process of cost accounting for plans and payers.

The U.S. General Accounting Office found that limited enrollment periods could also pose special problems for the Medicare population when it came to coordinating benefits with employer-sponsored supplements, and could inadvertently slow enrollment in man-

5 See Robinson and Powers, “Restructuring Medicare: the Role of Public and Private Purchasing Alliances,” in *Medicare, Preparing for the Challenges of the 21st Century*, (Washington, DC: Brookings Institution Press, 1998).

aged care (122). While lock-in is generally the rule in employer-sponsored insurance, freedom of choice is popular among beneficiaries, and may provide important market incentives to plans as well. The possibility that enrollees can leave at any time might induce plans to be more attentive to beneficiary satisfaction and quality of care issues, and the ability to enroll new beneficiaries throughout the year could facilitate the orderly development of the capacity to serve new members (8).

The 1997 reforms create a modified lock-in provision. Enrollment in Medicare+Choice plans will include a coordinated open enrollment period, in which all plans must accept new members for the following year, but monthly enrollment and disenrollment will still be permitted until 2001. Beginning in 2002, beneficiaries would be allowed one opportunity during the first six months of the year to switch plans or return to traditional Medicare, except under special conditions. Starting in 2003, beneficiaries would have one opportunity to change their plan selection during the first three months of the year. After that period, no further changes will be effective until the following year.

The statute fixes the effective date of enrollment following the open season at the beginning of each year, as it is in the Federal Employees Health Benefits Program (FEHBP). If large number of beneficiaries opt to change plans each year, it could create administrative burdens on HCFA and the plans. Rolling open enrollment periods, in which beneficiaries pick a plan in the month of their birth, would spread the enrollment/disenrollment burden throughout the year (149). It would, however, also reduce the intensity and focus associated with annual

open seasons, and create a new set of problems with respect to data reporting and monitoring plan performance.

In addition to beneficiary choice and plan management issues, open enrollment and lock-in provisions are linked to three other components of beneficiary health security: employer-sponsored supplemental insurance, private Medigap insurance, and Medicaid. Coordinated open enrollment periods could reduce duplication of supplemental coverage, and help in setting up coverage packages that promote continuity of care. Annual open enrollment periods, or annual consumer education seasons for Medicare could help beneficiaries increase their understanding of their options regarding supplemental coverage, particularly if supplemental insurance open seasons coincided with Medicare's (98).

Paying for Medicare Managed Care Services

Many of the crucial decisions about how and how much to pay for managed care revolve around whether (1) prices will be established through administrative decisions or market competition, and (2) whether Medicare's payments to plans will be based on the price of a defined benefit package, or a defined Medicare contribution toward the purchase of insurance.

The geographic variations in Medicare HMO rates and the complexity of the formulae that have been devised to try to adjust for these variations illustrates the serious limitations of administered pricing by HCFA for managed care services across the United States. A wide range of experts have proposed establishing a system in which health plans compete directly in the market for Medicare enrollees on the basis of price and quality. This could, it is argued, lead to more efficient and cost-effec-

tive delivery of care to beneficiaries (see Aaron and Reischauer (1); Butler and Moffit (21); and Feldman and Dowd (39)). These proposals vary significantly, however, with regard to how competition would be managed. At one end of the spectrum, Medicare beneficiaries would be given vouchers that they could use to pay premiums in the health plan of their choice on an open market. At the other end, Medicare would administer a system in which health care plans meeting Medicare qualifications negotiate premium rates, on a plan-by-plan basis or in a structured group bidding process conducted in each market area, and beneficiaries select among qualified plans, in the much the same manner as employees of large private and public sector employers offering a choice of plans.

As discussed below, systems based on negotiated pricing appear to have worked well in some systems. Negotiation in a plan as large as Medicare, however, may not be the most efficient approach (96). Laws and regulation regarding procurement can make negotiations complicated, and it might be to explain to beneficiaries that they have to leave a plan because negotiations could not be completed successfully.

Work by Feldman and Dowd commissioned by the Study Panel examined a variety of options for structuring competition in Medicare markets (39). If Medicare defines a standardized benefits package, plans could be asked to submit bids for a “standard” plan. Plans could also submit bids on supplemental benefits packages, or these could be marketed entirely outside of the Medicare program. Medicare could then peg payments

to plans based on the lowest bid or an average of the bids. The success of this approach might, however, depend on keeping supplemental benefits separate from the basic benefits package, so that plans compete on the real costs of Medicare services, rather than supplemental services that are included in the “standard” plans and in supplement packages.

Managing competition also requires decisions about contribution levels from Medicare and from beneficiaries. Medicare’s indemnity insurance program was designed as a “defined benefit,” or “service support” system, in which insurance pays for a defined set of benefits whenever they are used [appropriately] by beneficiaries. Managed competition models proposed for Medicare generally include a “premium support” or “defined contribution” approach in which Medicare could pay a defined sum toward purchase of a defined insurance policy or health plan premium (1). Premium support models can, however, include elements of both a defined benefit and defined contribution approach. For example, Medicare could choose to pay 90 percent of the average cost of all plans agreeing to provide at least a defined set of benefits. This differs significantly from voucher models in which the program would provide a specific dollar contribution that individuals could use toward the payment of premiums for a wide range of insurance products with different benefits designs.

The specific procedure for setting the Medicare contribution to premiums for each plan is also important.⁶ The simplest approach is to base the Medicare capitation payment on the lowest bid submitted by

6 Alternative methods for setting the Medicare premium contribution rate are discussed in detail in Feldman and Dowd (39).

competing plans. Beneficiaries (or employers providing retiree health benefits) would then be responsible for any additional premium charged by other participating plans, and for supplemental coverage. Low bids, however, may not lead to the optimal payment level from the perspective of the Medicare program. If bids do not reflect the real costs of providing appropriate quality care, low Medicare payment rates could lead some plans to withdraw from participating in Medicare (assuming that plans cannot bill beneficiaries to make up for low payments from Medicare).

Many bidding procedures are possible. For example, Reischauer proposes that a bidding system could be designed so that the federal contribution toward plan premiums is set at the median of plan bids, (is long as plans submitting lower bids were capable of serving at least half of the market's Medicare population) (96). To offset incentives to "low ball" bids, payment rates could be set at the second lowest bid rate for the approved benefits. Another option is a "Dutch auction," in which Medicare would start negotiations with plans by announcing rates that are attractive to plans, then reduce them gradually, until plans begin to drop out of the competition. The rate paid to plans would be the rate at which the "nth"-to-last bidder dropped out. Options such as the Dutch auction approach might help Medicare establish the true cost of providing basic benefits. More complex formulae could also be developed that would set the premium contribution paid by Medicare at some percentile of the distribution of bids (e.g., paying at a rate equal to the 50th percentile); or at a fixed percentage of the lowest bid (e.g., 110 percent of the lowest bid); or the weighted (to reflect by beneficiary enroll-

ment in each plan) average of the bids submitted by all of the qualified plans (39).

Different approaches to setting the Medicare premium vary in complexity and ease of administration, and in the strength of the incentives they give plans to submit low bids. Decisions would still have to be made about how far plans could bid above the median premium bid and still qualify for participation in the Medicare market. In theory, any competitive approach should provide incentives to hold down premium costs.

These approaches do not, however, address the more difficult issue of adjusting for risk so that plans do not have incentives to avoid high-cost enrollees, and beneficiaries with greater health care needs can be assured access to the services they need under managed care arrangements. As is outlined in the previous chapter, risk adjusting Medicare payments involves an array of conceptual as well as technical issues; these are discussed in greater detail in Chapter 4.

Oversight of Medicare Managed Care

In addition to administering a system for pricing capitated payments, Medicare needs to ensure that competition is fair. Medicare is required by law to protect beneficiaries from discrimination, substandard care, and fraudulent or abusive practices. For structured choice to work, however, the program also needs to ensure that beneficiaries get the information they need to make informed choices among plans. Among the administrative issues are: enrolling and disenrolling beneficiaries, ensuring that relevant, accurate, and usable information is developed and disseminated, addressing grievances, and overseeing quality review activities. Responsibility for oversight functions could be performed

either by the Medicare program (through regional office), through contractors, or through accountable sponsor organizations such as those described above. Chapter 5 examines the tradeoffs among these options in greater detail.

The Relationship of Medicare Fee-for-Service to Managed Care in Structured Competition

One more aspect of the Medicare managed care market that differentiates it from other insurance markets is that most beneficiaries have remained in traditional Medicare fee-for-service insurance. In the employment-based health care market, incentives to control costs have led many purchasing organizations to limit plan choice to a range of managed care organizations and/or indemnity plans with structured utilization controls. Medicare's indemnity insurance has generally offered beneficiaries more freedom to choose among physicians and hospitals. Without solid evidence regarding the quality of care provided by managed care organizations, consumers may be reluctant to give up the ability to switch physicians whenever they think it is appropriate or necessary. Freedom of choice may be valued highly by some beneficiaries in particular, such as individuals who prefer to seek out specialty services on their own, without going through their HMO to obtain referrals. If managed care organizations provide patients with greater flexibility in seeking specialty care, however, they may also be less able to effectively manage the use of these services.

Competing against fee-for-service in the Medicare market is also more difficult

because many beneficiaries are shielded from financial incentives to enroll in more cost-effective health plans. Most Medicare beneficiaries have some form of supplemental insurance which may cover most or all of deductible and coinsurance costs (with about one-third paying for the full cost of these policies; see Chapter 2). Beneficiaries may incur little or no out-of-pocket cost when they use Medicare-covered services in the fee-for-service market (149). Medicare in effect subsidizes fee-for-service use, because when supplemental policies protect beneficiaries from additional costs for using more services, they tend to use more services (148). This may reinforce the preference for fee-for-service medical care among beneficiaries whose interest is in having immediate and unlimited access to care, i.e., beneficiaries with more serious health care problems. If fee-for-service continues to be more attractive to beneficiaries with greater health care needs, the market for managed care services may remain distorted, and Medicare's ability to obtain savings through managed care may be limited.

LESSONS FROM STRUCTURED CHOICE SYSTEMS

Systems that administer choice among alternative health care plans in both the public and private sectors have demonstrated that structured competition can work effectively in some markets. The models that have been put in place differ along many dimensions, including how participating health plans are selected, how benefits packages are defined, and how premium rates are set. Basic characteristics of these systems are summarized in tables providing basic information on each.

Several of the working systems offer potential models for managing competition among Medicare capitated health care plans, while other innovative approaches may offer insights into ways to address special issues that shape the Medicare health care market.

Federal Employees Health Benefits Program (FEHBP)

FEHBP was created by Congress in 1958⁷ to administer health insurance for active and retired federal employees, postal workers, and members of Congress (see box 3-1). Participation in FEHBP is optional, but almost 9 million working and retired persons and families are covered by 388 separate health plans (96). The proportion of policy holders who are retirees has grown substantially over the past two decades; by 1992 about 40 percent of individual FEHBP policy holders were retired. Plans participating in FEHBP are prohibited from charging higher premiums for segments of their enrollment who are high-risk by strict community rating provisions within each plan, and plans cannot impose waiting periods or exclusions from coverage for pre-existing medical conditions (20).

The administration of FEHBP is done by the federal Office of Personnel Management (OPM), which is authorized by law to: contact health insurance carriers, prescribe “minimum reasonable standards” for plans, approve or disapprove plan participation, prescribe regulations governing participation in the program by employees, retirees, and family members, make information about plan options available to potential enrollees, and

administer the trust fund for FEHBP, which is funded from contributions from the government and enrollees (20). The FEHBP statute defines the types of benefits that may be provided, and sets out minimum standards for insurance carriers, but does not specify a comprehensive set of standard benefits to be provided by FEHBP plans.

Overall, FEHBP plan benefits approximate those in the private employer-based market (65). All of the plans cover hospital and physician care, outpatient diagnostic lab tests, certain specialty procedures, such as bone marrow transplantation for the treatment of breast cancer, some mental health services, some preventive services such as mammograms and prostate cancer screening, and smoking prevention (20), and provide catastrophic coverage which generally limits total annual out-of-pocket costs to \$1,000 to \$2,000 (65). Most cover prescription drugs, and some form of “extended care facility” benefits. FEHBP benefits for the full range of preventive services, however, are not typically as generous as in the private sector, and FEHBP plans generally do not include the level of dental coverage offered in private sector employee policies.⁸ Most of the health plans participating in FEHBP include some form of care or utilization management (including under that heading HMOs, PPOs and point-of-service (POS) plans offering incentives for beneficiaries to use a specified network of providers in a particular service area). Seven plans that are national in scope are available to all federal employees and annuitants (65). FEHBP also includes fee-for-service insurance options. In 1996, 72 per-

7 Federal Employees Health Benefit Act (P.L. 86-382).

8 The annual estimates developed by Hay/Huggins, Inc. place the relative value of FEHBP plans at about 10 percent lower than the average value of private sector plans, primarily because of the difference in dental care provisions (65).

Box 3-1

Federal Employees Health Benefits Program (FEHBP)

<i>Operating Since</i>	1959
<i>Enrollment Characteristics</i>	Federal employees, annuitants, and their families; 9 million people.
<i>Enrollment Type</i>	Through employer (federal government and the U.S. Postal service) Enrollment period Fall open season period of three weeks. Lock-in for the year.
<i>Benefits Package</i>	Not standardized. Congress defines the types of benefits that may be provided. The OPM sends out a 'call letter' each spring to insurance carriers and discusses their expectations for rates and benefits. The carriers respond by offering proposals. Contributions to the health plan by enrollee and employer (federal government)
<i>Contributions to the Health Plan by Enrollee and Employer (Federal Government)</i>	Defined contribution. The OPM sets the government contribution to retirees' health benefits through a formula established by law. The beneficiary must contribute at least 25 percent to the health plan through their paycheck or retirement annuity.
<i>Risk Adjusting or Assessing Method</i>	No risk adjustment is done in payments to plans. FEHBP uses a group rate where the same premium is charged to all participants.
<i>Selection of plans</i>	Private plans must meet reasonable minimum standards with regard to benefits and financial stability.
<i>Rules to Participate</i>	Same as above.
<i>Number of Plans</i>	388 health plans are available through FEHBP; the majority of the plans are only available in particular geographic areas; most participants can choose between 10-20 plans.
<i>Information Required of Plans</i>	Applicant plans (limited to HMOs) complete application package, once accepted, plans submit claims and/or operating (financial) information annually. Information provided to consumers
<i>Information Provided to Customers</i>	The OPM produces the <i>FEHBP Guide</i> which includes a health plan comparison chart. Consumers also receive plan brochures.

Source: National Academy of Social Insurance, 1998.

cent of FEHBP consumers chose PPO or fee-for-service plans (149).

FEHBP uses a negotiation process rather than a competitive bidding approach to setting premiums. Each year, OPM negotiates with the plans on issues including benefit design, premium setting, and communication of information to enrollees. The process begins with a call letter to plans which specifies the design changes that OPM will consider for the coming year. A key provision in this process is that OPM requires that any revised benefit package not be any more expensive than the prior year's package.

Therefore any new benefits proposed by the plans have to be offset by some other benefit reduction or reduction in the estimated cost of a benefit. After the benefits are set, OPM and the plans negotiate premiums.

Negotiation focuses on establishing the lowest premium that OPM finds to be actuarially sound (149). The process is designed to produce a premium that reflects the benefits paid for the FEHBP enrollees in each plan plus administrative costs and profit. The payment formula set in statute determines the share of each premium to be paid by the government and by the enrollee. OPM also requires that participating HMOs and POS plans charge no more for premiums under FEHBP than they charge their large private sector customers.

The federal contribution to employees' health insurance is a defined "premium support" payment, i.e., a defined percentage contribution for a benefit package meeting

FEHBP requirements. Prior to 1997, the government paid HMOs and POS plans 60 percent of the average premium for six large plans, but no more than 75 percent of the cost of individual plans.⁹ Provisions of the Balanced Budget Act of 1997 (P.L. 105-33) revised the formula for the government contribution to 72 percent of a "weighted average" premium computed from plan premiums and the number of subscribers in each plan (to begin with the first day of contracts beginning in 1999). Federal premium contributions to health plans under FEHBP are not adjusted for beneficiary health risk.

Each year, FEHBP holds a month-long open season in the Fall in which employees and retirees are allowed to choose from the plans available in the area in where they live. In 1996, FEHBP beneficiaries could choose from among nine to twenty health care plans, depending on where they lived (149). OPM sends beneficiaries the *FEHBP Guide*, which includes a chart comparing key features of the plans available to them, including descriptions of benefits, premiums and cost-sharing information, restriction on provider choice, and provisions for emergency and out-of-area care. In addition, OPM develops and disseminates the results of consumer satisfaction surveys of over 300 plans which include ratings on plan performance such as waiting times, perceived quality, access to specialty care, and interaction with care providers (117). Additional detailed information on plans is also produced by consumer organizations. After selecting a plan, beneficiaries are "locked-in" for one year,

9 The maximum annual government contribution in 1997 was \$1,600 for individuals and \$3,490 for families (20). The actual federal contribution for individuals ranged from about \$1,000 up to \$1,600, while individuals contributed anywhere from about \$400 to \$1,800. For the 19 largest FEHBP plans, the federal contribution ranged from 75 percent (the maximum allowed) for the least expensive premiums, to about 47 percent of the premium for the most expensive plans (149).

beginning January 1.¹⁰ Historically, about 5 percent of enrollees have opted to switch health plans each year (96).

The FEHBP model is generally viewed as a fairly successful one. FEHBP is cited as a model in the development of demonstrations for Medicare competitive bidding called for in the 1997 Balanced Budget Act (see below). FEHBP is popular among its enrollees, and it has been relatively successful in holding down rates of increase in premium costs of managed care plans. About 95 percent of enrollees have indicated in surveys that they believe the options they are offered in FEHBP compare favorably with options in the private sector, and over 85 percent are satisfied with their own plan. Over the 1983-96 period, the average enrollee premium rose by less than 4 percent per year. In the 1996-7 period, the growth rate in FEHBP premiums, like that in the private sector, was about 2 percent (96), but for 1998, premiums increased by 8.5 percent (142). The bureaucratic structure for FEHBP is quite modest. In 1996, the OPM staff running FEHBP included less than 150 full-time equivalent employees, and an administrative budget of around \$20 million. This staff was not, however, responsible for information dissemination, enrollment, disenrollment, and initial handling of questions and complaints, all of

which is handled by the human relations staff at individual government agencies, making total administrative costs difficult to estimate (96).

While FEHBP provides an important example of an efficient system that offers broad choices among health care plans, some adjustments would be needed to fit the model to Medicare. In testimony before the Senate Committee on Finance, Reischauer identified four issues: First, the lack of a mechanism for adjusting premiums to reflect beneficiary health risk, and resulting in biased selection into plans would likely be more serious in the Medicare population than it has been in FEHBP.¹¹ If there is biased selection into plans, some participants would end up paying higher premiums not because they select less efficient plans, but because they enroll in plans with sicker enrollees. Second, the FEHBP model does not include standardized benefit packages. Comparing multiple benefits packages across a wide range of plans would be particularly difficult for Medicare beneficiaries with extensive medical care needs.¹² Third, FEHBP does not require fixed market area participation by plans. In most instances, FEHBP plans are free to define the areas in which they provide services. This may not be a significant problem in FEHBP, where the population is fairly

10 Limited exceptions to lock-in include moving to a new location, change in family circumstances, e.g., divorce, or certain exceptions "for cause" such as a plan's demonstrated inability to provide needed care.

11 In the 1980s, adverse selection (enrollment of persons with higher health care costs) led to rapid increases in premium rates for two large FEHBP plans, eventually leading one of the "high-option" plans to leave the FEHBP program in the early 1990s (149). The system appears to have stabilized with the single high-option plan continuing to be a significant part of the FEHBP system.

12 Standardization versus flexibility and innovation in benefits design is a hotly debated issue in managed care. The importance of standardized benefits packages *per se* versus the need to understand how plans actually cover and provide care for serious illnesses has also been debated. Even comprehensive descriptions of benefits may not provide the information beneficiaries would like about people "like them" (see Chapter 5). Some administrators of large benefits systems engaged in managed competition, however, argue that standardized packages make plan comparisons far more practicable (see below).

homogeneous, but it could lead to gerrymandering to avoid high-cost Medicare populations. Finally, the methods FEHBP has adopted for determining plan premiums are not necessarily the most effective strategy for a program as large as Medicare. Negotiations between FEHBP and plans focus on making adjustments to plan bids to reflect specific characteristics of the FEHBP plan package and beneficiary population. A more aggressive approach to negotiation, like that employed in CalPERS (see below), might be possible, given Medicare's considerable market power. Negotiating with individual plans throughout the United States on the scale required for Medicare could, however, be administratively burdensome (96).

California Public Employees' Retirement System (CalPERS)

A second program that has been successful in offering a choice of plans to a large population is the CalPERS, which was established in 1962 (see box 3-2). CalPERS is a quasi-public entity that purchases health care for state employees and for other public employees including municipal workers, and employees of California district schools. It provides a choice of health plans providing basic individual or family health coverage to working enrollees and retirees not eligible for Medicare, and supplemental coverage to those enrolled in Medicare. Members can choose from among 14 HMOs, 4 association plans (e.g., firefighters' union), and two self-insured PPO plans (103). There are over one

million CalPERS members; of these over twenty percent are retired.

CalPERS is governed by a board appointed by the governor, the California legislature, unions, non-state public agencies, and others (103). The state's contribution is determined largely through negotiations between the state and employees' unions. Employers' contributions vary by sector, with the contributions in municipal government tending to be somewhat lower than in some of the other public sector groups. Plans therefore have an incentive to keep premiums down to attract municipal employees. The state, however, contributes at a flat rate for each type of annuitant (active workers, retirees, Medicare beneficiaries, and families), regardless of the actual plan premium cost. This contribution reflects the higher average health care costs in California, and is therefore higher than FEHBP levels.¹³ Many state employees pay no premium costs at all, since the state contribution covers the entire premium. Premium costs are therefore not a strong factor driving consumer competition among plans.¹⁴ For most beneficiaries, competition is therefore more likely to focus on issues of satisfaction, perceived quality, convenience, etc. What is perhaps most significant, from the perspective of those interested in facilitating choice in Medicare, is that CalPERS has been very effective in using consumer satisfaction surveys to generate comparative information on preventive services, satisfaction with care, and administrative aspects of plan

13 In 1996, the maximum contribution for state employees (self only) was \$2,088, compared to \$1,599 in FEHBP (149).

14 There is only one CalPERS plan, a PPO, that requires a consumer premium payment (\$984 per year in 1996). This plan offers a number of benefits such as inpatient mental health coverage and home health and skilled nursing care that may attract high-cost enrollees. The large difference in premium costs for this plan, compared to the other CalPERS PPO, which has a premium in the same range as the other (HMO) plans in the system, but requires greater out-of-pocket spending and has less generous benefits than the high-option plan, provides some additional evidence that high-option insurance may result in biased selection (149).

Box 3-2**California Public Employee's Retirement System (CalPERS)**

<i>Operating Since</i>	1962 for California state employees; expanded to other public employees in 1967.
<i>Enrollment Characteristics</i>	Over 1 million members; 20 percent retired.
<i>Enrollment Type</i>	Enrollment through the public employer.
<i>Benefits Package</i>	Annual open enrollment process for six weeks. Benefits package Standard benefits package for all HMOs.
<i>Contributions to the Health Plan by Enrollee and Employer (Federal Government)</i>	Defined contribution. The state and other public sponsors set their premium contribution at a level lower than the PPO premiums but similar to many of the HMO premiums. Enrollees pay the difference out-of-pocket if they choose a high cost plan.
<i>Risk Adjusting or Assessing Method</i>	Negotiation strategy encompasses age and sex factors.
<i>Selection of plans</i>	Plans must meet and maintain standards for quality, access, and service, and be competitive on price.
<i>Rules to Participate</i>	CalPERS negotiates premiums each year with HMOs.
<i>Number of Plans</i>	All members choose between 14 HMOs, four association plans, and 2 PPOs. Effective 1/1/98 they will offer 11 HMOs due to mergers and consolidations.
<i>Information Required of Plans</i>	CalPERS and the Pacific Business Group on Health collaborate to obtain independently audited quality of care data.
<i>Information Provided to Customers</i>	An annual health plan quality and performance report is sent to each member's home. Members also have access to customer service staff working within CalPERS.

Source: National Academy of Social Insurance, 1998.

performance to help enrollees with plan selection. Recently, it has also developed plan performance scores based on beneficiaries who are high users of services (e.g., hospitalized within the last year. (103).

Over time, CalPERS has made significant changes in the way that it manages the purchase of health coverage. Initially, the state paid 100 percent of the individual premiums up to the average of the four largest plans (plus 90 percent for dependents). That formula clearly limited plan incentives to reduce premiums. In 1992, the state's financial crisis led it to freeze maximum contributions to 1991-92 levels. In 1993, CalPERS implemented a standard benefit design for all HMO plans as a means to simplify plan selection, provide a more comprehensive, uniform scope of benefits, reduce administrative costs, and improve its ability to negotiate with health plans. It also began to be far more aggressive in its negotiating with plans. Plans that were unwilling to set premiums at what CalPERS considered reasonable levels might have their enrollment frozen, or even be dropped from participation entirely. After a decade of double digit inflation, the premiums for CalPERS HMOs decreased each year from 1993 through 1997 (103). In effect, a pressing need to contain costs led CalPERS to move from being a passive payer of insurance premiums to an active sponsor with a defined benefit package, limited employer contributions, and aggressive premium bargaining.

The Health Insurance Plan of California (HIPC)

Because the small insurance market serves groups and populations who have difficulty purchasing health insurance at a reasonable price, organizations that have been set up to

help small groups and individuals obtain health insurance also provide insights for Medicare. The Health Insurance Plan of California (HIPC) is a statewide employer purchasing cooperative administered by the state's Managed Risk Medical Insurance Board (see box 3-3). It was set up to help employers with two to fifty employees, but also accepts individuals and groups of any size who are supported by qualifying "Guaranteed Associations." The HIPC covers about 6,900 groups, representing 73,000 employees plus an additional 59,000 dependents. It provides basic benefits only, and does offer Medigap supplemental coverage. The HIPC offers 20 plans to participating groups, including HMOs and several other managed care types, including PPOs and POS plans (109). All plans are available to all participating groups. Employers are required to contribute at least 50 percent of the premium for their employees, but many contribute the full premium (103). They charge a community rate (adjusted for age, family size and region only) to all enrollees (110).

The HIPC is responsible for marketing, eligibility and enrollment functions as well as negotiating rates with participating plans. A standard benefit design and annual open enrollment periods facilitate decision-making. Plans are required to charge rates that vary by the age of the subscriber, which is intended to partially adjust for risk. Because the relatively large number of plans available to enrollees could result in significant market segmentation and risk selection, the HIPC has developed a risk adjustment methodology that identifies plans incurring higher costs (see Chapter 4). Plans with a risk score above a specified threshold, based on gender and age factors, number of children covered, and documented treatment of specified high-cost

Box 3-3**Health Insurance Plan of California**

<i>Operating Since</i>	July 1, 1993
<i>Enrollment Characteristics</i>	6,890 groups, 7 guaranteed associations, and 73,000 employees. Including dependents, the total number of enrollees is over 132,000
<i>Enrollment Type</i>	Government sponsored voluntary purchasing cooperative for small employers with 2 to 50 employees Enrollment period Annual open enrollment period and a lock-in
<i>Benefits Package</i>	Standard benefit package with 2 copay level options. HMO and POS plans are offered.
<i>Contributions to the Health Plan by Enrollee and Employer (Federal Government)</i>	Employer and employee premiums; employers must contribute at least 50% of the lowest cost plan.
<i>Risk Adjusting or Assessing Method</i>	Risk assessment (using 120 key marker diagnoses and demographic factors) and risk adjustment (transfers funds to plans +/- 5% of the threshold).
<i>Selection of plans</i>	HIPC negotiates and selectively contracts with plans.
<i>Rules to Participate</i>	HIPC negotiates premiums with health plans annually; negotiates contract language and health plan performance standards every two years.
<i>Number of Plans</i>	20 plans offering 24 products
<i>Information Required of Plans</i>	Plans must report the proportion of members with marker diagnoses (high cost conditions) which is used to determine risk assessment. Demographic information is obtained from central enrollment database.

Source: National Academy of Social Insurance, 1998

medical conditions, receive additional payment from a risk transfer pool containing funds collected from the plans. Assessments for the risk transfer fund are calculated from each plan's risk factor scores, so that plans with lower-risk enrollees are assessed at higher rates. The methodology is designed to focus in particular on high-cost outlier cases. Most plans do not need transfers, and just over one percent of total premium dollars needed to be transferred to bring all plans' risk assessment values within the threshold of acceptable variation (5 percent) set by the HIPC in 1995 (110).

Pacific Business Group on Health (PBGH)

Both the HIPC and CalPERS are members of a larger purchasing coalition, The Pacific Business Group on Health (PBGH) (see box 3-4).¹⁵ A subset of 18 PBGH members participate in an alliance which negotiates with California HMOs about issues including premiums, quality improvements, and other performance features. In 1996 the Negotiating Alliance represented 380,000 active employees, dependents, and early retirees, and 40,000 Medicare-eligible retirees. Employers in the Negotiating Alliance agree to use the PBGH-defined standard benefit package, which is similar to the CalPERS package. The Alliance also negotiates on behalf of individual firms on modified benefits packages, such as varying copayment levels or mental health or prescription drug services. Participating firms agree to use rates negotiated by the Alliance, without seeking firm-specific rates based on firm-level differences in risk-mix. But because PBGH is a negotiating, rather than a purchasing alliance, each member firm contracts directly with a subset

of plans that have met PBGH criteria. The negotiation function is important to employers who can benefit from the lower rates that PBGH may be able to obtain.

The PBGH firms also maintain their own self-insured plans outside of the Negotiating Alliance. Approximately two-thirds of all covered individuals have chosen HMO coverage. All the member firms are committed to basing their premium contribution on the rates of lower-priced plans, but they are phasing in this approach to setting contribution levels over several years. The PBGH obtained average HMO decreases of 9.4 percent in 1995 and 4.3 percent in 1996; in 1997 premiums remained at the 1996 levels. Members opting to offer different benefits (including the HIPC and CalPERS) do not participate in the Negotiating Alliance, but do participate in the PBGH quality improvement and data sharing activities. The PBGH has steadily increased the range of issues over which it bargains with health plans. In the area of performance measurement, PBGH negotiations have addressed customer service, quality, enrollee satisfaction, and data reporting. Plans failing to achieve acceptable performance ratings risk losing two percent of premium payments. PBGH is also increasing its role for Medicare-eligible retirees, by negotiating with Medicare risk plans over network scope and composition, administrative issues, and supplemental benefits. Employers are interested in having plan design for Medicare-eligible retirees mirror the design for active employees and early retirees. Parallel design helps ensure continuity in care, and also maintains cost-sharing elements designed to promote "cost-conscious choice." Negotiated performance criteria for

15 The discussion of PBGH is drawn from Robinson and Powers, "Restructuring Medicare: the Role of Public and Private Purchasing Alliances" (103).

Box 3-4**Pacific Business Group on Health (PBGH)
And PBGH Negotiating Alliance**

<i>Operating Since</i>	1989
<i>Enrollment Characteristics</i>	3 million enrollees
<i>Enrollment Type</i>	Through employer
<i>Enrollment Period</i>	Annual open enrollment period. Some off cycle enrollment too. All enrollees are locked in for a year except for Medicare beneficiaries in some cases.
<i>Benefits Package</i>	Standardized benefit package; supplements can be negotiated by the PBGH negotiating alliance.
<i>Contributions to the Health Plan</i>	Varies by company. In some enrollees pay the difference out-of-pocket if they choose a high cost plan, while in others they do not.
<i>Risk Adjusting or Risk Assessing Method</i>	PBGH has collected data and developed risk adjustment procedures. Early analyses did not indicate that risk adjustment was warranted, but analyses continue, and risk adjustment may be used in the future.
<i>Selection of plans</i>	Any Knox-Keene licensed plan may participate in the Negotiating Alliance process.
<i>Rules to Participate</i>	PBGH negotiates the premium levels with health plans, each member company then chooses the plans they want to offer to employees.
<i>Number of Plans</i>	15 HMOs
<i>Information Required of Plans for the Negotiating Alliance</i>	Requests for proposals (RFPs) detailing capabilities; some plans provide ten performance measures, including HEDIS, through the California Cooperative Health Care Reporting Initiative.
<i>Information Provided to Customers</i>	Consumers receive descriptions of the health plans and information on quality and price during the open enrollment period.

Source: National Academy of Social Insurance, 1998

PBGH Medicare HMOs cover flu shots, health risk assessments, and maintenance of good communications and relations with medical groups and hospital systems.

Buyers Health Care Action Group (BHCAG)

A private sector alliance in Minnesota has taken a rather different approach for structuring health care choices that may provide additional insight into ways to integrate Medicare managed care and fee-for-service options.¹⁶ The Buyers Health Care Action Group (BHCAG) includes 26 large private firms with 250,000 employees and dependents in the Minneapolis area (see box 3-5). The alliance contracts directly with medical groups and physician-hospital organizations called “care systems.” The BHCAG has developed a strategy that does not rely on capitation, but instead uses budget targets to calibrate fee schedules for fee-for-service reimbursement to providers. This method allows BHCAG to remain exempt from state insurance regulation; it is not an insurer, because it does not contract with health plans, or share risk with the care systems (see Chapter 5). Each member firm sets its contribution below the level of the lowest care system premium, giving employees the incentive to make price-conscious decisions when they choose plans. The BHCAG does not negotiate the “claims targets” with the medical groups, but instead relies on consumer choice to keep prices low. Under the BHCAG system, member firm benefits costs declined from the previous year by an average of 9 percent for 1997, its first year of direct contracting with providers.

Because payments are based on fee-for-service bills, there are itemized data on medical encounters that can be used to calibrate payments to plans, and to generate detailed information on the utilization and quality of services provided. In collaboration with the care systems and a large HMO, BHCAG has developed very extensive information on each care system, its medical groups, primary care providers, specialty referral panels, and hospitals, which is made available to consumers choosing among systems. The alliance works closely with major provider organizations, such as the Mayo Clinic and the Park Nicollet Medical Foundation, on clinical protocols and other quality improvement methods (13). It also works closely with the Minnesota Health Data Institute, a public-private partnership created by the Minnesota legislature, to obtain community data for comparison of clinical and service quality at the care center level. A risk adjustment method based on information in itemized bills is used to adjust the fee schedules of each provider organization (see Chapter 4). This transfers monies among providers, but not among employers, who pay all the claims for their own employees. This system therefore provides direct compensation to providers — doctors and hospitals — for caring for sicker patients, rather than to health plans. Differences among health plans may be small while variations in patient mix at the provider level are large; Robinson and Powers report that there is a 35 percent difference in risk (using the BHCAG risk adjustment measure) among the 15 care systems 17 with BHCAG contracts in Minneapolis (see Chapter 4).

16 The discussion of BHCAG is also drawn largely from Powers and Robinson, “Restructuring Medicare: the Role of Public and Private Purchasing Alliances,” (103) and updated information provided by BHCAG in September 1997.

Box 3-5**Buyers Health Care Action Group (BHCAG), Minnesota**

<i>Operating Since</i>	Direct contract fully implemented in 1997; BHCAG established in 1991.
<i>Enrollment Characteristics</i>	250,000 employees and dependents in the Minneapolis area
<i>Enrollment Type</i>	Enrollment through 26 large employers
<i>Enrollment Period</i>	Enrollees designate care system at time of annual enrollment - each family member selects, and may change to lower or equal cost care systems during the plan year.
<i>Benefits Package</i>	Standard point-of-service benefits.
<i>Contributions to the Health Plan</i>	Each member firm sets its contribution below the level of the lowest care system premium, thereby requiring employees to pay increased premiums costs for more expensive care systems.
<i>Risk Adjusting Method</i>	Risk assesses (through fee-for-service claims data processed through the Ambulatory Care Groups software); risk adjusts (the fee schedules to each provider are adjusted based on whether their risk mix is above or below the average for all organizations.)
<i>Selection of plans</i>	All core systems which meet minimum quality standards.
<i>Rules to Participate</i>	Qualified care systems submit budgets. Member premiums are based on the core system budget.
<i>Number of Plans</i>	19 "care systems," which are groups of hospitals, clinics, and medical practices
<i>Information Required of Plans</i>	BHCAG does not contract with plans, but claims data is made available to both employers and providers.
<i>Information Provided to Customers</i>	Referral rules for care systems, quality data for adults and children, information on participating providers, office hours, on-site services, individual physicians' background and training, and care system prices.

Source: National Academy of Social Insurance, 1998

CONCLUSIONS AND RECOMMENDATIONS

The Academy Study Panel on Capitation and Choice believes that building the infrastructure that can support a system of structured choice that will work well for beneficiaries will require careful experimentation and analysis of options. The experience of systems for structuring choice of alternative health care plans can provide some important direction for restructuring Medicare.

First, it seems clear that systems offering choice among competing plans, such as FEHBP and CalPERS, have succeeded in holding down the rate of premium growth while retaining a large number of plans from which to choose, and maintaining high levels of consumer satisfaction. These systems also demonstrate that competitive systems can also be designed to include national health plans as well as regional and local plans that can offer enrollees some forms of managed care options virtually anywhere in the United States. FEHBP offers options among plans even in sparsely populated areas. Second, public and private organizations include health plans which offer both managed care and fee-for-service arrangements. Models for administering preferred provider organization plans (with discounted fee-for-service reimbursement), or paying providers directly (such as the Buyers Health Care Action Group) provide lessons for operating a competitive system that could offer Medicare beneficiaries both managed care and traditional insurance coverage. Third, both public and private systems for structuring choice have developed innovative and successful approaches for collecting, analyzing, and disseminating comparative information on health plan options and plan performance

that is useful to both employers and to beneficiaries.

RECOMMENDATION

The models used by government and private organizations to structure insurance choice for their employees, retirees and dependents should be studied closely so that their successes and failures can inform decisions with respect to Medicare. Examining approaches to offering both capitated and fee-for-service options within structured choice systems is particularly important.

There are, however, some important differences between Medicare and the private markets in which managed competition has succeeded. Negotiation with plans has been successful in some structured choice systems, but analysis conducted by the Panel suggests that more structured approaches to competitive pricing, i.e. competitive bidding, might offer advantages in a program as large and complex as Medicare. Further, in employer-sponsored insurance markets, which are group-based markets, structured competition among health care plans and insurers appears to have some notable successes from the perspectives of cost and consumer satisfaction. From the perspective of Medicare beneficiaries, as individual purchasers, at least some of the appeal of Medicare HMOs stems from the fact that a significant number of risk plans offered a far better deal than fee-for-service Medicare. The additional benefits that Medicare risk plans have been able to offer are important to beneficiaries. Obtaining these benefits at little or no additional cost is of particular value to beneficiaries with limited resources and/or those without employer-

paid retiree health benefits to supplement Medicare coverage. If system reforms reduce plans' ability or willingness to provide additional benefits relative to the traditional program, the popularity of Medicare managed care may wane, and opportunities to create more effective delivery systems for Medicare beneficiaries could evaporate (10). Put somewhat differently, the inadequacy of the current Medicare benefits package, in comparison to the insurance products offered in the commercial employer-based market and in terms of beneficiaries' needs, distorts market incentives.

RECOMMENDATION

Reconsidering the Medicare benefits design in the light of the health care needs of the current and future beneficiary populations is essential for successful Medicare reform. Legislatively prescribed Medicare benefits should maintain or improve upon current Medicare benefits.

Systems administering choice have adopted several approaches to stabilize their markets. Fixed open enrollment seasons and lock-in provisions limit switching from a lower-cost managed care plan to a higher-cost fee-for-service plan that does not control access to physician or specialty services. The Balanced Budget Act of 1997 (P.L. 105-33) institutes a gradual phase-in to a modified open enrollment and lock in period. Because Medicare beneficiaries include a significant proportion of chronically ill people and people who have little or no experience with managed care, and because managed care organizations are only beginning to enter into Medicare contracts in many areas of the United States, moving more quickly to limited enrollment

periods could be counterproductive. The gradual phase-in introduced in 1997, if coordinated with other changes in consumer protections and quality improvement, could help both plans and beneficiaries. Looking ahead, coordinating Medicare open enrollment periods with enrollment in Medicaid, Veterans and Department of Defense health care programs, and supplemental insurance could, with appropriate consumer education and outreach, also reduce duplication of supplemental coverage, and help in setting up coverage packages that promote continuity of care.

RECOMMENDATION

In the long-term, Medicare should adopt annual open enrollment and information periods that are coordinated with enrollment and lock-in for Medicaid, other federal health care programs (e.g., Medicaid and the Department of Veterans Affairs managed care), and Medigap policies. To protect beneficiaries and ensure appropriate opportunities for choice, there should also be periodic opportunities for beneficiaries to opt out of choices that are unsatisfactory for them. Provisions for retroactive disenrollment protections in current law, e.g., for beneficiaries who were enrolled through deceptive or fraudulent practices, should be maintained.

Structured choice systems also provide evidence that lack of standardization among benefits options could undermine beneficiaries' ability to make informed choices among health care plans. While innovation and flexibility in benefits design could provide important advantages in a market-based Medicare

choice system, wide variations in benefits make it difficult to compare plans on cost, comprehensiveness of services, and quality.

RECOMMENDATION

HCFA should use its demonstration authority to assess options for standardizing the ways in which benefits are described to facilitate comparisons among plans, and to explore options for developing and evaluating the marketing of a small set of basic plus supplemental standardized benefits sets through the Medicare+Choice program, analogous to the standardized supplementary benefits packages created under provisions of Omnibus Budget Reconciliation Act of 1990.

Chapter 4

Paying for Medicare Managed Care

Payments to health plans enrolling Medicare beneficiaries should provide incentives for plans to compete on price, quality of care, and consumer satisfaction. A variety of methods or approaches for adjusting payments to health plans or to providers have been proposed to help ensure that competition works to the benefit of elderly and disabled persons who incur higher health care costs, as well as for those who have more limited health care needs. This chapter divides these into four general areas:

- methods for direct adjustment of capitation rates to reflect risk (risk adjustment);
- combining risk adjustment with other financing and reinsurance mechanisms (risk sharing);
- the potential for developing special approaches to delivering services or paying for particular types of medical care (carve-outs); and
- capitation and partial capitation of providers within health care plans.

RISK ADJUSTMENT

When health care plans enroll members, they agree to provide them with the health care services they need in return for fixed premium payments and some configuration of cost-sharing, i.e., copayments and deductibles. Because health plans do not necessarily know in advance who will choose to enroll, they also do not necessarily know how much it will cost to provide care for new enrollees. Some risk is systematic while other risk is random. Systematic risk reflects variation in health spending associated with measured characteristics such as age, gender, or

chronic conditions, i.e., factors predictably related to use (see below). Random risk is unpredictable, and cannot by definition be estimated from known characteristics. The terms “risk selection” or “biased selection” refer to the active or passive recruitment into insurance pools or health care plans’ panels of enrollees with measurably different expected health costs, based on health status or demographic characteristics (84).

“Risk adjustment” is the term used to refer to methods for adjusting payments to compensate for spending that is expected to be lower or higher than average, due to biased selection in the health status or demographic characteristics of enrollees (149). Table 4-1 gives examples of risk adjustment models. Concretely, risk adjusted payments are designed to pay plans more if their enrollee population needs more costly health care, and less if their enrollees are healthier. Prospective risk adjustment methods (i.e., predicting health care expenses for a subsequent year to determine payments to plans) can only account for sources of systematic risk, while concurrent or retrospective methods (i.e., those that use data from a current or prior year to determine payments to plans for that year) reflect both random and systematic risk. For example, it is possible to predict that some enrollees will fall and break a hip in a particular year, and this estimate can be refined based on knowledge of the enrollee population demographics and health status. Adjusting for this risk prospectively will not account for a particularly icy winter that results in many fractures, but methods based on costs incurred for treating these cases can.

“Risk assessment” involves placing relative weights on factors hypothesized to influence expected health spending. Demographic characteristics such as those included in the Adjusted Average Per Capita Cost (AAPCC) formula that has been used in the Medicare program are associated with levels of health care spending, but, overall, they explain only a small proportion of the variation in spending for Medicare beneficiaries (32). Some of

the remaining variation in risk can be predicted from past experience. Information on individuals’ past spending for health services can be used to estimate the level at which a person’s spending is likely to vary from others in the same demographic group. There is some consensus that at least 20 to 25 percent of variance in spending should be predictable, if sufficient information on past utilization of health care is available (83).

Table 4-1. Risk Adjustment Models

Type of Risk			
Adjustment model	Example(s)	Explanation	Source of Data
Demographic (age, gender)	Actuarial models; AAPCC	Group individuals in actuarial cells based on their age and gender and calculate expected cost of each subgroup	Current Medicare files; plan administrative data
Survey-based	Self-reported health status/functional status; chronic conditions	Group individuals using regression	Survey to all or sample of beneficiaries about health status, chronic conditions, or other
Encounter/Diagnosis-based	Ambulatory Care Groups (ACGs), Diagnostic Cost Groups (DCGs), Hierarchical Coexisting Conditions (HCCs)	Group individuals by disease using ICD-9-CM codes and calculate average cost of each subgroup	Claims data or equivalent; discharge abstracts; medical records
Prior use	Prior use, prescription drugs	Compute relationship between prior use and current use	Claims data (fee-for-service)
“Risk sharing”	Reinsurance; partial capitation	Blend fee-for-service with capitation payment; reimburse plans above capitation rate for high-cost cases	Claims data (or equivalent measure for reinsurance)

Medicare Risk

Risk factors for the Medicare population reflect the particular distribution of health care problems among the elderly and people unable to work due to disability. Unlike the working population covered by employer-sponsored health insurance, the vast majority of Medicare beneficiaries remain covered and continue to receive benefits until they die. The utilization of Medicare-covered services indicates that there are distinct subpopulations of people with extensive health care needs in the 65 and older population of beneficiaries as well as among disabled beneficiaries, and that both the use and cost patterns of these subpopulations persist over time. These patterns reflect a variety of factors, including functional impairment, extended periods of illness prior to death, and repeated hospitalization associated with certain serious medical conditions (56). Medicare beneficiaries are more likely than younger people to have chronic diseases or acute exacerbations of chronic diseases (60). Serious acute conditions such as cardiovascular or respiratory disease which account for a large proportion of health care costs among the elderly each year are also likely to result in high costs over a protracted period of time. Health problems common among younger populations are more often acute and time limited in nature (e.g., injuries, infectious diseases in children), and very high cost conditions in young populations are more skewed than in the Medicare population.¹ Adjustments for risk in the Medicare population can build on these differences in the prevalence and types of conditions found in the beneficiary population. Prior hospitalizations, for example, better predict the elderly's health care costs

than the non-elderly's, due to the low hospitalization rate of the non-elderly. Conversely, risk adjusters tested on non-elderly populations may not work very well for the Medicare population (51).

Overall, the distribution of costs within the population is similar to the distribution in other groups, that is, a small proportion of beneficiaries accounts for a large proportion of health care costs (55). The Medicare population, however, comprised of persons over age 65 and persons with disabilities, is considerably more expensive to insure than the working population. The average per capita cost of Medicare is about \$5,500; FEHBP per capita costs for annuitants (including workers, dependents and retirees for whom FEHBP is a supplemental insurer) is about one third of that amount (65). About 23 percent of Medicare beneficiaries (termed "high cost beneficiaries" because their annual expenditures exceed the mean for all beneficiaries) accounted for over 78 percent of total Medicare expenditures in 1992 (75). About 18 percent of beneficiaries residing in the community are "high-cost." For the highest-cost groups (51 percent of the high-cost users), inpatient hospital costs for the year averaged \$34,478 in 1992. And while disabled and End Stage Renal Disease (ESRD) beneficiaries are more likely to be high-cost users, the fact that the great majority of beneficiaries are those age 65 years and older living in the community means that this group (rather than ESRD or disabled) makes up the largest share of high-cost users (74). Among Medicare community residents (i.e., excluding those in long-term care or other institutional facilities), the high-cost

¹ Serious conditions result in very high expenditures among children in particular (6), but these are concentrated among a very small subset of the population (63, 60).

Medicare beneficiaries are disproportionately those with chronic conditions and functional limitations, and persons in their last years of life (75). The implications for managed care are striking: close to one of five potential enrollees may have above average care needs in a given year, and once enrollees experience significant health care problems, there is a fairly good chance that those care needs will continue over time (56). If reimbursement for high users is not adequate, managed care organizations face a serious long-term problem.

Severity of Illness

Even within sub-populations, such as persons with particular medical conditions that predict above average medical risk, there is significant variation in actual costs of care, and in outcomes of care (56, 105). The concept of medical risk, which is used in the context of insurance to predict (or retrospectively to account for) utilization and costs of care, is sometimes also used to refer to the clinical concept of severity of illness. Severity measures are designed to account for the physiological factors that determine the types of medical care patients need, and how they are likely to respond to that care. The two concepts are interrelated, and both are important for Medicare. The information needed to determine severity of illness can predict use and costs of services because more severe illness is generally associated with increased use of services and higher costs of care. The data needed to assess severity of illness help to explain the variation in the use (and cost) of services within disease or condition groups (42). Severity measures are also critical for monitoring and measuring outcomes and quality of care.

For example, the value of studies that have compared the outcomes of care in different hospitals has been challenged because the studies may not adequately account for the differences in severity of illness among patient populations. A hospital that specializes in treating complicated cases might show a higher complication or failure rate than one caring only for simple, uncomplicated cases (54). Similarly, if patients with a particular condition such as diabetes are found to be disenrolling from a managed care organization in large numbers, it is essential to determine whether the patients who are leaving are more, or less, seriously ill than others who remain in the plan. Hypothetically, if patients with more severe health problems are disenrolling and then receiving above average amounts of care in fee-for-service settings, it could be an indication that the plan was failing to provide appropriate care. If diabetic patients with less severe health problems are disenrolling, but more seriously ill patients are staying, another dynamic may be involved. Some patients may not be comfortable with a health maintenance organization (HMO)'s care management approach, which might emphasize diet, exercise and education programs to encourage active patient self-management. They might prefer a fee-for-service provider who emphasizes pharmaceutical treatment and frequent office visits and laboratory tests. The Medicare program would want to know this, because it would mean that the increased visits after the enrollee returned to fee-for-service do not reflect underservice by the HMO. The HMO would want this information, because it would help it to target education (both to providers and to patients who develop diabetes) that might increase patients' acceptance of an effective approach to managing diabetes.

Risk Adjustment Methods for Medicare

A variety of methodologies for adjusting payments to plans to reflect risk have been developed with the support of HCFA and other public and private funders.² Risk adjustment has been used by some purchasing alliances, some Medicaid programs, and some employers. Some methods are prospective (i.e., estimate future costs based on enrollee characteristics), others retrospective; some are based on demographic data (e.g., age, gender) and are associated with a population's morbidity or demand patterns (49); others on health status measures (e.g., functional health status, used as proxies for health conditions); and still others on clinical information and severity of illness measurement systems extracted from claims files or medical records. Methods can also draw on combinations of variables. Table 4-1 provides a comparison of general approaches to risk adjustment modeling. Methods applied within plans to allocate resources for high-cost care are discussed later in this chapter.

Much of the research on risk adjustment for Medicare has focused on two general approaches, one utilizing information on patients' medical encounters in conjunction with other patient-level information derived from administrative or clinical data systems; the other on information that can be obtained from patient surveys. Encounter-based systems use a classification system to group people by diseases, conditions or diagnoses recorded in claims data, hospital discharge abstracts, or other records systems used in the management of patient care. The

classification systems are closely related to systems used to assess severity of illness (42). A set of weights is calculated to reflect the average costs associated with the presence of each condition or diagnosis. Demographic information, such as age and gender, and other variables, such as whether people are eligible for Medicare as the result of disability, or whether people are eligible for Medicaid (a proxy for socioeconomic status) can also be incorporated into these systems for predicting risk. Survey-based systems use information provided by beneficiaries, such as perceived health status, functional limitations, or use of health services, to estimate risk (32).

There is a growing body of evidence demonstrating that both encounter-based and survey-based risk adjusters can significantly improve Medicare's ability to calculate payments that reflect the actual costs of providing care to patients with greater care needs (71, 42, 32). Encounter-based systems, however, appear to be better able to predict costs, particularly costs for groups of patients either sicker or significantly healthier than average enrollees, than survey based methods (42). Preliminary findings from a study commissioned by HCFA comparing the explanatory power of alternative risk adjuster systems show that one method, the Hierarchical Coexisting Conditions (HCC) model developed by researchers at Boston University and the Center for Health Economics Research can predict about 40 percent of the predictable portion of variation in costs³ for Medicare enrollees. Other models based on

2 An overview of methods and listing of HCFA research projects supporting risk adjustment methods development are presented in Appendix A and B of this chapter.

3 HCFA estimates that, for prospective models, the maximum proportion of cost variation that can be predicted from any model (given that a large proportion of risk is random), is about 20 percent (32); a 40 percent reduction in explainable variation in risk is therefore equal to explaining about 8 percent of total variation.

Ambulatory Diagnostic Groups and Diagnostic Code Groups (both using encounter-based data), and a comprehensive survey based model evaluated by HCFA could explain about 30 percent (32) (see Appendix A).

Table 4-2 illustrates the potential for improving on the AAPCC, by comparing predicted costs, based on simulated payments using the variables included in the AAPCC formula to payments based on the HCC adjustment, to actual costs for beneficiaries likely to incur greater than average health care costs.

Using the HCC adjusters, payments to plans would very closely approximate the actual costs of care found in Medicare claims files for the groups of beneficiaries falling into the groups listed. Health plans would not lose money caring for these patients if they enrolled a representative set of patients within each group. The AAPCC rates, however, would fall short for each group of enrollees listed on the table.

HCFA is committed to implementing improved risk adjustment for Medicare capitation. The Medicare reforms passed in 1997 require the Secretary of the Department of

Health and Human Services (DHHS) to submit a report by March 1, 1999, on a risk adjustment method that accounts for health status for use in Medicare+Choice program payment, and implementation of a risk adjustment methodology (based on health status and other demographic factors) no later than January 1, 2000. The decision about the specific method to be used involves issues of data availability and ease of administration, as well as the expected improvement in the accuracy of the resulting payments.

Data from sample surveys of beneficiaries could provide direct measures of beneficiaries' health status, functional limitations, and actual experiences with health care plans. It could be used to adjust for risk, but in addition, it would be useful for quality improvement efforts, and would be valuable information for consumers to use in making selections among plans. Surveys are, however, expensive. HCFA has estimated that surveys would cost between \$25 and \$75 per person per year (135); the cost of obtaining information on every beneficiary's health or functional status appears prohibitive (and also could constitute a considerable burden to

Table 4-2. Predictive Ratios (predicted costs for group/actual costs for group)

Beneficiary Group	HCC Adjustment	AAPCC-like adjustment
One hospitalization	.99	.64
Diabetes without complications	1.02	.63
Diabetes with complications	.93	.45
Breast cancer	1.08	.68
Hip fracture	.99	.59

Source: Table 4, "Predictive Ratios for Alternative Risk Adjustment Models by Subgroup," in Ellis, R.P., Pope, GC et al., "Diagnosis-Based Risk Adjustment for Medicare Capitation Payments," *Health Care Financing Review*, 17(3): 101-128, spring 1996.

beneficiaries), so sampling would be required. This would increase the likelihood of problems such as non-response bias, and possible gaming by plans (to secure more positive responses). It is likely that non-response would be a more serious problem among the sickest and functionally impaired enrollees, so that the most vulnerable might not be adequately represented in the surveys. In addition, estimates of functional status from samples would limit risk adjustment to the plan level; data would not be available to estimate on individual risk. Individual-level risk estimators make it possible to implement systems that could adjust payments to plans when high-cost individuals moved from one plan to another (as might happen if a beneficiary relocated to another area following a serious illness); measurement based on samples are not designed to account for small but important fluctuations in the enrollee population's health care needs. Further, sampling error could lead to fairly significant fluctuations in plan payments from year to year.

For the survey of beneficiary experience and satisfaction with plans being implemented using the Consumer Assessment of Health Plans (CAHPS) instrument, HCFA has estimated that 600 beneficiaries per plan is adequate (see Chapter 5). Whether samples of 600 per plan would also provide sufficiently accurate information for risk adjustment depends on the specific method to be used.⁴ If the method seeks to identify gradations between fair and poor health status, or to measure small changes from year to year in

the enrollment or disenrollment of people in poor health, larger sample sizes or a system for stratifying the sample might be necessary. Because response rates on surveys are often low, obtaining sufficient numbers of responses for newer and small Medicare plan options, such as provider sponsored plans (which may have as few as 500 Medicare enrollees in rural areas), could be especially problematic.

Access to the information from plans needed for encounter-based risk adjustment would give HCFA the ability to compare utilization and intermediate outcomes (such as complications, readmissions, etc.) in managed care with fee-for-service Medicare. Encounter-based methods are more robust, and because they can be calculated for all beneficiaries, they may generate sufficiently stable payment rates from year to year. Validating and analyzing encounter data would, however, be a major responsibility for HCFA, and would entail significant expense for HCFA and for plans. HCFA would incur costs for data collection, management, analysis and reporting. More plans have begun to develop their ambulatory encounter data in recent years, but to use an encounter-based risk adjustment system in Medicare, plans' systems would need to conform to national data definitions and standards. The availability and quality of ambulatory diagnoses data in health plans depends on the type of HMO and how its practitioners are compensated. Until the mid-1990s, independent practice associations (IPAs), the most common form of HMO in Medicare (141), generally main-

4 The Washington State Health Care Authority is requiring the nineteen plans that participate in its public employees' health benefits program to administer the CAHPS survey, which includes some health status items, in addition to requirements for comprehensive diagnostic and encounter data to be used by the State in developing risk adjusters (see text box). The State has estimated that the cost of the CAHPS survey project to be billed back to the plans in 1998 (proportional to their enrollment) at \$250,000 (157).

tained detailed records on ambulatory encounters required for encounter-based risk modeling, but in some staff model HMOs and (to a lesser extent) group model HMOs, cost or diagnosis information was not collected at the visit level because claims are not produced (41). This appears, however, to be changing, as more HMOs have instituted encounter-level data systems. Data capabilities and recording techniques also differ greatly across plans, and practitioners and offices use varying guidelines in recording the ambulatory care data (107, 82, 12, 30).

Over the long term, health care data are expected to become easier to incorporate into the types of systems needed for risk adjustment. The Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) mandates the development of uniform standards for definitions of data elements and technical standards for transmitting data on a range of health care transactions, including claims and encounters. The Act does not require that plans report these data, but it does stipulate that health plans and providers use the standardized data format if they are requested to provide these data. While plans do not have to use the standardized formats internally, they will need to put systems in place that can provide the data if necessary. The legislation applies to Medicare, Medicaid, the Veterans Affairs Health System, the Civilian Health and Medical Program for the Uniform Services and the Federal Employee Health Benefits Program, and to all private health care plans. If the schedule set out in the law is met, most health plans should be able to provide data in the standardized format in the year 2000 (149).

HCFA has estimated that it could cost an average-sized plan operating in a single market area \$750,000 to set up a system for reporting encounter data, and about \$30,000 per year per plan to generate the needed data (135). Other estimates are much higher, in part because they include additional administrative costs associated with changing a host of internal data and reporting systems as a result of moving to an encounter data system. One expert who has been involved in the implementation of purchasing alliances in California estimated that the capital investments needed to collect and report risk adjustment data for diagnosis-based methods could cost \$5-10 million for average sized plans (14). The total costs for a very large national managed care system could be several orders of magnitude higher still. In addition to meeting Medicare requirements, data systems need to provide information for other payers, and for other related purposes, such as internal management, quality assurance, outcomes measurement, etc. For plans that already have data systems that could supply the data HCFA would need for risk adjustment, the costs would clearly be lower. In a report prepared for the Physician Payment Review Commission, analysts at HealthSystem Minnesota, which manages data used in risk adjustment by the Buyers Health Care Action Group (see Chapter 3) estimated that the cost of a claims-based system would be \$.20 per member per month; for a plan with 10,000 beneficiaries enrolled, this would be \$24,000 per year. (41). Because data would need to be audited, plans would also incur additional administrative costs; one expert estimates the full range of administrative costs at about 3 percent of total premiums (108).

HCFA has considered various approaches to implementing a risk adjustment system for Medicare capitation payment. A list of 1997 research projects on risk adjustment funded by HCFA is included as Appendix B of this chapter. Given a need to move quickly, HCFA will need to adopt interim methods that could be used while a more complete transition to a system based on encounter data is put in place. The most feasible approach appears to be one based entirely on inpatient data systems, which are already available, to compute diagnosis-based adjusters for patients who have been hospitalized (as is done by the Health Insurance Plan of California —(see box 4-1)). Regulations require that HMOs submit “no-pay” bills. Compliance with these regulations has been uneven: some HMOs currently submit 100 percent of hospital bills, but nationally many still do not (149). But if these data are needed for risk adjustment, plans seeking additional payment for high-cost cases have an incentive to submit these data, and HCFA has stronger incentives to enforce the no-pay bill regulations.⁵ Hospitals already process this information for the fee-for-service sector; the technology and expertise is clearly available to generate these data.

Other interim approaches have some serious drawbacks. For example, one option would be to keep the current geographic (county) payment system based on fee-for-service payment, but supplement the AAPCC demographic adjusters with a risk adjustment system based on health status measures. An

interim approach could use area by area comparisons of health status (from surveys) to adjust for significant variations in risk between different types of Medicare choice plans.⁶

There is not a great deal of experience with risk adjustment in non-Medicare markets. Although insurance carriers have a great deal of experience with and data for underwriting, there are relatively few systems in which plan payments are adjusted post-enrollment to reflect cost disparities across plans due to variation in patients’ health care needs. Some systems that administer health plans choice are, however, using risk adjustment assessment methods, either to provide information to use in negotiation with plans, or to actually adjust payments to plans. Among the most sophisticated of these are the California Health Insurance Purchasing Group (see box 4-1 and Chapter 3); Washington State (see box 4-2), which is testing a statewide risk adjustment system for its state employees health care program under a multi-year grant from The Robert Wood Johnson Foundation; and the Buyers Health Care Action Group (see box 4-3).

RISK SHARING

No risk adjustment technique by itself could ever be expected to predict expected costs for the whole range of Medicare beneficiaries. “Unmanaged” fee-for-service places almost all of the risk on the government, because the government reimburses the provider for covered services.⁷ Under the current

5 All plans would have an incentive to submit the data if a fixed proportion of all payments were set aside into a risk adjustment pool, which was then allocated to providers based on their submitted data (see below).

6 PPRC had proposed reducing payments for new enrollees to reflect the fact that their use of services is significantly lower than other beneficiaries (149).

7 The diagnosis-related group (DRG) prospective payment methodology requires hospitals to assume risk within DRG groups, since the DRG pays hospitals for the average cost of each case (unless the case qualifies as a high-cost outlier).

Box 4-1 Health Insurance Plan of California

RISK ADJUSTING IN HIPC

HIPC is the only small employer purchasing cooperative to risk assess, and one of the largest efforts to risk adjust overall. Health plans price based on seven age tiers, four family size tiers, and six geographic regions. HIPC measures the level of risk in a plan based on age-stratified gender, the number of children per contract, and a marker diagnosis (from a list of high-cost ICD-9 codes). The marker diagnosis used does not require the level of detail that may be required of other methods such as the DCG approach. Premium rates charged to HIPC participants vary based on age, geographic region, and family size. Premiums may not differ based on sex or health status. Each plan receives a score for their gender/age mix compared to the HIPC average, which always receives a score of 1.0. The plan also receives a child per contract score compared to the HIPC average, and a marker-diagnosis score compared to the HIPC as a whole. The three scores multiplied together gives the aggregate risk assessment value (RAV) for each health plan. HIPC decided to use plus or minus five percent as the threshold. Thus only plans with an overall risk assessment value above 1.05 or below .95 would receive money or have to pay into the pool, respectively. No risk adjustment is necessary for health plans within the threshold.

One of the risk assessment factors the HIPC uses is whether a condition required an overnight stay, as indicated on inpatient hospital records. As with DCGs, an expensive condition will likely require hospitalization throughout the year. Plans very good at coding or with few members may receive a high risk assessment score, not necessarily signifying a much worse than average risk mix. Conversely, plans who have little knowledge of their beneficiaries' diagnoses will receive a lower risk assessment score. Plans with fewer than 1,000 enrollees receive their weighted blend within the HIPC weight based on the number of enrollees. Plans with fewer than 300 receive the average HIPC score, regardless of the plan-specific risk.

HIPC updates the list of marker diagnoses annually. Marker diagnoses were considered to be the most important indicator of likely differences in risk. A list of 120 marker diagnoses is used in calculating the risk adjustment value. Diagnoses considered for the analysis were those that have higher than average costs, are reasonably predictable, and are subject to a limited degree of coding discretion. The marker diagnoses scores are adjusted for the age of persons enrolled in each health plan. Marker diagnoses on the final list are those ICD-9-CM groupings of codes associated with an inpatient stay and have average annual health care charges of \$15,000 or more.

Risk adjusting transfer amounts must take into account the factors for which health plans are able to price in their monthly HIPC premiums so that risk differences already incorporated into premium rates are not incorrectly included in the risk adjustment transfer amounts. To remove these effects, a factor that measures each health plan's age, geographic region, and family-size mix against the HIPC average is calculated and called the rated risk factor. A theoretical average monthly premium is used as a reference point in calculating the risk adjustment transfer amounts. The first step in risk adjusting is to calculate the amount of funds needed to move the high and low end outlier health plans to the risk threshold. This total amount is considered the risk transfer pool. If the risk transfer pool is insufficient to move the high end outliers into the risk threshold, additional funds are collected from the lowest risk plans until the risk transfer pool is fully funded.

Source: Shewry, S. et al., "Risk Adjustment: The Missing Piece of Market Competition," *Health Affairs*, 15 (1) 1996.

Box 4-2 Washington State Health Care Authority

RISK ADJUSTMENT IN THE PUBLIC EMPLOYEES BENEFIT PROGRAM

The Washington State Health Care Authority (HCA) administers three programs providing health care benefits. The public employees benefit program serves state employees, school districts employees and retirees of political subdivisions. In 1996, total enrollment in the public employees plan was 291,410. The HCA purchased benefits from nineteen managed care plans using a managed competition model. The HCA also acts as an administrator of the plan through the operation of a state-owned P.O. fee-for-service plan that is available to all members. There are two Medicare supplement plans offered to state retirees and all Medicare-eligible state residents. Four of the 19 plans offer Medicare risk contracts. Researchers from the University of Washington School of Public Health and Community Medicine are working, with support from The Robert Wood Johnson Foundation, with the HCA to design, implement and evaluate risk adjustment models for the public employees plan.

The project has worked with an enhanced demographic model and two health/diagnostic models, one using ambulatory care groups (ACGs), the other diagnostic cost groups (DCGs) (see appendix A). After analyzing the strengths of the models, the HCA selected the DCG model, and will begin phasing in assessments of health-based risk in participating plans in 1998. The assessment will apply only to non-Medicare enrollees. The model first calculates the probability, based on demographic, diagnosis and encounter data, that each person enrolled in a plan will incur some medical cost. It then computes the expected monthly cost given that some cost is incurred. The prediction is used to index costs to a standard, that is to establish a relative cost prediction. The first phase in implementing the risk adjustment system included collecting data from plans to assess the feasibility of data collection and the accuracy of the data collected, then simulating the results of generating adjustment factors based on the data. There were some initial problems obtaining accurate data from some plans, but revised simulations that used 1995 plan data were completed and the results were shared with the plans in 1997. The simulations showed that DCG-based adjusters predicted more accurate (and significantly higher magnitudes of adjustment than the demographic adjusters.

Initially, HCA's implementation of the adjusters is limited to plus or minus 2 percent of the demographic formula amount. This was done because of initial data problems, Eight plans received a full 2 percent phase-in adjustment based on the 1997 simulation, and four received a -2 percent adjustment. Five received smaller adjustments. The HCA plans to increase the level of adjustment, with full adjustment using the DCG-based method by the year 2000. The HCA system requires budget neutrality, so that as risk adjustment results in an increase in premiums for plans, the base rate for all plans has to be reduced to compensate. The 1997 simulations required the base rate to be reduced by .48 percent. The HCA contract request for proposal cautions plans that the simulations have shown that the quality of the health data submitted by one plan can affect all the plans' adjustment factors, and that failure to provide accurate and up-to-date data could result in a plan's risk factor slipping in relation to others.

Source: Washington State Health Care Authority, 1998 Request for Proposals for Health Care Services for the Public Employees Benefit Board Plans (PEBB), Basic Health Plan (BHP), Healthy Options (HO).

Box 4-3 Buyers Health Care Action Group

RISK ADJUSTING IN BHCAG

The Buyers Health Care Action Group (BHCAG), an employer coalition in Minnesota, uses a risk adjusted payment system. Their method follows a payment approach that uses expenditure targets to pay health care systems. In the BHCAG system the health plan contractors bid per member targets. The basis for adjustment of the prospective fee-for-service payment schedules for each contractor is the amount of disagreement between the targets and the actual expenditures. Each quarter the fee-for-service payments to the health plan are checked against the target. The fee-for-service payments to the plan are adjusted for the next quarter by the amount that payments were either above or below the targets. Therefore, the price adjustment is based on retrospective performance but is applied prospectively. The design specifies that the quarterly price adjustment is continuous and unlimited. The per member targets are set quarterly to allow the smaller care systems to more easily learn to manage under fixed reimbursement.

The targets and fee-for-service payments are risk adjusted through the Ambulatory Care Group (ACGs) case mix measure. Variations in patient mix at the provider level appear to be significant: Robinson and Powers (103) reported a 35 percent variation in health risk using ACGs among the 15 care systems participating in BHCAG in 1997.

The BHCAG does not capitate payments to the health care systems or engage in risk sharing with the health care systems because these activities would mandate insurance regulation of providers under Minnesota law. This rationale led to the development of the BHCAG system where performance from one quarter affects future payment levels. This approach is not actually risk sharing since profits and losses are not shared.

Source: American Hospital Association, State Issues Forum, "Risk Sharing Methods," prepared by AHA Office of Policy Development, Office of General Counsel, October 1996; Wetzell, S., "Consumer Clout," *Minnesota Medicine*, 79:15-19, February, 1996.

Medicare system for paying under capitation, HMOs bear all of the risk while the government (i.e., Medicare) faces no risk for the costs of care that is delivered.⁸ Partial capitation, reinsurance, and other high-cost condition pools compensate contracting entities for some of the costs of providing needed services directly, or by allowing providers to "share" risk with the insurer; i.e., in the case of Medicare, the government. Sharing risk should mitigate provider incentives to stint on services or avoid enrolling individuals with costly health care needs. HCFA is evalu-

ating options for risk sharing in a series of demonstrations and simulations.

Partial Capitation

Risk adjusters predict costs using information on past utilization and costs for groups of people in different categories, such as those with specific medical conditions, people with certain types of functional limitations, or people who have been hospitalized, etc. The predicted costs are generally set at the average cost for all people in each group. There are, however, considerable variations among patients within diagnostic groups (32), in

⁸ Medicare does, however, bear the costs of capitation payments for beneficiaries who receive no services.

how medical care is provided for particular diagnoses (164), and in patients' preferences regarding treatment (73). Because the "right" treatment method for each enrollee in each risk group cannot be determined from the data on utilization for the risk group for which they are assigned, the weights used to risk adjust payment can never be precisely correct for each enrollee. Full capitation will therefore always provide some financial incentive to stint on care regardless of how risk is measured.

A partial capitation system involves paying for some services, or some portion of services, by capitation, but also making some portion of payment based on actual utilization. In Medicare, "costs" to the program are determined through complex payment systems utilizing prospective payment methods and fee schedules. Throughout this discussion, reimbursement to providers for services used (costs to Medicare) would be based on what Medicare would have paid for the service under its normal payment mechanisms. That is, if a provider were paid partially on capitation and partially on services provided, the payment for "use" would be the Medicare payment for that service, rather than a payment based on the "true" economic cost of providing the service.

The Balanced Budget Act of 1997 (P.L. 105-33) strictly limits risk-sharing in Medicare+Choice options. In theory, the major advantages of full capitation are that it reduces the program's financial liability, and at the same time provide powerful incentives to health care plans to manage care efficiently and effectively. Dividing payment into two

separate components may introduce some practical planning and management problems. Partial capitation systems increase plans' uncertainty about revenues, because types and rates of service utilization fluctuate. This might mean that some plans have to set aside reserves to stabilize their finances. At the same time, however, a partial capitation system which provides for additional payment for service use increases plans' ability to predict profit, because payment will increase with use. Like other types of fee-for-service payment, the use-based portion may be subject to various adjustments (e.g., utilization reviews), and may be delayed while the information is processed. In effect, the use-based payment in a partial capitation system might be viewed by plans as a form of after-the-fact settlement of claims.⁹ In fee-for-service-based systems, partial capitation would also create incentives to increase the amount of care provided beyond the efficient level if fees were greater than marginal costs of providing care. Questions remain, moreover, about whether methods can be devised that can distinguish high Medicare costs resulting from the patient's condition from high costs resulting from low quality care (104). Nevertheless, the inherent risk of biased selection in managed care has led some experts (32, 83, 96, 145) to argue that pure capitation is not optimal for the Medicare population.

The additional data needs for a partial capitation system may be substantial, although some partial capitation models would require more data than others. Claims and/or encounter data would be required for all services or at least some categories of services.

9 For some plans, a significant reduction in capitation payments (under a partial capitation arrangement), together with delays in receiving use-based payments, might create financial problems. A plan reserve fund could be used to stabilize its finances, but not all plans could afford to hold sufficient funds in reserve.

While HCFA and many Medicare providers have substantial experience collecting fee-for-service data, a partial capitation system would increase the burden and complexity of managed care administration and data reporting. Any partial capitation arrangement would require plans to track and report actual service use of individuals in order to be paid. HCFA would also need to audit plan reports (62). As with any claims-based payment method, “upcoding” (taking the greatest possible advantage of coding rules to maximize payments) and other threats to data accuracy and completeness would have to be monitored. Partial capitation could, however, be designed to work in conjunction with risk adjustment to minimize additional data processing. Combining partial capitation with a diagnostic (encounter or claims) based data system would be easier than with survey-based models since both diagnostic-based risk adjustment and partial capitation rely on similar data.

Some states use partial capitation programs for Medicaid enrollees and for behavioral health care services (mental health and substance abuse programs). Often, the system is structured so as to give provider, i.e., primary care physician (PCP) groups incentives to control costs of specialists’ services and hospitalization. The PCP receives about half of the savings relative to some target (163). Proposed approaches to partial capitation are based on a blended rate, which would base part of the payment to plans on capitation and the rest on a fee-for-service basis depending on current use (85, 83). A blended rate could serve as a more useful tool than risk adjustment used alone, because it takes into account the HMO’s actual use, thereby reducing risks to plans. An example of a partial capitation approach is for HCFA to pay a

capitation amount of 60 percent of the AAPCC (or of the low bid, for example, in a competitive pricing scenario) and then reimburse the HMO for 40 percent of what traditional Medicare would have paid for the services rendered during the year on a fee-for-service basis. If a beneficiary does not use any services, then Medicare only pays the HMO the capitation amount (for example, 60 percent of the AAPCC). For beneficiaries who also use services, the HMO would receive 40 percent of the Medicare fee schedule. Thus, “the HMO would profit less from enrolling healthy individuals, but would be penalized less from enrolling sicker individuals” (166).

One advantage of blended rates is that this approach to partial capitation is relatively straightforward, and flexible, in that the blend can be phased in gradually over time and adjusted easily. A blended rate could include a feature that allows the proportion that varies with use to increase at some level(s) of use so that plans have less incentive to try to systematically avoid very high-cost beneficiaries. Partial capitation could increase plan participation in rural areas and among other smaller plans due to the lower level of financial liability. Risk adjustment could be applied to the capitated part of the payment. The decision on which proportions to assign (e.g., 60 percent capitation, 40 percent use) involves certain trade-offs. A blended rate in which payment is based on 90 percent of the capitation amount and 10 percent on use would seem to have little effect on plans’ incentives to seek out only the healthiest beneficiaries while trying to avoid the sicker ones. Conversely, the greater the weight on actual use (e.g., 10 percent capitation, 90 percent use), the greater the incentives for plans to deliver services that may or

may not be of benefit (thereby increasing costs beyond the efficient level). One primary disadvantage is that Medicare could end up subsidizing inefficient health plans (116). However, improved care to high cost beneficiaries and reduced incentive to risk select may offset this potential efficiency loss (85).

Other and Combined Approaches to Risk Sharing

Risk corridors and individual outlier approaches, including reinsurance also provide alternatives to full capitation. These methods are particularly important for smaller health care organizations, where a relatively small number of catastrophic cases can threaten the viability of the entire plan. A risk corridor approach would alter payments to HMOs depending on whether costs or use for all services or a subset lie outside a predetermined corridor. Both the range of the risk corridor and the proportion of risk sharing can be adjusted in this approach. For example, the corridor can be set at 20 percent above and below the average per person per month premium, and HCFA could decide to share 50 percent of the Medicare costs (as they would be calculated under Medicare fee-for-service methodologies) above the corridor with the plan, and require the plan to return 50 percent of difference between premiums and incurred costs when costs were more than 20 percent below the average cost. Cost-sharing proportions could also be adjusted for level of risk, with higher rates of cost sharing at higher corridor boundaries (i.e., HCFA shares 25 percent of risk above a 25 percent corridor, but only 10 percent of risk when costs exceed premiums by 10 to 25 percent) (118). Reinsurance for catastrophic cases and a corridor system for sharing plan losses for moderately expensive cases has also been proposed. Trapnell, for example, pro-

poses setting the plan share of losses at 100 percent for small deviations from the set per-person per-month base rate, 50 percent for modest variations, and 100 percent government assumption of costs for catastrophic cases. Finally, risk corridors can be capped or uncapped, that is, there may be upper limits on the amount of catastrophic cost that the insurer will reimburse, e.g., \$100,000. If there is a cap, plans incur full responsibility for all costs under the cap. Risk corridor approaches are conceptually simple, and, like partial capitation, provide predictability with respect to profits for plans. This is particularly true for start-up plans, or plans planning to expand to new areas (118).

Some proposals would provide for a risk corridor approach applied only to inpatient hospital costs. They are the largest component of high cost cases and are the best documented. Wallack et al. provide another example of this type of partial capitation (117). Medicare could capitate provider services and establish a risk pool in which losses or profits from hospital service use beyond a certain threshold are shared 75/25 with the plan. Such a system would require only measuring hospital use and costs accurately. As stated earlier, plans typically keep better inpatient data. Medicare Choices is testing prospective risk adjustment with a risk corridor (see Chapter 2 and Appendix A) (119). The prospective payment system (PPS) for reimbursing hospitals serves as experience in Medicare for making outlier payments on the basis of costs (as is done with private stop-loss reinsurance). In the PPS, between 5 and 6 percent of total hospital payments are made for high cost (and/or long length of stay) outliers (11).

The outlier approach applied to Medicare HMOs would reimburse plans for a portion

(e.g., 75 percent) of beneficiaries' costs above a certain threshold (say, \$20,000), or after a medical event occurs such as a stroke. The threshold can exceed upwards of \$100,000, depending on the size and financial condition of the plan. Such a policy limits the burden of a plan if it has high-cost events occur during the year for its beneficiaries. The lower the portion a plan is reimbursed, and the higher the threshold, the greater the incentives to reduce costs associated with capitation (including stinting on care) and the greater the liability of plans. A very low threshold (e.g., \$20,000) and a high portion reimbursed above the threshold (e.g., 90 percent), would potentially lessen incentives for plans to reduce costs. Such a threshold, though, should minimize plans' incentives to try to avoid high-cost beneficiaries.

HCFA is currently testing reinsurance in a demonstration of outlier payments with three plans in Seattle, Washington. Plans will be paid 97 percent of the AAPCC with 2 percent going into an outlier pool. Plans with an above average number of high cost cases will receive more from the pool than they put in, while those with few high cost cases will receive less. Plans must cover a set proportion of the Medicare costs (e.g., 30 percent) and establish a method to administer the outlier payments. Participating plans must submit encounter data on all their Medicare risk enrollees (135). There were significant problems in obtaining encounter data from one of the participating plans (119).

Reinsurance

Risk adjustment could be combined with reinsurance (with Medicare as the reinsurer). Reinsurance is primarily useful for a smaller

plan, which may face financial difficulties from having an unexpected handful of high-cost beneficiaries. Reinsurance for Medicare need not, however, be administered as a public program (18). Reinsurance in Medicare would allow the plan and federal government to share the costs of care for a particular case, type of care, or whole group through reaching a predetermined threshold (e.g., over \$25,000 in Medicare reimbursement costs) or through having a particular diagnosis. HCFA would use Medicare fee-for-service data to identify the proportion of spending that falls under the catastrophic spending and reduce the capitation payment by that proportion. Plans would submit use or cost data to HCFA, which would reimburse plans for their catastrophic or high-cost spending for serious chronic conditions.¹⁰ Applying to the pool for reimbursement could in fact be voluntary, so that only that plans that chose to submit appropriate data would qualify for reimbursement (61, 62). Reinsurance could also be financed through withholding funds from premiums at the beginning of a payment period. Proposals for Medicare include creating reinsurance pools for high cost cases; and putting plans at risk for Medicare Part B services but using reinsurance for Part A (167). Because this could create incentives for hospitalizations for conditions that could be treated on an outpatient basis, different approaches to addressing risk in inpatient setting versus office-based care would need to be evaluated carefully.

One proposal for Medicare would establish a government-sponsored, universal reinsurance program through a high risk pool funded by an additional 2 percent of the current AAPCC rates, thus raising HMO payments

¹⁰ HCFA probably would determine plan spending per catastrophic case through using existing payment rates (using the Resource-Based Relative Value Scale (RBRVS) and DRGs).

to 97 percent of the AAPCC (11). The money left would then be distributed at the end of a time period. The pool would pay 45 percent of costs above a \$50,000 threshold for each enrollee with costs above that level, with the remaining 55 percent of costs above \$50,000 paid by the HMO (in order to continue incentives to manage care). If the pool covered only 45 percent of costs exceeding the threshold, HMOs likely would still want to purchase additional, private stop-loss reinsurance for the remaining high costs of Medicare beneficiaries. Some HMOs would probably prefer to purchase private reinsurance, rather than government-sponsored, with the extra 2 percent payment (11).

Stop-loss Reinsurance

Individual stop loss reinsurance is designed to protect providers from catastrophic case costs. It could be set such that Medicare would pay all or part of expenses above a predetermined threshold (e.g., \$5,000 to \$100,000). Plans' reinsurance payment would be some amount per beneficiary per year or month. Individual stop loss reinsurance requires the reinsurance pool to pay all or part of expenses above a predetermined threshold (\$5,000 to \$100,000+) for an enrollee in a plan. Small group reinsurance pools usually have lower thresholds (\$5,000 or so) while large plans frequently purchase private reinsurance for spending above \$100,000 or even higher (113). Some of the states' reinsurance pools require that the plan pays 10 to 30 percent of the cost of caring for the enrollee once the threshold was met, often up to some maximum amount.

Individual stop-loss reinsurance has been common in the private sector, most often for costs exceeding a range from \$25,000 to \$75,000 (16). Additionally, states have

implemented public reinsurance as a means of financial protection for plans that, under state health reform initiatives, must accept high risk enrollees in the small group indemnity market (115).

Voluntary Reinsurance: Experiences in Several States

Some states have offered voluntary reinsurance, but they have found it difficult to compete with the private market. The state of Oregon previously sold reinsurance to Medicaid HMOs, primarily as a risk buffer to start-up plans, but now allows plans to purchase reinsurance through the commercial market. The plans who accept can obtain the reinsurance at a lower rate than Oregon could offer (99).

California's MediCal program (Medicaid) offers plans the option of participating in a risk pool. The goal of their stop-loss reinsurance program was to protect plans that enroll beneficiaries that have high expenses. The program acts "cost neutrally" in that the State expects to pay out in claims as much as it collects in premiums. Even with the cost neutrality, the state reports that much paper work is involved in reviewing the claims (especially with a lower threshold), thus increasing the administrative burden. Like Oregon's, California's experience also indicates that most plans have not chosen the state-sponsored program but instead have gone outside the system. The risk pool needs to be large enough to work, thus raising the question of partial versus mandatory enrollment (104).

Reinsurance has been common in the small group markets in many states. In 1996, 26 small employer health reinsurance programs (pools) existed in 25 states (67). United

Healthcare administrators in 23 programs in 22 states. Participation by carriers (plans) is voluntary. Thus, plans can elect to bear the risk themselves rather than reinsure. The reason for reinsurance programs in the states derives from the guaranteed issue requirement in small employer markets. States wanted to ensure that carriers had the ability to pass on a portion of their risk to the rest of the market. Plans can select the risks and notify the pool of the risks to cede, then pay the monthly premium. The pools accept all eligible risks.

Reinsurance can be both prospective or retrospective. Under prospective reinsurance, plans would identify individuals or groups they believe to be high risk and pay a reinsurance premium to the reinsurer (which could be Medicare). The reinsurance mechanism (the pool of contributions from each insurer) would then cover all or part of the claims associated with the reinsured beneficiaries. On the other hand, retrospective reinsurance would cover individual claims exceeding a predetermined dollar amount (e.g., \$20,000) without having plans prospectively identify which high risk individuals to cover. In both cases (prospective and retrospective), the reinsurance mechanism would incur financial losses that would be spread among all health plans that participated in the system (57). Prospectively identifying high risk enrollees and paying for their care out of a pool has been proposed by researchers in the Netherlands (153, 152). Such reinsurance would spread the costs associated with very high-cost beneficiaries among all plans.

Similar to partial capitation, reinsurance would require HCFA to gather new data because plans currently do not have to report complete encounter data for beneficiaries.

Plans would have to follow and report actual service use of individuals in order to be paid. HCFA would need to establish uniform data requirements across plans. Additionally, the federal government would have to audit plan data to validate coding and to determine appropriate thresholds as well as to assess whether plans had reached the thresholds for a beneficiary or group of beneficiaries.

Some agreement about valuing the cost of care would be necessary to implement reinsurance or any retrospective adjustment based on spending (167). Some plans capitate their providers and may have difficulty reporting such claims data. Reinsurance of Part A requires only claims for hospital services, skilled nursing facilities (SNFs) and the Part A portion of home health. Data for hospital stays are more readily available (11). The experience of Medicaid managed care programs and managed competition systems such as those described here suggest, however, that over time data for reinsurance for Part B could be generated.

Costs (used to compute the threshold and to determine whether the threshold had been reached) based on fee-for-service reimbursement rates may be larger than the prices that risk plans pay providers for comparable services. Evaluations have shown that Medicare managed care organizations have lower rates of hospital admissions than fee-for-service plans, and while enrollees in Medicare HMOs, on average, have about the same level of physician visits as fee-for-service beneficiaries, more HMO enrollees have visits, but fewer have frequent visits (74).

Additionally, Medicare would have to determine whether the plan's costs for outpatient drugs (and other non-Medicare benefits) should count toward the threshold, and, if

so, whether the federal government would share in those benefits' costs once the threshold was exceeded (116).

Reinsurance (and outlier) approaches share several weaknesses compared to cost-sharing approaches that blend capitation and cost-based reimbursement. Reinsurance does not affect plan incentives to expand resources to attract low-risk enrollees, while blended rates reduce payments for enrollees with low service. Outlier policies still leave plans with significant costs for higher-cost cases before they reach the thresholds for additional payment. And while reinsurance may help mitigate incentives to risk select, it may also reduce incentives to manage high-cost cases efficiently (83, 118). Plans may oppose a reinsurance proposal for Medicare (especially if it is mandatory for participation in the risk program) if they view the system as subsidizing less efficient plans. Reinsurance costs would cut into profits for plans that have low-risk enrollees. Cost sharing, as described above, may increase incentives for cost management, but may be set so high that incentives for risk selection (and solvency concerns) persist (57). The more plans are financially liable, the more they will manage costs but the more incentive they will have to risk select (and vice versa).

Other Fixed Payments for High-Cost Conditions

High-cost condition pools can supplement a risk adjustment system. Outlier pools can be devised to deal with conditions or treatments with high costs per beneficiary that are unpredictable even in large groups (50). Plans have little influence on whether such conditions occur. The incentives in high-cost condition pools differ from traditional stop-loss reinsurance, which retrospectively reim-

burses plans at fee-for-service rates for any expenses above a certain stop-loss amount. A retrospective payment system such as reinsurance could provide little incentive to manage care in a cost minimizing way above the stop-loss amount (although, as stated earlier, this loss of efficiency could be offset by improvements in quality for chronically ill). Reimbursement in high-cost condition pools, on the other hand, is not retrospective or done on an expenditure-only basis, but made prospectively on a capitated basis, for cases with defined clinical features. This type of protection is particularly valuable for small plans, because it provides more complete protection and eliminates fears about enrolling people with conditions that would otherwise be very costly. The defined clinical features could include diagnoses, treatments, or combinations. Care for the high-cost conditions would be financed outside of the capitated system, so treatment needs to be non-discretionary (50).

High-cost condition pools would make payments to plans as enrollees qualify for the pool. Plans receive a capitated rate specified by the pool's administrator for each beneficiary with a certain condition. Beneficiaries qualifying for the pool because they receive certain treatments for a condition are financed by flat, predetermined payments, also specified by the pool's administrator. Although the payment rate is prospectively determined, plans can identify high-cost cases when they occur and be paid retrospectively. Rather than used alone, high-cost condition pools would function by compensating for risk selection not mitigated through risk adjustment. Small plans, as well as large plans, become vulnerable to risk selection by enrolling persons with high-cost conditions.

Perhaps the primary policy issue in designing high-cost condition pools is determining the expense level and the medical criteria to base the pool on, in order to decide which expenses are covered by capitation and which are covered by the pool (50). Setting a small pool with only a few conditions included makes running a high-cost pool more manageable to run and has less impact. Key considerations in choosing medical conditions and treatments to be financed through the pool include minimizing plans' financial vulnerability to high-cost catastrophic cases, discouraging gaming, and managing care at the efficient level. As examples, the approaches to pooling risk in New York and Kentucky are similar, as are the problems. In both states, a demographic risk adjustment pool is combined with a specified medical condition pool consisting of transplants, AIDS, neonates, and ventilator-dependent conditions. Because of its limited scope, the approach could not succeed in determining differences in risk among participants. The pools were set up by identifying a specific payment amount for each person that a plan identifies as having the given condition. Every plan has an assessment made up front in terms of some percentage of their premium dollars. In New York, payments to health plans are to be made as claims come in. In Kentucky, a calculation is made once per year to determine distributions from the pool. All plans pay into the system. High risk plans then receive their own money back as well as a portion of funds distributed by low risk plans (64).

In New York, a group of health plans challenged the state's demographic pool in court, claiming that the regulations put in place to set up the pool were preempted by the Employment Retirement Income and Security Act (ERISA, P.L. 93-406). An initial

judgement enjoining enforcement of the regulations setting up the pool was later overturned by the United States Court of Appeals, leaving the pool in place (86). In response to resistance by plans, however, the state is exploring ways to restructure the diagnosis pool and try to develop a more comprehensive risk adjustment methodology in response to complaints by plans that the diagnosis pool does not effectively risk adjust. HMOs have complained that they have no other reason to collect and report the required data, and that complying entails a large amount of time, effort, and administrative costs. Kentucky also has experienced problems obtaining necessary data from plans (64).

Medicare has itself experimented with payment systems for one very high-cost condition — end stage renal disease. The payments to providers in HCFA's ESRD demonstration project consist of risk-adjusted monthly capitation payments for individuals on kidney dialysis or with functioning kidney grafts, lump-sum "event" payments to cover the expected incremental costs of kidney transplantations or graft failures, plus outlier payments for unusually expensive payments. Evaluations found that the methodology explains about 25 percent of the variation in annual payments per patient, and that the risk adjustment system is able to capture substantial variations across patient groups. Outlier payments reduced health plan risk by up to 15 percent. The outlier system can, however, account for only a small percentage of variation across individuals (37).

Programs designed to coordinate home and community-based care for chronically ill persons or very frail elderly persons at risk of institutionalization represent another

approach to capitation for high-cost patients. HCFA has supported the development of two programs that focus on coordinating acute and chronic care for Medicare beneficiaries. Thus far, evaluations have been unable to show that these programs generate significant cost savings (160).¹¹ There is, however, strong support for view that comprehensive community-based care can provide important benefits, including improved physical, social and psychological functioning, as well as reduce burden on care givers (156).¹²

The Program for All-Inclusive Care for the Elderly (PACE) specifically targets frail elderly persons receiving Medicaid who are eligible for nursing home care but are living in the community. The programs integrate social and medical services using multi-disciplinary teams. Services include adult day care and preventative and rehabilitative services as well as physician services, hospitalization, therapies, pharmaceuticals, and equipment. PACE providers receive a fixed monthly fee for each participant. The fee level is set to approximate the average cost of participants' care needs, but is not adjusted for individuals. The payment rate (administered through the state Medicaid program) is based on the AAPCC, multiplied by a "frailty adjustment" of 2.39 to reflect the costs Medicare would bear in a fee-for-service arrangement. To pro-

tect against unanticipated costs,¹³ however, PACE demonstration project sites have shared the risk with Medicare and Medicaid. During the first three years of operation, the sites are assuming progressively more risk, and by the fourth year the sites are at full risk. The original PACE demonstrations have been small in scope, with about 3000 enrollees in the original ten sites, and enrolling the target population has been problematic (38) Based on initial experiences with the PACE sites and state interest in developing additional sites, however, the Clinton Administration proposed making the program permanent in 1996 (156). The Balanced Budget Act of 1997 (P.L. 105-33) converted the PACE program from a demonstration program to a permanent benefit category under Medicare and an optional benefit program under Medicaid. States can choose to limit the number of persons enrolling in PACE programs.

Waivers for states to operate a second demonstration program, Social Health Maintenance Organizations (S/HMOs) which provides integrated health and limited long-term care services on a prepaid capitation basis through Medicare HMOs, were extended through December 31, 2000. Unlike the PACE programs, which are intended for Medicaid-eligible individuals at risk of nursing home placement, the

11 Analysis conducted by the Lewin Group found that in three states that have focused on limiting nursing home admissions through a range of programs including efficient use of home and community-based services, there savings on Medicaid spending on nursing home care have been realized. The analysis links these saving to the states' success in targeting services to a seriously impaired population, keeping per-person spending low, by using government funds only after exploiting all other resources, keeping provider payments low, and screening people applying for Medicaid-funding nursing home care to determine if they can remain in the community (2).

12 The Balanced Budget Act of 1997 (P.L. 105-33) calls for a demonstration project to explore coordinated care as a means of improving quality and reducing costs for the care of serious chronic conditions among beneficiaries in fee-for-service Medicare.

13 Sites, which serve as "health plans," may incur unexpected losses due to unanticipated costs and unanticipated enrollment. Stop-loss insurance is not available for these arrangements (156).

S/HMO's enroll a cross-section of elderly living in the community. Financing is based on a prepaid capitation arrangement, using a pool of Medicare, Medicaid, and member premiums and copayments. The S/HMOs have a dollar cap for the long-term care benefit. Both benefits and capitation rates vary by state, with plans negotiating benefits and financing. Three of the original four sites operating since the program was established in 1985 are still operating (in Portland, Oregon; Brooklyn, New York; and Long Beach, California). About 20,000 Medicare enrollees are currently enrolled in S/HMOs. The Balanced Budget Act of 1997 (P.L. 105-33) also expanded the number of people who could be enrolled per site from 12,000 to 36,000.

Evaluations of the S/HMO program have indicated that those beneficiaries who are enrolling are healthier than the average Medicare beneficiary. Enrollees have had lower than average disenrollment, and have expressed overall satisfaction with the program. Comparison of frail S/HMO enrollees to those in fee-for-service have shown mixed results. Cost savings were evident in some sites but not others, and no improvements in mortality or life expectancy were found. Satisfaction was higher among the S/HMO enrollees with respect to cost and benefits of care, but not in other areas, such as assessment of quality or competence of care access to care, or interpersonal relationships with physicians (156).

CARVE-OUTS

Arrangements that involve paying separate entities with distinct sets of providers to care for specific medical conditions, procedures, benefits, or patients are collectively referred to under the broad heading of "carve-outs." These arrangements can be structured as high-cost condition payments, or incorporate a range of risk-sharing approaches.¹⁴ Carve-outs differ from some other types of specialized programs for managing particular diseases or medical conditions in one basic respect — providers agree to accept risk for these programs separately. The medical services provided may be administered separately by insurers (employers or public agencies) or a health care organization may contract with a group of providers in a capitation basis for a distinct set of services.¹⁵ Conceptually, carve-outs present the possibility of delegating administrative and legal responsibility for the care of complex chronic or high-cost conditions to organizations that specialize in such care, and can provide it effectively. Carve-outs for mental health services are fairly common among large employer health plans and also in state Medicaid programs.¹⁶ Managed care carve-outs for pharmacy services are also common.

Review of what is currently known about how carve-outs are structured, how they work, and with what results, however, suggests that this type of approach may have limited potential for improving access to

14 Existing carve-out programs are not necessarily capitated for claims costs. Some arrangements are essentially administrative, and involve capitation for administrative costs.

15 Programs implemented within health care plans such as disease management systems or sub-contracts for specialty services or providers are not included in the discussion here as "carve-outs."

16 Towers and Perrin estimated that about 80 percent of Fortune 500 companies carved-out employee assistance programs, mental health services, or both in 1995; 12 state Medicaid programs are currently using mental health carve-outs (12).

appropriate, effective care for Medicare beneficiaries.

Analysis of carve-out options conducted by Melinda Beeuwkes and David Blumenthal for the Study Panel provides a comprehensive overview and analysis of carve-out arrangements (12). The definition of carve-outs encompasses a variety of arrangements that vary in scope of services covered, patients or conditions covered, the degree of financial responsibility assumed by providers and payers, the degree of integration between the carve-out and other providers of care, and the organizational characteristics of the carve-out entity. Generally, however, carve-outs fall into two basic categories, population carve-outs and specialty benefit carve-outs.

Population carve-outs involve separating a particular population sharing a health-related characteristic out administratively or legally, so that all of their health care is provided in a distinct program. An example is the ESRD demonstration, in which all enrollees with end stage disease receive all of their health care through a managed care organization contracting specifically to provide their full range of health care. Specialty benefit carve-

outs assume responsibility for care associated with a specific disease, condition, or procedure. Examples include arrangements for paying for coronary bypass graft surgery, or carve-outs to pay for behavioral health (mental health and substance abuse services).

Table 4-3 illustrates basic types of carve-outs. Contracting with “centers of excellence” for particular medical procedures is another form of carve-out used by some employers as well public programs. Descriptions of carve-out programs drawn from Blumenthal and Beeuwkes’ work are included in text boxes 4-4 and 4-5.

The potential advantages of carve-outs for Medicare relate to specialization and benefits of scale. Managed care models that stress the importance of primary care may require patients to work through their primary care providers before seeing specialists. Carve-out arrangements could facilitate access to specialty care for people with special health care problems. This could be particularly helpful for enrollees with chronic illness.

Arrangements designed specifically to deal with particular conditions could also lead to improved quality of care, if the carve-out

Type of Carve-Out	Scope of Services	Example of Carve-out
Specialty Benefit	Education	Self-care and monitoring for diabetics
	Procedure	The Coronary Artery Bypass Graft
	Surgery Demonstration	
	Disease entity	A Cancer Care Carve-out
	Group of related diseases	A Behavioral Health Carve-out Population
	Comprehensive care	The ESRD Managed Care Demonstration

Source: Beeuwkes M. And Blumenthal, D. “Carve-outs for Medicare: Possible Benefits and Risks, ” *Medicare: Preparing for the Challenges of the 21st Century*, R.D. Reischauer, S. Butler and J.R. Lave (eds.) (Washington DC: Brookings Institution Press, 1998).

Box 4-4 Community Medical Alliance

An HMO Exclusively Serving Disabled and Chronically Ill Patients

The Community Medical Alliance (CMA) in Boston, Massachusetts was the first HMO developed exclusively for severely disabled and chronically ill patients, including AIDS patients. The organization has its origins in the Urban Medical Group, a group that specialized in caring for frail elders and the severely disabled. The Urban Medical Group pioneered the use of nurse practitioners as primary care providers for home-bound or institutionalized patients and made care available 24 hours a day, 7 days a week. Its strategy of giving nurse practitioners the responsibility and time for case management, the ability to make home visits, and offering continuously available care improved patient care and reduced hospitalizations and emergency room visits.

In 1992, CMA entered into a capitated agreement with the Massachusetts Medicaid Agency to care for severely disabled and end-stage AIDS patients. Dr. Robert Master, the medical director of CMA, felt strongly that capitation would give the organization the freedom to develop special systems of care. This included continuing its innovative home care and case management programs and providing flexible DME benefits, among other things.

The praise for CMA since then has been universal. A review of CMA by the National Committee for Quality Assurance found that enrollee satisfaction was "impressively high" and that members of an enrollee focus group could not think of any way in which to improve CMA's services. Although an appropriate comparison group is difficult to find, a review found that CMA's patients seem to utilize more primary and home care and less inpatient and specialist care than comparable patients. CMA has been held up as a model program by the Department of Veterans Affairs, and Dr. Master was recently given an award by HCFA for his work in the care of AIDS patients. In another indication of support, CMA was given approval to expand its service area to cover all severely disabled patients in the state of Massachusetts — it currently serves only 300 patients in the Boston area. In order to finance this expansion, CMA merged with the Neighborhood Health Plan, another HMO in Massachusetts.

According to Dr. Master, "[CMA] would feel strongly that the plan within a plan framework has strong applicability" to the Medicare program but that a specialty benefit carve-out would "not fit the clinical reality" of severely disabled or chronically ill patients. He hopes that his partnership with the Neighborhood Health Plan will demonstrate that the "plan within a plan" concept is "the next generation of capitated plans."

Source: M. Beeuwkes and D. Blumenthal "Carve-outs for Medicare: Possible Benefits and Risks," *Medicare: Preparing for the Challenges of the 21st Century*, R.D. Reischauer, S. Butler and J.R. Lave (eds.) (Washington DC: Brookings Institution Press, 1998).

brings together providers with special expertise. Research has shown that for some conditions, physician specialists provide better care than primary care physicians, and that treating higher volumes of patients is associated with better patient outcomes. Giving organizations responsibility for managing

specific conditions or patient groups could also provide these organizations with the incentive to develop innovative patient management strategies tailored to patients' needs.

The benefits of specialization could also translate to cost savings, if the carve-out

Box 4-5 The ESRD Managed Care Demonstration: A Population Carve-Out

The ESRD managed care demonstration was Congressionally mandated under the Social HMO legislation. Under the demonstration HCFA awarded four contracts to health plans to develop and implement comprehensive managed care plans for ESRD patients. The health plans chosen were either existing HMOs or subsidiaries of HMOs.

The demonstration is designed to test whether: (a) year-round open enrollment of Medicare's ESRD patients in managed care is feasible; (b) integrated acute and chronic care services and case management for ESRD patients improves health outcomes; (c) capitation rates reflecting patients' treatment needs increase the probability of patients receiving kidney transplants; and (d) the additional benefits offered by the awardees are cost-effective.

The demonstration project is intended to be cost-neutral for the Medicare program while offering expanded benefits to enrollees. The four awardees will bear the full risk for all of the health care costs of those ESRD patients who choose to enroll. Within the areas served by the awardees, 21,000 Medicare beneficiaries with ESRD are eligible to enroll. One capitation rate will be paid for patients receiving maintenance dialysis, a higher payment will be made for patients while they are undergoing a transplant, and a lower rate will be paid for those who have been successfully transplanted. The first and third types of payment will be risk adjusted based on patients' age and whether or not diabetes was the cause of kidney failure. However, despite this risk adjustment there could be risk selection that increases costs for the Medicare program. Because the program is voluntary, enrollees may differ from non-enrollees in ways unaccounted for by the risk adjustment system.

Awardees will have responsibility for all of their enrollee's care. Health Options Inc. in southern Florida and Phoenix Healthcare of Tennessee intend to have nephrologists act as PCPs for enrolled ESRD patients. The third remaining awardee, Kaiser of Southern California, will integrate the ESRD demonstration into its existing case management structure.

The awardees have one year to develop their capabilities. Enrollment in the first of the projects began in December 1997. The awardees will provide services for the remaining three years of the demonstration. The Institute for Health Policy at Brandeis University is providing technical assistance during the development period.

Source: Beeuwkes M. And Blumenthal, D. "Carve-outs for Medicare: Possible Benefits and Risks," *Medicare: Preparing for the Challenges of the 21st Century*, R.D. Reischauer, S. Butler and J.R. Lave (eds.) (Washington DC: Brookings Institution Press, 1998), and B. Eddington, HCFA, 1998).

entities can manage care more efficiently, either by using more effective medical management strategies, or through economies of scale in purchasing goods and services. More important, carve-outs could, in theory, reduce the incentives for risk selection, thereby helping the market for managed care work better. If high-cost patients enroll in specialized carve-out programs, managed care organizations face less risk in the Medicare market, and it would be easier for Medicare to determine appropriate premium rates for more homogenous enrollee groups. Adequate prices (based on market standards) for carve-out groups could also help stimulate competition among providers.

Carve-outs also pose a number of potential problems for the Medicare population, however. Specialization can interfere with coordination of patient care, and for Medicare beneficiaries, many of whom have multiple health care problems, it may be both difficult and inadvisable to carve out special payments for particular conditions, procedures or services. Lack of coordination and continuity of care over time appears to increase the risk of quality of care problems. For example, if patients in special carve-out programs are receiving care from a set of providers who are administratively and financially separate from other providers they need to see for health care problems not included in the carve-out, serious problems of lack of communication with regard to prescription medicines can occur. For some chronic conditions where management by primary care physicians appears to be generally as effective as care by specialists (e.g., hypertension and chronic obstructive pulmonary disease), there might be duplication of effort.

Blumenthal and Beeuwkes also suggest that the ability to save money through carve-outs could be limited by administrative, political and technical problems. Carve-outs could result in segregating risk in special plans without eliminating provider incentives to avoid the highest cost cases. This could be countered by restricting the carve-out services to one provider in each area, using a competitive bidding system (44). This would, however, limit choice on the part of Medicare beneficiaries. If the carve-out were mandatory, such a limitation on choice would likely be politically unacceptable; if participation were voluntary on the part of beneficiaries, the advantages of serving the population through the carve-out are diluted. In addition, once a contractor became the exclusive provider for a carve-out group, it might be difficult to maintain a competitive market for these services. The cost of changing contractors could be high, and Medicare could find itself captive to a provider responsible for a vulnerable Medicare population.

Carve-outs also raise what Beeuwkes and Blumenthal call “boundary issues” related to defining which services, conditions and boundaries would be covered by a carve-out. Under capitated arrangements, contractors would have incentive to define the services covered under the carve-out narrowly. In chronically ill populations, however, it is difficult to sort out what medical problems are associated with a specific medical condition (covered under the carve-out), and which are primary care problems. Administrative solutions to boundary issues would involve complex regulations and oversight, which can be expensive. The administrative costs for managed care behavioral health carve-outs are estimated to be between 10-15 percent of

benefit costs; given the complexity of sorting out responsibility for multiple conditions common in the Medicare population, administrative costs could be even higher.

Given the potential problems, Beeuwkes and Blumenthal suggest that carve-outs in Medicare should be confined to conditions or populations with conditions that are relatively common and high-cost, and would benefit from specialized care, or from treatment in settings dealing with high volumes of the condition. In addition, carve-outs should not be targeted to conditions associated with high rates of co-morbidities, or conditions that are characterized by gradual onset or are difficult to pinpoint (in terms of onset and severity). Among possible candidate conditions for carve-outs meeting these criteria would be solid organ transplantation, and certain cancers that have chronic courses or very rapid and predictable ones. Carve-outs for end-of-life care might also meet these criteria, if a reasonable way to define the onset of "end-of-life" could be developed. Effective carve-outs for these conditions would, however, require careful development and refinement in demonstration projects, such as the ESRD demonstration. The same criteria could be useful in considering appropriate demonstration projects required by the Balanced Budget Act of 1997 (P.L. 105-33), which are to evaluate methods for coordinating care as a means to reduce costs and improve quality of care for Medicare beneficiaries with chronic illnesses who are enrolled in the traditional fee-for-service Medicare program.

CAPITATION PAYMENTS TO INDIVIDUAL PROVIDERS

Risk adjustment methods can mitigate problems of adverse selection or stinting on ser-

vices by health plans, but cannot address problems that could result from payment systems within plans that are based on the capitation of individual providers. Specific issues related to the disclosure of payment incentives to providers are considered in the following chapter, which focuses on consumer information and protection. Because "sub-capitation" raises many of the same technical and conceptual issues as capitation at the enrollee/plan level, however, it is included in the discussion here as an aspect of decisions about capitation of the Medicare program.

Managed care plans pay physicians either by salary, capitation, or fee-for-service arrangements, which can also include a variety of cost-sharing arrangements, productivity bonuses, or other types of incentive payments (51, 58). An important aspect of provider payment arrangements, however, is the distinction between two-tiered and three-tiered arrangements. In three-tiered arrangements, a medical group mediates between the plan and the individual physicians. Health plans may not even know how a medical group pays the individual physicians in the groups with which they contract. Capitated payments to the medical group are often converted to salaries or fee-for-service payments to the primary care providers (52). In a two-tiered approach, such as capitation arrangements between employer-sponsored health plans and providers, capitation payments put primary care providers directly at risk. Data from the 1992 HMO Industry Profile showed that 14 percent of HMOs paid individual primary care providers by salary, 44 percent by capitation e.g., "per enrollee per month" payments), and 42 percent by fee-for-service methods (52). A study by the Physician Payment Review Commission, the Medical College of Virginia and Mathematica

Policy Research, Inc. in 1994 found that, among a stratified sample of HMO and PPO plans, 56 percent of the network or IPA HMOs used capitation as the predominant methods of paying primary care doctors, compared to 34 percent of the staff or group models, and just 7 percent of the PPOs (51).

Information on capitation of specialists in managed care is limited. Data from a 1994 InterStudy report show that 30 percent of HMOs and 24 percent of IPAs paid specialists capitated rates (52). An industry survey conducted by Towers Perrin IHC showed substantial variation in the per-person per-month capitation rates for specialists in the Medicare as well as commercial markets. For example, the survey showed Medicare capitation rates ranging from \$3.67 to \$7.34 for urologists and \$6.06 to \$12.36 for ophthalmologists. The capitation rates for Medicare contracts also reflect significant differences in specialty-based risk from the commercial population. The Towers Perrin IHC survey found that capitation rates for Medicare populations for urology and cardiology specialty services are more than seven times higher than in the commercial population, while anesthesiology, radiology and general surgery were about three times higher (112)

Analysis of data from 1995 indicates that capitation payments to physicians are becoming an important part of revenues for many physicians (111). A 1995 survey found that nationally, 24 percent of physicians received

some form of capitation payment for their patients (97). In the physician capitation arrangements examined in the 1995 American Medical Association (AMA) Socioeconomic Monitoring System, more than one third of physicians engaged in patient care in 1995 were in a practice that had at least one capitated contract (compared to 26 percent the year before). These arrangements were generally contracts in which insurers pay physician practices a fixed fee (usually a per person/per month amount) for a panel of enrollees. Physicians in practices with capitation contracts were found to be bearing significant risk. Almost 20 percent of all revenues in practices with capitation contracts came from capitation arrangements, and many, particularly those in smaller practices, reported not having stop-loss protection or reinsurance. Overall, Simon and Emmons report that 86 percent of physicians with capitation contracts had no reinsurance on any of their capitation contracts, and 47 percent reported having no stop-loss provisions in their capitation contracts.¹⁷

There is little conclusive evidence, however, regarding the effects of capitated payments on physician productivity, costs, or quality of care. A review of the literature through 1996 by Rice and Gabel identified only a small number of studies that have examined the effects of capitated payment to HMO providers, and a number of those were conducted almost ten years ago, in a very different health care climate. The few studies that

17 Capitation arrangements are not necessarily the most prevalent in areas with the most mature managed care markets. California did not lead the nation in its proportion of physicians in capitated practices, but was first in the AMA analysis in share of capitated practice revenues. Physicians in Minnesota were less likely than the national average to be operating under capitation (109). This appears to reflect the fact that a large Minnesota-based HMO, HealthPartners, as well as the Buyers Health Care Action Group have opted to pay providers based on fee-for-service methodology (see Chapter 3). This has led some experts to argue that a mix of capitation and fee-for-service reimbursement is likely to develop in mature managed care markets (26).

have been published have found that capitation does affect the use and cost of physician services, but none has directly examined effects on quality of care (Rice and Gabel, 1996).¹⁸ Ongoing work is examining the effects of alternative methods of physician compensation.¹⁹

Capitation at the level of individual providers is an issue for Medicare because of the particular problems of biased selection in a population that includes a significant number of high-risk people. Under some capitation arrangements, physicians could be put at risk for all the costs incurred by an enrollee, including costs for services provided by a spe-

cialist or subspecialist to which the enrollee had to be referred for specialized diagnostic services or treatments. Currently, HCFA requires that plans disclose basic information of physician payment incentives, including the degree of risk assigned to physicians through capitated payment arrangements. HCFA, or states (in the case of Medicaid) review these on a case-by-case basis. The regulation establishes amounts of stop-loss protection that must be in place for any arrangements, including capitation systems, that put physicians at substantial financial risk.²⁰ While regulated, individual capitation arrangements are not prohibited.

18 Rice and Gabel (97) discuss two studies that assessed the effects of different physician payment methods on the use and cost of services. One (112) examined what happened when an HMO changed from a fee-for-service system to a capitated payment system for primary care physicians with risk sharing for hospital costs and specialist services. Primary care visits increased 18 percent the year the new system was put in place, and referrals to specialists outside the group went down by 45 percent. Hospital admissions and length of stay also declined. A second study (88) examined a switch from fee-for-service payment to IPA member physicians to a system of capitation for primary care physicians, with shared risk for specialist services and a bonus if hospitalization rates were held below a specified level. Specialist costs grew at a much lower rate, and hospital outpatient costs declined significantly, but hospital inpatient use was largely unaffected. Neither study examined effects on quality of care.

19 Results from one recent study looking at the effects of different physician compensation arrangements funded by the Robert Wood Johnson Foundation suggests that, when controlling for other factors, differences in utilization and costs are not significant across different types of payment systems, but this study did not include any groups paid on a capitation system that put individual physicians at risk. Other factors, related to enrollee, physician, and health benefit factors may explain more of the variations in use and cost of services (25).

20 The threshold set out in regulation for "Significant Financial Risk" is set at 25 percent of "potential payments" for covered services, regardless of the frequency of assessment (i.e., collection) or distribution of payments. With respect to capitation arrangements, the threshold is exceeded (thereby requiring stop-loss protection) if the difference between maximum and minimum possible payments is more than 25 percent of the maximum possible payments, or if such arrangements are not clearly explained in the physician/group's contract; or any other arrangement that could hold a physician/group/intermediate entity liable for more than percent 25 of potential payments. The rule regarding stop-loss protection specifies that managed care organizations may either provide stop-loss protection directly, purchase it, or let the physician/group purchase it. Protection can be either aggregate or per-patient. The rule specifies that if aggregate stop-loss is provided, it must cover 90 percent of the cost of referral services that exceed 25 percent of potential payments. Physicians and groups can be held liable for only 10 percent. If per-patient stop-loss is acquired, it must be determined based on the physician or physician group's patient panel size and cover 90 percent of the referral costs exceeding specified limits based on patient panel size (126).

Some degree of capitation may remain appealing to some plans. Sorting out the effects of specific physician compensation methods from a host of other organizational and market factors that affect the way that health care plans provide services to enrollees will be very difficult. Currently, many physicians are receiving compensation in a variety of ways from the different employer-sponsored plans with which they have contracts.

Whether physicians change their practice behavior to respond to the specific incentives of particular plans is not known. Providers do, however, generally know if the insurer is Medicare. As options such as provider-sponsored organizations (PSOs) and private contracting with physicians outside of the Medicare program expand, it will be increasingly important to understand more about how financial incentives affect physician behavior. The notion of “steering patients” based on financial incentives raises difficult ethical and political questions. Physicians concerned about patients’ access to care could, for example, encourage patients with limited financial resources to enroll in plans that provide supplemental benefits without additional out-of-pocket costs. Alternatively, physicians could steer patients with adequate resources to settings where they have easier access to specialty services than might be the case in some managed care arrangements. If research were to show conclusively that physicians steer patients to maximize reimbursement, rather than to maximize patients access to appropriate care, or that physicians paid under capitation arrangements (even with stop-loss insurance protection) tend to underserve patients, the Medicare program would need to impose additional restrictions on the use of problematic payment arrangements. This adds to the weight of arguments

for collecting encounter-based data; without individual-level data on the use of health care services, neither plans nor HCFA could identify either actual costs or access or quality of care problems associated with capitation arrangements with individual providers.

CONCLUSIONS AND RECOMMENDATIONS

Risk factors for the Medicare population reflect the particular distribution of health care problems among the elderly and people unable to work due to disability. The utilization of Medicare-covered services indicates that there are distinct subpopulations within the 65 and older subset of beneficiaries, and that both the use and cost patterns of these subpopulations persist over time. These patterns reflect a variety of factors, including functional impairment, extended periods of illness prior to death, and repeated hospitalization associated with certain serious medical conditions. Medicare beneficiaries are more likely than younger people to have chronic diseases. Serious acute conditions such as cardiovascular or respiratory disease which account for a large proportion of health care costs among the elderly each year are also likely to result in high costs over a protracted period of time. This risk has not been randomly distributed among health care plans participating in Medicare. There is convincing evidence that Medicare risk HMOs as a whole have enrolled a healthier population on average than Medicare fee-for-service.

The nature of health care risk in the Medicare population and the market dominance of fee-for-service in the Medicare market seriously undermine the utility of unadjusted capitation to pay for Medicare managed care. Despite the success of employer-based systems in lowering costs

while maintaining access to care and high levels of enrollee satisfaction, special issues remain for Medicare. In the employer-based sector, analysis has generally shown that fee-for-service plans tend to enroll people who use more health care services. In systems where premiums are set competitively, biased selection into fee-for-service plans leads to higher premiums in those plans, or tighter controls on benefits in the fee-for-service plans. Medicare presents a special case, because fee-for-service is the dominant type of coverage, and supplemental insurance appears to dilute the market incentives that help managed care options succeed in the employer-based markets. Risk adjustment is necessary to ensure that plans are paid fairly, and to help ensure beneficiary access to appropriate care in managed care settings.

Risk adjustment methods are now available that could reduce current incentives for biased selection into managed care. The methods based on health status and demographic data, as called for in the 1997 Balanced Budget Act, can significantly improve Medicare's ability to adjust for risk in payments to plans, and this information is important in evaluating access and quality. The most robust of risk adjustment methods currently available are based on diagnostic encounter and/or administrative information detailing diagnosis and service use. The information needed to assess risk is generally available in systems using fee-for-service billing, and in some managed care plans. Data standardization requirements set out in the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) should facilitate the development of risk-adjustment methods. For some plans, the costs of implementing systems to provide standardized risk adjustment data would be minimal, for others, substantial.

Much of the information needed to assess risk, however, is also needed to monitor utilization, quality, and outcomes of care. The data should be as useful to plans for internal management and quality improvement as it is to HCFA and other public agencies and insurers responsible for program oversight and beneficiary protection.

RECOMMENDATION

The Panel endorses HCFA's ongoing efforts to meet the requirements in the Balanced Budget Act of 1997 (P.L. 105-33). HCFA should work aggressively, on a fixed timetable, to design and recommend to Congress a system for assessing and adjusting for risk in payments that is based on the best available encounter/diagnosis-based method. HCFA should also develop (with adequate funding) the infrastructure to administer this risk adjustment system. In collaboration with other public and private sector research organizations, HCFA should support a broad-based research and evaluation program to use these data to examine issues of cost effectiveness, outcomes and quality of care.

The Panel is also concerned that, over the long term, as managed care models diversify and expand, capitation payments to individual providers in managed care plans could create additional incentives to under serve Medicare beneficiaries. This could become increasingly problematic as new types of organizations enter the Medicare market, or if there are not enough cases within a provider's panel to spread risk.

RECOMMENDATION

The extreme case, full risk capitation for all services applied to individual physicians or other providers, should be prohibited in the Medicare program. The Panel also believes that there will need to be close monitoring and full disclosure of arrangements in which individual physicians or other individual providers are substantially at risk, particularly for services that are not directly under their control.

Until an effective risk adjustment system, as well as quality and consumer protections, are fully in place across the full range of Medicare options, incentives to stint on care in capitated systems will remain a serious concern. A variety of methods including reinsurance, stop-loss protection, special payments for high-cost cases and special capitation arrangements for high-cost conditions or patient populations have been devised. The Panel's review of carve-outs, in which separate entities with distinct sets of providers assume risk for specific medical conditions, patients, benefits, or procedures, identified some limited potential for this approach to increase the quality and effectiveness of care for some beneficiaries. The Panel encourages the continued evaluation of all

these approaches; Chapter 6 further develops a recommendation for targeting research on alternative approaches to cost sharing.

The Panel believes, however, that partial capitation payment may have some advantages for Medicare. Combining risk adjusted capitation with payments linked to actual use of services of individual beneficiaries could maintain some incentives for efficiency while reducing incentives to under serve enrollees with the most costly health care needs. Because some of the utilization data needed for risk adjustment could also provide the information needed to partially reimburse based on service use, a blended payment system may not require extensive additional administrative burdens compared to outlier or high-cost case sharing methods (e.g., risk-sharing above threshold levels). The potential effects on provider incentives to do more will, however, need to be assessed carefully.

RECOMMENDATION

HCFA should also design experiments to determine what level(s) of risk sharing, in a blended partial capitation rate, can protect against biased selection (avoiding or under serving high-cost cases) without inducing unacceptable reductions in treatment efficiency.

Appendix A

Overview of Risk Adjustment Models

DEMOGRAPHIC MODELS

Demographic models group individuals in actuarial cells based on their age and gender, and then calculate the expected cost of each subgroup. Demographic risk adjusters have been used often by insurance companies to assess risk and establish premiums for both individual and group insurance products. Employers who risk adjust often only use age and gender. The Medicare reimbursement formula based on the Adjusted Average Per Capita Costs (AAPCC) payment method system is a somewhat more sophisticated demographic model. AAPCC uses age and gender to determine reimbursement rates for participating risk plans, but in addition it adjusts payments for county fee-for-service spending, with additional adjustments made for enrollee Medicaid status, institutional status, and employment (working aged) status (see Chapter 3).

DIAGNOSIS MODELS

Several models have focused on medical diagnoses as predictors of chronic conditions or other ongoing costly medical requirements. Each of these models groups individuals by disease using diagnostic (ICD-9-CM) codes and then calculates the average cost of each subgroup. Diagnostic-based risk adjusters have been recently implemented by the Health Insurance Plan of California (HIPC) and are being implemented in Washington State.

ACG

The Ambulatory Care Group (ACG) model developed by researchers at the Johns Hopkins University uses ambulatory claims as its basis. The system was originally designed for use as an ambulatory care case-mix measure (not just for the Medicare population) (161). The system has since been refined to use as a potential risk adjustment tool for Medicare and other populations. The ACG system helps predict ambulatory health services use based on a beneficiary's demographic characteristics and pattern of disease over a certain length of time. One of HCFA's research projects has developed revised models of ACGs to determine capitated rates for Medicare HMO enrollees based on their expected medical expenses.

The basic ACG model begins by using the 5000 ambulatory diagnostic (International Classification of Diseases, Ninth Revision or ICD-9-CM) codes (161). Each code, reflecting a unique diagnosis (e.g., cancer), is assigned to one of 34 Ambulatory Diagnostic Groups (ADGs). ADGs are classes of diseases, with each class having similar cost implications for the year following the data collection period. Thus, the class a disease is assigned to depends on its expected relationship to health care resource use (e.g., the expected persistence of the condition over time, the likelihood of a return visit for continuing treatment, etc.). From there, the original model placed enrollees into one of 51 Ambulatory Care Groups (ACGs) based on their age, gender, and ADGs to which they were assigned.

ACGs have been incorporated as risk adjusters in recent years in different places. For example, the Buyers Health Care Action Group (BHCAG), a large employer coalition in Minnesota, uses ACGs for risk adjustment purposes, although not prospectively. After actual claims are incurred, BHCAG uses ACGs to adjust payments. If payments were too low, they increase the next quarter, while if they were too high, they decrease (165).

PACS

Other researchers at Johns Hopkins devised the Payment Amount for Capitated Systems (PACS) method specifically to adjust payments to plans for Medicare. The technique uses demographic information (age, sex, disability status) with prior inpatient and outpatient use as well as clinical diagnoses. In particular, PACS use the major diagnostic categories associated with each hospitalization (categories used as the building blocks for the Diagnosis-Related Groups (DRGs) used in Medicare Prospective Payment System), and the chronicity of each disorder. The method makes an urban/rural distinction and applies the Medicare wage index for the geographic region (7).

ADC-MDC and ADG-HOSDOM

ACG models continue to evolve. HCFA currently is testing several newer derivatives with features from both ACGs and PACS. The ADC-MDC Model and the ADG-HOSDOM Model both employ Ambulatory Diagnostic Groups (ADGs), derived in an intermediate step when finding ACGs. Patients can be assigned to one or more of the 34 ADGs. Additionally, these two new models (ADC-MDC and ADG-Hosdom) both utilize aspects of the PACS model. They incorporate use, age, gender, and prior disability status in the risk assessment, and an

inpatient measure based on a beneficiary's prior year hospitalizations derived from the beneficiary's Major Diagnostic Category (MDC). MDCs are used to group patients into one of 27 broad organ-system categories based on the patient's principal hospital discharge ICD-9-CM diagnosis (162).

Both models use inpatient diagnoses and ambulatory records. The first model, ADG-MDC, includes 13 ADGs based on diagnoses made in ambulatory care encounters with providers (135). The model combines a refined set of MDCs with the 13 ADGs to reflect inpatient diagnoses and ambulatory diagnoses, respectively. The second model, the ADG-Hosdom, is similar to the first. The researchers developed a measure called the Hospital Dominant or Hosdom marker to reflect diagnoses that often are treated in an inpatient environment, but could be made in an ambulatory setting. Using data files of over a million Medicare beneficiaries, the researchers developed the Hosdom marker by empirically finding the likelihood that a patient received care in an inpatient or ambulatory setting based on the researchers' data files for each ICD-9-CM diagnosis (162).

DCGs

The Diagnostic Cost Group (DCG) model classifies patients based on expected medical expenses of enrollees. The system can be used for risk assessment and risk adjustment of payments to plans. The system was developed by Ash et al., using data on the Medicare population. HCFA continues to test and refine the model in its demonstration project. This approach uses diagnostic information from hospitalizations occurring during a base year to classify beneficiaries into one of eight DCGs. The eight DCGs, together with demographic characteristics,

are used to predict health costs in a subsequent year. (32). The system uses Medicare FFS claims to classify the ICD-9-CM codes into clinical groups that have similar cost implications for the year following a 1 year data collection period (135). Beneficiaries are classified under one and only one DCG. DCGs consist of categories of diagnoses grouped by the average amount of spending.

NEW VARIANTS OF DCGS: PIPDCG AND ADDCG; HCCS

Ellis et al., also discuss two recent variants of the DCG model, the Principal Inpatient Diagnostic Cost Group Model (PIPDCG) and the All-Diagnoses Diagnostic Cost Group Model (ADDCG). The PIPDCG model groups individuals based on their AAPCC factors and their single highest-cost principal inpatient diagnosis. The second variant, the ADDCG model, adds information on secondary inpatient, hospital outpatient, and physician diagnoses (for either inpatients or outpatients) to the principal inpatient diagnosis, and classifies people based on their single highest predicted cost diagnosis. No distinction is made as to the source of the diagnosis (32).

Ellis et al., also recently have developed Hierarchical Coexisting Conditions (HCC) models, which will be tested as part of Medicare Choices. Unlike the DCG models, HCC models consider multiple co-existing medical conditions, not just the highest cost condition. Each medical condition affects expected costs. While a beneficiary can belong to only one DCG, the same beneficiary can be classified under 0 or 1 or more of the 34 prospective or 44 concurrent HCCs. The models continue to experience refinements and will be incorporated for the under 65 population as part of a HCFA

grant. The HCC model has performed significantly better at predicting costs than the DCG or ACG models (149, 71). DxCG, Inc. has begun to market the model to the private sector (92).

SURVEY-BASED MODELS (SELF-REPORTED HEALTH STATUS)

Risk adjustment systems based on self-reported health status can also be used prospectively or retrospectively. Surveys could ask beneficiaries in HMOs and fee-for-service to rate their health, from “excellent” at the high end to “poor” at the low end. Beneficiaries reporting their health status to be poor could be expected to use more services than those reporting their health status to be good. Surveys could also be used to discover whether beneficiaries have chronic conditions or difficulties performing basic activities of daily living (e.g., walking). Survey models group individuals using statistical regressions, and assign weights depending on the results of the regression.

Possible surveys include the RAND Short-Form Functional and Health Status Survey (RAND 36 or SF-36), and a list of self-reported chronic conditions. HCFA has recently completed an analysis using the Medicare Current Beneficiary Survey (MCBS) data on chronic conditions and health status that predicts HMO enrollees to cost Medicare about 12 percent below average FFS beneficiaries, after adjusting for age, gender and other factors used in the AAPCC (101) Chronic conditions can also be determined from administrative data. The MCBS is a multipurpose face-to-face survey of the Medicare population (administered 3 times a year over 4 years to a sample of beneficiaries) that provides comprehensive data on health and functional status, health care expendi-

tures, and insurance for demographic and socioeconomic subgroups of beneficiaries in Medicare (135). Thus, the MCBS was not initially designed for risk adjustment purposes, and the survey would need to expand the sample of managed care enrollees to be used for this purpose, which would be costly.

PHARMACY RECORDS

Some prior use models predict costs based on prescription drugs, which can be used to indicate non-discretionary medical care. Chronic diseases such as diabetes, hypertension, and chronic pulmonary disease can be identified through prescription drug records. Additionally, examining the particular drugs used can provide an indication of severity (17). However, Medicare does not provide

prescription drugs as part of the basic benefit package, although some risk HMOs choose to do so.

COMBINATION SYSTEMS

As part of a HCFA project, researchers at the Kaiser Foundation Research Institute are working to develop a global risk assessment model that would cover all age groups. The researchers will develop a new system based on diagnoses and demographics, starting from classifications such as ACGs, ADGs, DCGs, clinical behavioral diagnosis groups, and chronic disease scores. The model would assess the expected costs of individuals or groups with respect to each other, and would reflect HMO practices (132).

Appendix B

HCFA Risk Adjustment Projects Active in 1997

(With HCFA Project Code Numbers from
HCFA Active Projects Report, 1997)

ALTERNATIVES TO CURRENT AAPCC METHOD

Actuarial Methods for Improving
HCFA Payment to Risk
HMO 92-022

Alternative Health Risk Adjusters for
the Medicare Risk Program 94-107

Comparison of Concurrent DCG
Models and Partial Capitation as
Payment Alternatives for Managed
Care Organizations 96-038

Evaluating Alternative Risk Adjusters
for Medicare 94-106

Refinements to Medicare DCG
Risk-Adjustment Models: Task
Order: Health Economics Research,
Inc. 96-037

Use of Health Status Measures from
the Medicare Current Beneficiary
Survey to Improve the Adjusted
Average Per Capita Cost 94-020

DEVELOPMENT AND EVALUATION OF RISK-ADJUSTMENT SYSTEMS

Development and Testing of Risk
Adjusters Using Medicare Inpatient
and Ambulatory Data 93-046

Development of Risk-Adjustment
System under Health Reform:
Lewin/VHI, Inc. 94-101

Development of a Risk Adjustment
System under Health Reform: Rand
Corporation 94-016

Development of Global Risk
Assessment Model 94-117

SPECIFIC RISK MODEL STUDIES

Risk-Adjustment for Medicaid
Recipients with Disabilities 96-058

Risk-Adjustment of Payment for
Mental and Substance Abuse 94-124

OUTLIER STUDIES

Evaluation of HMO Outlier
Demonstration 95-006

Outlier Pool Demonstration IM-058

OTHER RELEVANT STUDIES

Enrollment and Utilization Across
Medicare Supplement Plans 94-100

Evaluation of Cost HMOs and
Health Care Pre-payment
Plans 94-075

Evaluation of Medicare Choice
Demonstration 95-018

Physician's Capitation for Medicare
Services: Feasibility Study and
Demonstration Design 94-093

Chapter 5

Information Needs and Beneficiary Protection

Market-based competition among health plans rests on the assumption that consumers are able to make good choices about plans and about the use of health care services. Public agencies, benefits administrators, plans, providers and enrollees have different information needs, and different responsibilities when it comes to making it possible for the marketplace to work. Managing competition across a wide range of plans and provider organizations depends on providing beneficiaries with information they need — and can actually use — to select health plans that best meet their needs, but it also requires an accountable infrastructure to ensure program integrity, efficiency, effectiveness and quality in the delivery of services across a wide range of health plans.

In 1996, a study panel of the Institute of Medicine reported its recommendations for improving public accountability and information for informed purchasing by and on behalf of Medicare beneficiaries. The Medicare reforms included in the Balanced Budget Act of 1997 (P.L. 105-33) include extensive requirements for collecting and disseminating comparative information on plan coverage, benefits, costs, beneficiary satisfaction, provider payment incentives, and other plan characteristics as well as performance data to beneficiaries. The Advisory

Commission on Consumer Protection and Quality in the Health Care Industry, charged with a series of tasks related to consumer information and beneficiary protection in managed care, worked throughout 1997, and issued its final report to the President in early 1998.¹

States and federal government are moving quickly to address concerns about consumer protection issues in managed care. Even before the Advisory Commission on Consumer Protection and Quality completed its work, President Clinton directed federal agencies to adopt the principles and implement the recommendations set out in working subcommittee reports (23). While the implementation of the Commission's recommendations in law is not yet clear, federal programs, including Medicare, will start implementing the recommendations in the near term.

Drawing on available research, ongoing public discussion, and experiences of the organizations discussed in previous sections of this report, this chapter reviews major issues in consumer information and beneficiary protection in the context of the longer-term restructuring of the Medicare program, focusing in particular on the implications of local or regional competitive Medicare mar-

1 The Commission's official functions, as defined in Executive Order 13017 of September 5, 1996, are to: (1) review the available data in the area of consumer information and protections for those enrolled in health care plans and make such recommendations as may be necessary for improvements; (2) Review existing and planned work that defines, measures, and promotes quality of health care, and help build further consensus on approaches to assure and promote quality of care in a changing delivery system; and (3) collect and evaluate the data on changes in availability of treatments and services, and make such recommendations as may be necessary for improvements. President Clinton specifically charged the commission with developing "a consumer bill of rights so that health care patients get the information they need when they need it" (88). The Commission's final report is to be delivered to the President by March 30, 1998 (22).

kets offering multiple insurance products within a national entitlement program.

INFORMATION TO SUPPORT CONSUMER DECISION-MAKING

There are a number of different types of information needed for appropriate management and public oversight of the Medicare program. Plan-level data on administrative factors such as staffing levels and provider qualifications, organization and financial arrangements with employees and contractors, financial condition, plant and equipment, internal quality assurance and risk management capacity, marketing practices, etc. are essential in determining plans' qualifications to participate in the Medicare program. Some of these data are also important to providers, whose working environment is directly affected by these factors, and to enrollees (or potential enrollees). Similarly, the data needed for risk adjustment, for making appropriate payments under any partial capitation or risk-sharing arrangements, and for quality improvement, monitoring and oversight may also serve a variety of internal and external needs, if they can be reported in ways that provide useful information.

Not all plan data are equally useful to consumers, however, at least in the forms in which the data are collected and reported to oversight agencies such as the Health Care Financing Administration (HCFA). Providing Medicare beneficiaries with the information they need will, moreover, become increasingly challenging as the range of choices among insurance products expands. Different types of plans offer differ-

ent potential advantages and risks to beneficiaries, in terms of potential out-of-pocket costs, choice regarding providers and treatment options, availability of specialty services, accessibility to out-of-area services, etc.

For example, policy makers and program officials need information on health status as well as satisfaction with health care in the Medicare population, both to plan for the program's future, e.g., to assess needs for chronic and long-term care services, and to evaluate the success of policy reforms. This type of information can be developed through carefully designed surveys, which can be conducted periodically on a sample basis. Data on health status and on enrollee satisfaction are, however, also important at the plan level. Enrollees as well as those responsible for program oversight should be able to tell how people with functional health limitations or chronic illnesses are faring in particular plans.² Collecting this information for each plan, and presenting the results in a way that is actually helpful to enrollees, are complicated as well as potentially expensive. Plan-specific measures of clinical performance should also play an important part in beneficiary choice (90). The source of this information is detailed diagnostic data and data on health care encounters (see Chapter 4). These data may not, however, be of immediate interest to enrollees without considerable effort to make the information understandable and relevant.

Palmer and Chapman distinguish four categories of information that can be useful to beneficiaries in choosing health plans: plan characteristics, policies, and procedures;

2 Without effective risk adjustment, however, high-quality plans might be reluctant to provide information on how well they provide care for chronically ill beneficiaries or beneficiaries with very high-cost medical problems, because they cannot afford to attract large numbers of these beneficiaries to their plans.

information on management and performance; results of surveys of patient satisfaction; and information on clinical quality (90). It is not clear that beneficiaries will weigh all of these factors in their decisions about health plans. HCFA, other federal agencies, and other health care and research organizations have supported qualitative and quantitative research designed to determine the types of information consumers want, how to present information in ways that it is understandable, and how consumers use information when making decisions about health care. Focus groups with Medicare beneficiaries have found that there are many gaps in beneficiaries' understanding of Medicare as well as managed care (34, 45), and that making decisions about health care plans can be intimidating to beneficiaries (95).

In focus groups conducted by Research Triangle Institute (RTI) for HCFA, some beneficiaries expressed concerns about making decisions about selecting plans when, in the past, these decisions had been made for them by an employer, or by a spouse. Consistent with other studies, RTI found that access to particular providers was the most-often mentioned factor in selecting a health care plan. Access to specific hospitals or specialists was also mentioned by focus group participants as important factors. Other factors included coverage of ambulance services and out-of-area coverage. Beneficiaries view costs from the perspective of future risk rather than short-term economy, and they would rather pay more for their coverage in order to be sure that future costs would be covered. With regard to the source of information they use in making choices

about health plans, friends were mentioned most often, although some mentioned their physician or insurance agent. Some had contacted a state counseling program to get information on health plans (95).

Medicare beneficiaries, like others who have participated in focus groups, are very interested in comparative data on plans when the data are presented to them.³ The available research indicates that Medicare beneficiaries, like other people interested in their health care arrangements, generally prefer detailed information, but they also want to know how the information was obtained, if it is objective, and if it reflects the experiences of "people like them" (95, 69). Across most focus groups, there was a clear preference for impartial information. Insurance representatives were not generally viewed as impartial, while friends, state government, and government sponsored research were. Information from the federal government was "viewed with caution" (79, 69). Focus groups of Medicare beneficiaries conducted under a grant from the Henry J. Kaiser Family Foundation also found, consistent with previous research, that beneficiaries prefer to attend meetings or have private counseling sessions to working through written information on their own (45).

HCFA and other government agencies, federal and state, have begun to develop some of the methods and infrastructure needed to help beneficiaries make informed choices among plans. Several HCFA regional offices (San Francisco, Seattle, Philadelphia and Denver) are in the process of distributing comparative information on benefits offered

3 A comprehensive review of the literature on what consumers want and need in terms of information about health plans and health care can be found in the Institute of Medicine report *Improving the Medicare Market: Adding Choice and Protections* (69).

to Medicare enrollees by area plans, including payments for hospital coverage, physicians and specialists, home health care, emergency care, preventive services, pharmacy benefits, dental, and mental health coverage. Other initiatives are examining ways to provide relevant information on plan disenrollment rates to beneficiaries, as well as information from surveys of enrollee satisfaction and plan performance, using measures from the Health Plan Employer Data and Information Set (HEDIS®).⁴ HCFA is also building the capacity to put comparative information on health plans on the Internet (an early version went online in November 1997), as well as making it available at beneficiary insurance counseling centers (47). To help make this information more available to beneficiaries, HCFA is loaning more than 500 computers to senior centers across the country (131).

HCFA also provides grants to help support information, counseling and assistance (ICA) programs in every state. Established under provisions of the Omnibus Budget Reconciliation Act of 1990, these programs offer individual counseling, group presentations, telephone hotlines, and written materials about Medicare, supplemental insurance, long-term care insurance, managed care options, Medicaid eligibility, etc. (78). About three fourths of all counties nationwide have at least one counseling site. The program is staffed primarily by trained volunteers. In

1997, the 43 federally-funded programs (of a total of 53) responding to a survey conducted by the ICA Resource Center housed at the National Association of State Units on Aging reported employing a total of 103 full time and 73 part-time paid staff at the state level, along with about 4,200 volunteers. Most volunteers receive between seven and 28 hours of pre-counseling training, and about seven to 14 hours of continuing education per year. Another 582 paid staff (mostly full-time) and 8,119 volunteers worked at the local level for the ICAs (66). Most ICAs have statewide consumer “hotlines,” but, as of 1997, only 28 of 43 reporting programs had Internet access at the state level, and most local program office did not have Internet access.

Only a small percentage of the information sought by users has concerned managed care (69). More important, the largely volunteer staffs in most areas of the country are not yet able to access the detailed, comparative information they would need to help Medicare beneficiaries deal with complex managed care choices (124). The ICAs, which have been funded at about \$10 million per year in federal funds (from the HCFA contracting budget)⁵ are charged with providing assistance on the full range of Medicare consumer issues, including Medigap options, helping beneficiaries eligible for supplementary benefits through the Medicaid program, directing beneficiaries with grievances and complaints

4 HEDIS includes information on quality of care and access (e.g., delivery of preventive services and some information on outcomes for selected conditions), use of services, staffing levels and provider qualifications, enrollment/disenrollment, and plan financial health and stability. HEDIS was developed by the National Committee for Quality Assurance, which is working collaboratively with HCFA to refine measures appropriate for the Medicare population (155).

5 In addition, the ICAs seek funding from state and private agencies. In 1997, the ICA Resource Center found that the 43 reporting state programs had obtained about \$5 million in direct state funding, plus an additional \$1 million in in-kind assistance (office space, use of equipment and staff time, etc.), and another \$1.27 million in cash, plus \$1.27 million in in-kind assistance from local governments, and private and sponsoring agencies (65).

about billing or quality of care issues to the appropriate sources, etc. A little more than half (28) of the ICAs reported having training materials available on managed care in the 1997 survey, and 21 handled appeals or grievance related to managed care. Only a handful of ICAs, generally in areas with relatively high levels of health maintenance organization (HMO) enrollment such as California, Oregon, New Jersey, and Colorado reported producing publications on Medicare managed care topics. Several present comparative information on available HMO plans (67).

HCFA is also working in collaboration with the Agency for Health Care Policy and Research (AHCPR) on a Medicare module for the Consumer Assessment of Health Plans Study (CAHPS), which is now in use.⁶ The CAHPS project is developing surveys designed to provide standardized information from all types of health care plans on issues that consumers want regarding enrollees' experiences with health care plans. The project is also providing technical assistance to plans on how to present this information to consumers in understandable formats. CAHPS surveys have also been designed for use in Medicaid and by privately-insured persons.⁷ (see box 5-1) In addition, the Balanced Budget Act of 1997 (P.L. 105-33) codified HCFA regulations that require plans which utilize provider payment incentives that put providers at significant financial risk to conduct and report the results of disen-

rollee surveys. Use of standardized data collection instruments should make it possible to compare beneficiaries' experiences with different types of managed care, and eventually to compare managed care and fee-for-service, across markets, regions, and population groups.

Other agencies and purchasing groups also have experience with producing information to facilitate consumer choice. The California Public Employees' Retirement System (CalPERS), which is the second largest purchaser of health benefits after the federal government, offers 18 health plans, each including a standard package that is designed for Medicare beneficiaries, to about 117,000 Medicare enrollees. Each year CalPERS produces a health plan quality and performance report that contains three key pieces of information for each plan it offers: the results of a customer satisfaction survey; the results of an open enrollment exit survey, which provides information on why people chose to leave plans; and plan scores on standardized quality measures. As discussed in Chapter 3, CalPERS moved to standardized benefits packages because it greatly facilitates meaningful comparisons of plan benefits (113). The quality measures are developed in collaboration with the Pacific Business Group on Health, based on independently audited HEDIS® quality of care data. CalPERS uses feedback from members to modify the reports annually. For example, based on members comments, they plan to use larger

6 AHCPR and the National Committee for Quality Assurance (NCQA) are currently analyzing the NCQA's Member Satisfaction Survey as well as CAHPS (67).

7 The Office of Personnel Management is evaluating CAHPS and will decide, based on its assessment, if it will use CAHPS to obtain information on plans that would be included in the materials provided for federal employees in future health plan open seasons. The CAHPS Medicaid module is being evaluated in demonstration sites in New Jersey, Kansas, Florida, and California. Maryland will be using CAHPS in its Medicaid managed care waiver demonstration starting in 1998. Other states have also decided independently to use the CAHPS instruments to survey Medicaid managed care enrollees (28).

Box 5-1 Consumer Assessment of Health Plans (CAHPS)

CAHPS is a 5-year project funded by the AHCPR to help consumers identify the best health care plans and services for their needs. The overall goals of the project are to develop and test questionnaires (both mail and telephone versions) that assess health plans and services, produce easily understandable reports for communicating information to consumers, and evaluate the usefulness of these reports for consumers in selecting plans and services. The work is being conducted under cooperative agreements between AHCPR and Harvard University, Rand Corporation, and Research Triangle Institute. CAHPS modules have been developed for private health care plans and for Medicaid; and special question modules have been developed to address chronic care and children's health.

The project teams are working collaboratively with HCFA to develop a version of the CAHPS questionnaire for Medicare managed care enrollees. For HCFA, the primary purpose of Medicare CAHPS is to collect, analyze, and disseminate information to Medicare beneficiaries to help them choose among health plans. The data will be used, together with HEDIS® measures, disenrollment data, appeals, and other information to monitor and evaluate the quality of care and relative performance of managed care, and, ultimately, to compare the satisfaction of beneficiaries in the managed care and fee-for-service systems. AHCPR is working with the National Committee for Quality Assurance to integrate parts of CAHPS into the Health Plan Employer Data Information Set (HEDIS), which has an enrollee satisfaction survey component.

Medicare CAHPS includes the standard CAHPS Adult Core set of questions, a chronic care question module and a specialized Medicare module. The Adult Core is also part of the CAHPS surveys designed for privately insured health plan enrollees and the module for Medicaid enrollees. Questions focus on experiences or satisfaction with interactions with physicians and access to specialty care, getting appointments, waiting times, ability to get needed information, complaints, etc., as well as reported use of health services. Optional modules covering topics such as dental care, mental health coverage, prescription drugs, transportation, and communication are also available for use in the Medicare module. The Medicare questionnaires include mandatory items designed to obtain information on the experiences of persons with chronic health problems related to heart disease, cancer, stroke, diabetes and chronic obstructive pulmonary disease, as well as information on enrollees' overall health status, health risks, and ability to perform the activities of daily living.

HCFA is requiring all Medicare managed care plans that have a contract effective for at least one year to participate in an independent third party administration of the CAHPS survey. HCFA will draw a sample of 600 non-institutionalized beneficiaries per plan to be included in the surveys; for plans with too few beneficiaries to draw a sample of 600, HCFA will include all beneficiaries continuously enrolled for a year or more (but results from the low-enrollment plans will not be included in statistical analyses). Mail survey forms will be sent by the contractor, with telephone follow-up as necessary to obtain sufficient responses. The target response rate for the survey is 70 percent, which is designed to produce plan level estimates at the 95 percent confidence level +/- 5 percent.

The HCFA CAHPS contract was awarded to a team headed by the Barents Group (with Westat, Data Recognition Corporation, and Picker Institute) 1997.

Source: HCFA, RFP No. HCFA-97-013/DB; AHCPR, Overview of Consumer Assessments of Health Plans Study, Rockville MD 6/10/97; T. Riley, HCFA, 1998.

print to increase readability in 1997, simplify the wording, and add information on the percentage of members disenrolling from each plan in the last year (113).⁸ The state of Minnesota has also been active in developing consumer information on health care plans; the Minnesota State Employees Survey is a joint effort of labor and management in the state (127). Large employers such as Southern California Edison and Xerox also provide employees choosing among plans with comparative information such as premium rates, benefits, out-of-pocket costs, and member satisfaction results (124).

As managed care has expanded, consumer organizations and affinity groups such as labor unions, consumer organizations, and community groups have taken on the task of providing information and ombudsman services on managed care issues. The National Association of Retired Federal Employees, for example, publishes detailed comparisons and ratings of federal health benefits available to retirees for their use in FEHBP open seasons, and *Washington Consumers' Checkbook* also prepares annual comparative guides for federal employees (65, 96). These non-government efforts can supplement information provided by Medicare, and serve as laboratories for developing innovative approaches to educating consumers. They can also play the role of intermediary for consumers, reviewing and analyzing data on plan value and performance, in much the same way that employers do when they sort through plan data to determine which plans will serve their employees needs at the best prices. Assuring

that complete and accurate information is available to all beneficiaries is, however, a basic government responsibility.

The Balanced Budget Act of 1997 (P.L. 105-33) will require HCFA to generate comparative information on the full range of Medicare+Choice options. These greatly expanded data reporting responsibilities could significantly change the environment in which Medicare beneficiaries make choices about health care plans.

The information that HCFA will supply to beneficiaries each year is to include a description of benefits under traditional Medicare fee-for-service, including coverage, cost-sharing, and beneficiary liability for balance billing; the Part B premium rates; a description of beneficiary rights (including appeals and grievance procedures); information on Medigap and Medicare Select; information on the potential that Medicare+Choice plans may terminate or not renew their contracts; and information comparing plans available to beneficiaries. In addition, materials must include descriptions of benefits, cost-sharing and limits on out-of-pocket spending; differences in cost sharing and balance billing associated with the medical savings account option; plan monthly premium rates; service area descriptions; and information on quality and performance, including indicators that can be used to compare managed care options to fee-for-service Medicare in the area. Among the performance indicators specified in the legislation are disenrollment rates for the prior two years, information on Medicare enrollee satisfaction; information

8 CalPERS calculates the cost of its open enrollment materials, including an information booklet and a booklet on quality of care in participating plans, at \$.63 per member for printing and postage. These costs are passed on to the plans, because they are a substitute for the marketing materials they would otherwise distribute. CalPERS has a staff of 17 devoted to customer service; administrative costs are estimated to be about one half of one percent of premiums (113). (See Chapter 4).

on health outcomes, the extent to which enrollees can select their health care providers, including out-of-network providers, and an indication of exposure to balance billing and restrictions on coverage of services provided out-of-network. Comparative information on supplemental benefits options offered by the plan, and on physician compensation arrangements is also called for in the legislation. The statute specifies that all participating Medicare +Choice organizations provide this information to the Secretary, Department of Health and Human Services (DHHS), and further states that the Secretary may enter into contracts with non-federal entities to carry out the consumer information activities.

The Balanced Budget Act also requires plans to disclose to beneficiaries, at the time of enrollment and not less than annually thereafter, specific information to beneficiaries, in "clear, accurate, and standardized form." The information specified includes descriptions of the plan's service areas; the number, mix, and distribution of plan providers; out-of-area coverage policies; emergency coverage policies; information on supplemental benefits (which are optional, what is covered, and premium prices); prior authorization rules; plan grievance and appeals procedures; a description of the organization's quality assurance program; and (upon request) information on utilization review policies.

To carry out its responsibilities with regard to collecting and disseminating plan information, including the collection (and validation) of a large amount of plan-specific informa-

tion and presenting this information in understandable comparative plan brochures, support of a national toll-free hotline for beneficiary questions, and conduct of annual health fairs for beneficiaries throughout the United States, the Balanced Budget Act of 1997 (P.L. 105-33) authorizes the Secretary of DHHS to charge a fee to Medicare+Choice organizations (proportionate to plan enrollment). Under the statute, the total funds that can be tapped are capped by the statute at \$200 million for fiscal year 1998, \$150 million in fiscal year 1999, and \$100 million annually thereafter (Sec. 1857(e)(2)B). The aggregate amount that can be tapped is contingent, however, on specific language that must be included in appropriations legislation. The amount that would be allowed to be collected (\$95 million for 1998) was therefore not known to HCFA before fiscal year 1998 began, because the DHHS 1998 appropriations bill had not been passed as of the end of fiscal year 1997.⁹ Planning the necessary activities is therefore problematic. HCFA will likely not know, in any year, precisely what level of resources will be available to support all the work that needs to be done to identify, collect, sort, and present the information consumers will need for Medicare+Choice enrollment periods until after it must begin the process of contracting out for the work. HCFA will also not know the number or likely enrollment of the new plans that will be entering the Medicare+Choice program. If plan fees are assessed on prior year enrollment, new plans will not pay their fair share; if fees are assessed to new plans based on

9 The fiscal year 1998 appropriations for HCFA, passed in November 1998, provided for the collection of \$95 million to beneficiary education programs for that year. The conference report stipulated that the amount was to be utilized on a "pro-rata basis, with the understanding that the amount may be reduced after the Appropriations Committees have the opportunity to review the needed resources to implement this program." (140) Regulations setting out how plans will be assessed were issued in late 1997.

expected enrollment, the fees could be seen as unfair barriers to entry into the market. Obtaining information on the new plans is, however, essential for informed beneficiary choice.

OVERSIGHT AND BENEFICIARY PROTECTION RELATED TO CHOICE

The Medicare reforms enacted in 1997 address a number of concerns about consumer information and protections, but raise a number of questions about program oversight and information over the long term.¹⁰ As discussed in Chapter 3, balancing regional or local market opportunities with national standards for Medicare may be difficult. Broadly, one set of issues revolves around establishing rules for participation in the Medicare market for these new entities; another revolves around maintaining standards for information available to beneficiaries regarding access to and quality of care.

Conditions for Participation

New Medicare options, such as Provider Sponsored Organizations (PSOs), preferred provider organization models (PPOs), or other contractual arrangements that assume financial risk are designed to provide more flexibility to organize systems of care efficiently. Greater variation in organizational design, however, makes it more difficult for Medicare to establish and enforce appropriate standards. For example, while PSOs generally can be defined as organizations owned, gov-

erned, operated, managed or supervised by physicians, hospitals, or other providers (149), these organizations may take a wide variety of forms, ranging from a loose affiliation of physicians to an HMO owned by physicians. These newer organizations tend to be smaller, less well integrated, and to have fewer financial resources than the other managed care organizations in the Medicare market¹¹ (147). Smaller organizations may be less financially stable, and, because they have smaller enrollee populations, less able to spread financial risk. Small, inexperienced organizations may not have the capacity to provide the data and consumer services that are required for Medicare; even if they obtain these services from more experienced vendors, they may not have the internal capacity needed to insure that these services are being provided effectively.

Determining where responsibility lies for regulating new types of Medicare risk plans has been controversial. There is ongoing debate about whether Medicare should establish and enforce uniform national standards for participation of all health plans, or whether plans meeting state licensure or certification should be allowed to participate in the Medicare market if state standards differ from federal standards. Most states regulate PSOs under existing state laws designed for HMOs, PPOs, or indemnity insurers, although some states have developed special laws or regulations for PSOs. State laws, like the Medicare rules for qualified health plans (see

10 A range of issues facing Medicare beneficiaries, and in particular beneficiaries with chronic illness, are presented in the commissioned paper by Stanley B. Jones, "Reinventing the Medicare Beneficiary as Consumer." The paper is included in *Medicare: Preparing for the Challenges of the 21st Century* R.D. Reischauer, S. Butler, J.R. Lave (eds.) (Washington, DC: Brookings Institution Press, 1998).

11 PPRC reported that about three fourths of physician-hospital organizations (PHOs), one type of PSO, have been operating less than two years. Over half of PHOs have no full-time employees in finance, utilization management, information systems, marketing, or provider relations. Provider-owned HMOs have fewer enrollees and per enrollee assets than other HMOs (147).

Chapter 2) are designed to protect enrollees by establishing provisions for financial solvency, quality assurance, and protection for consumers if the plan fails (149). One argument is that states, rather than the federal government, understand local markets and health care delivery issues, and that states can craft laws and regulations that meet the needs of state residents as well as the health care industry and provider communities.

State insurance regulators and the American Academy of Actuaries generally believe that all risk-bearing entities, including PSOs, should be regulated according to the same standards (91, 15). The National Association of Insurance Commissioners (NAIC) is working with the a task force of the Association of Actuaries to develop a consolidated model statute that states could use to license all risk-bearing health organizations. The model legislation would, for example, establish financial reserve requirements based on the amount of risk an organization assumes, rather than on its identity as a PSO or HMO (147). Physicians, on the other hand, view PSOs as health care organizations rather than insurers, and therefore they do not believe PSOs should be subject to state insurance regulation. Proponents have also argued that state HMO regulations are inconsistent, and that many create barriers to market entry for the smaller physician organizations (91).

The 1997 Medicare reform provisions require HCFA, in consultation with NAIC to issue regulations establishing solvency standards for PSOs. PSOs may apply for 3-year waivers to allow them to participate in Medicare if they otherwise meet state licensure standards and conform to federal solvency requirements and other federal definitional

parameters set out in statute (beginning in 1998). Those PSOs would be subject to lower enrollment thresholds than other Medicare+Choice plans (with minimum of 500 enrollees in rural areas, and 1,500 enrollees in all other areas)

Enforcing federal standards for all types of Medicare risk arrangements plans would help maintain a “level” playing field across states and markets, and, if designed flexibly enough to accommodate a range of plan types, stimulate the growth of new arrangements that could serve beneficiary needs. However, this could require a significant investment of resources. HCFA currently oversees compliance with federal certification standards in about 350 risk plans. The number of Medicare Choice plans that will enter the market as a result of the 1997 reform is difficult to predict, but HCFA estimates that the number of plans they would need to oversee could more than double (91). Responsibility for enforcing federal standards could be delegated to the states, as it is in the enforcement of the provisions of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191). If responsibility for some of the oversight functions were delegated to the entities administering a competitive Medicare choice system, however, it could increase their administrative costs relative to costs in organizations such as FEHBP and CalPERS (which rely on state and federal authorities to enforce provider regulations).

Consumer Protection

In addition to providing information to help beneficiaries make good choices about health plans, public authorities need to establish ground rules and enforcement mechanisms to ensure fair competition and protect bene-

beneficiaries against discrimination, abusive practices, or inadequate service.

Marketing. One area in which voluntary standards developed by industry or public/private consortia and/or regulation could protect Medicare beneficiaries is marketing of health plans. In some markets, Medicare beneficiaries are currently subject to intensive advertising campaigns, including radio, print and television ads as well as unsolicited mailings. Some HMOs employ marketing agents, who are paid on commission for each beneficiary they enroll (35). Advocacy groups and community organizations, as well as formally constituted third-party brokers can play an important role in providing information to beneficiaries (see Chapter 3). But some beneficiaries, particularly those with limited literacy skills and those not fluent in English, have particularly serious problems obtaining unbiased, comprehensive information on health plan options. The U.S. General Accounting Office as well as consumer organizations have reported serious marketing abuses, including plan marketing agents presenting incorrect information to potential enrollees, pressuring elders to join plans, and enrolling persons who were cognitively unable to make informed decisions (35, 123).

Medicare policy allows for “retroactive disenrollment” in cases where beneficiaries enrolled in plans after receiving false, misleading or incomplete information (133), or did not understand that they were being enrolled in a managed care plan, and in other circumstances, such as administrative errors on the part of the government or employers

(35). In these cases, the beneficiaries may have believed that they were still in fee-for-service, and submitted bills accordingly. Retroactive disenrollment in effect annuls the arrangement with the managed care organization, and treats the beneficiary as if they had never been enrolled in the managed care plan at all; bills submitted during the questionable enrollment period are paid as fee-for-service claims, and the managed care organization returns any payments it received for the individual (35). This policy provides an important check against illicit marketing. High disenrollment rates could be used to trigger increased oversight, or as a basis for invoking sanctions (36).

HCFA has also established marketing requirements for Medicare risk contractors. All marketing material (including membership and enrollment material) must be submitted in advance to HCFA. Door-to-door solicitation, marketing that is designed to target specific geographic areas or populations and avoid others, and misleading or deceptive marketing practices are prohibited (69). The “Medicare Managed Care National Marketing Guide” was released in August 1997, and HCFA plans to update it annually (46).¹² Consumer advocates have found, however, that HCFA has been slow to respond to documented problems (35; 123). The Balanced Budget Act of 1997 (P.L. 105-33) incorporated some marketing rules into law, including a requirement that all marketing materials be submitted to the Secretary, DHHS for review at least 45 days prior to distribution, the prohibition of cash rebates as an inducement to enrollment (or non-enrollment), and the prohibition of any

12 HCFA also plans to issue guidance on a specific provision of the Balanced Budget Act of 1997 (PL. 105-33) (Section 1851(h) (3) that provides that marketing materials that are approved in one instance are deemed acceptable in all other instances, except for provisions that are specific in a particular area (46).

Medicare+Choice plan completing any part of an election form for or on behalf of a beneficiary. Medicare's standards for plans are to include guidelines for reviewing all the marketing materials submitted by plans. Under the guidelines set out by DHHS, the Secretary is required to disapprove marketing materials that are materially inaccurate or misleading.

Distribution of objective, easy to read comparative information could diminish the effect of deceptive practices. Given beneficiaries' preference for face-to-face contact and discussion as a means of sorting through options, however, continuous oversight and meaningful sanctions may be necessary to protect the more vulnerable in the Medicare population, and to prevent discriminatory marketing based on socio-demographic factors. Close surveillance of marketing practices is most likely to be effective if it is done locally. In practice, the level of effort needed to ensure oversight is hard to achieve. Further, uniform standards should be applied to all market areas. The Consumer Coalition for Quality Health Care, for example, has developed model state legislation for managed care oversight that addresses many consumer protection issues, including standards for marketing practices for all managed care organizations (27). As with other consumer protection standards, Medicare could issue comprehensive national standards that would apply to local structured choice programs, with exceptions for special conditions or needs established by states or local authorities administering Medicare competition, as long

as such exceptions were consistent with Medicare policy.

Coverage, benefits, and appeals. A second area in which consumer protection would need to be secure goes to the core of managed care: what is covered, which services and treatments are provided, and what are the rights and obligations of health care providers and patients. Medicare coverage and benefits issues have never been clear-cut, and problems of consistency in interpretation of coverage rules, benefits limitations, and medical opinion regarding appropriateness and medical necessity have always been part of Medicare as they have in private indemnity insurance or managed care. Managed care, however, has brought these issues to the forefront of public attention.

Concern about managed care denial of services has led some state governments to require health plans to disclose protocols and coverage guidelines upon which coverage decisions are made. Other state laws or regulations also require plans to base clinical review criteria and utilization decisions on written criteria that are developed with the participation of plan providers, to employ individuals with appropriate training and expertise to make referral and utilization decisions, and to require that referral and utilization decisions take into account the unique needs of individuals (35). New Jersey's comprehensive consumer protection law specifies that consumer appeals within HMOs for limitation or denial of services must be heard by a physician with specialty certification in the areas under appeal; if the problem is unresolved after physician review,

the consumer can file an appeal with an independent utilization review organization (4).¹³ Other states, including Rhode Island, Florida, Texas, and Tennessee have, or are close to having in place, mechanisms for independent review of consumer appeals of managed care denials of service (3).

Medicare HMOs are required to provide all Medicare-covered services provided under fee-for-service Medicare in the area in which they operate (except for hospice care). They are also required to comply with written policies detailing criteria underlying medical review determinations (i.e., how decisions are made about medical necessity and appropriateness). Consumer advocates believe, however, that the coverage guidelines and medical review criteria and protocols used by managed care plans differ from those applied by utilization review and external quality review of fee-for-service Medicare (35). These criteria are considered proprietary by health care plans, because they may include data specifications, referral rules, outcomes management protocols, and even computer algorithms that have been developed or purchased by the plans to help them manage care effectively and compete successfully in marketplace.

Medicare does provide a structured appeals process for beneficiaries seeking to challenge denials of coverage. Consumer groups, the DHHS Office of the Inspector General, and a U.S. District Court.¹⁴ however, have found serious problems with the appeals system (35). In response to the Court's finding that

“procedures followed by HMOs fail to secure minimum due process for Medicare beneficiaries,” HCFA promulgated new regulations providing for expedited reviews in April 1997, and additional interpretation and explanation has also been issued (129) Under the 1997 regulations, Medicare put in place requirements that plans appeal procedures include a 72-hour process to reconsider adverse determinations that “could seriously jeopardize the life or health of the enrollee or the enrollee’s ability to regain maximum function. If the appeal is denied, it is automatically forwarded to The Center for Health Dispute Resolution, a HCFA contractor, for an independent review. The Center sends a letter with its decision about the appeal (129) within 10 days. HCFA has worked with the American Association of Health Plans to develop instructions to plans for implementing the new regulations. The Balanced Budget Act of 1997 (P.L. 105-33) codified the new regulations, and in some aspects provides additional beneficiary protection by calling for even shorter time times for reviews. The Act also stipulates that reconsideration reviews be conducted by a physician practicing in the specialty area of the provider of the service under appeal.

Quality of Care

Accountability for quality of care in managed care arrangements is divided among an overlapping set of public and private institutions. Managed care organizations are subject to state licensing requirements and laws addressing a wide range of issues affecting coverage, benefits design, staffing, and consumer

13 This type of external review could create serious problems if the external reviews resulted in determinations that particular services should have been covered, even if they were clearly excluded by Medicare coverage policy or the specific Medicare plan contract provisions.

14 U.S. District Court for the District of Arizona, *Grijalva v. Shalala*, Judgement Order, March 3, 1997.

protection. Accreditation is designed to provide standards, generally established by professional or industry groups themselves, that differentiate qualified providers from those unable to meet those standards. Five different accreditation bodies are now playing a significant role in different organizational arrangements of managed care (53).¹⁵ Federal health care programs, including Medicare, have instituted additional quality standards and requirements for internal quality assurance and improvement programs and for quality external review. In addition to reviews to determine compliance with contractual provisions relating to quality assurance (and utilization reviews) procedures and staffing requirements, HCFA has contracted with Peer Review Organizations for external review of HMOs (35) as well as hospitals. The Balanced Budget Act of 1997 (P.L. 105-33) requires Medicare+Choice plans to contract for external reviews with independent quality review and improvement organizations approved by the Secretary. The Secretary may, however, waive the external review requirement for plans that have “consistently maintained” an “excellent” record of quality assurance and compliance with Medicare quality review requirements.

The 1997 Medicare reforms further provide for specific quality elements to be addressed in quality reviews. Plan must have a program that (1) stresses health outcomes and develops data permitting measurement of health outcomes and other quality of care indices; (2) monitors and evaluates high volume and

high-risk services and the care of acute and chronic conditions; (3) evaluates the continuity and coordination of care that enrollees receive; (4) is evaluated on an ongoing basis regarding its effectiveness; (5) includes measures of consumer satisfaction; and (6) provides the Secretary, DHHS with certain information to monitor and evaluate quality. Plans are also required to have mechanisms to evaluate the utilization of services and inform providers and enrollees of the results of these evaluations (139).

The term “quality of care” is multi-dimensional, and, for Medicare, presents perhaps a more complex array of interrelated issues than in other segments of the health care system. Medicare beneficiaries have more serious health care problems than many other insured populations and the program involves enormous commitments of public resources. It is clearly in the public interest to ensure that Medicare and its beneficiaries get the best value they can in the health care market. Consumers, however, view quality from their own perspectives. Palmer and Chapman (90) identify three measurable aspects of quality that are of concern to Medicare beneficiaries. **Accessibility** is the extent to which beneficiaries receive care appropriate to their needs, as indicated by current professional knowledge. **Patient satisfaction** refers to the acceptability of care to patients. **Clinical performance** relates to the content of care, e.g., providing appropriate tests, providing appropriate treatments, and implementing them safely and effectively,

15 The National Committee for Quality Assurance (NCQA) has surveyed about one half of the HMOs in the United States; the Accreditation Association for Ambulatory Health Care (AAAHC) focuses primarily on ambulatory health care entities such as clinics and ambulatory surgical centers; the Utilization Review Accreditation Commission (URAC) has programs to survey and accredit both utilization review entities and provider networks; The Medical Quality Commission (TMQC) surveys medical groups and individual practice associations that provide care on a prepaid or capitated basis; and the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) has a network accreditation program (53).

within critical time frames, as measured by conformance with current professional standards. It also includes communicating with patients about the selection and implementation of a diagnostic and care plan.

Concerns about accessibility to appropriate care have become a serious issue for Medicare managed care. Analysis of national Current Beneficiary Survey data by the Physician Payment Review Commission (PPRC) indicated that most beneficiaries in risk plans have not experienced access problems, but the analysis raised concerns about access for the more vulnerable groups, such as the oldest, people in fair to poor health, and people with functional disabilities. For example, of those in fair or poor health, 10.8 percent reported experiencing delays while waiting for plan approval, compared to 4.8 percent of beneficiaries overall; 9.5 percent reported not being referred for specialist care they thought was needed compared to 6.2 percent of all risk plan enrollees). Those enrolling in HMOs have, on average, been healthier than those remaining in fee-for-service; access problems could become more prevalent if enrollment in managed care increases among the beneficiary population with more serious health care problems (149).

Some accessibility issues have been addressed directly through legislation. States have been particularly active in this area. Over a dozen states have passed legislation that requires managed care organizations to give enrollees direct access to certain types of specialists, including dermatologists, psychiatrists, oph-

thalmologists and obstetrician-gynecologists (149). Federal legislation prohibits HMOs from requiring prior authorization for emergency care and stipulates that a “prudent layperson” definition of emergency be used to determine coverage of emergency care.¹⁶ Other access issues are addressed more broadly in requirements for licensure or certification, and in plan disclosure requirements for consumer information (see above).

Satisfaction with care may be based on actual experience, or on values and preferences for care (90). Surveys of enrollees and disenrollees can provide important information on specific aspects of access to care, such as ease of making appointments, waiting times, time spent with providers, access to specialists, or ability to communicate with providers or plan administrators. Individual preferences or expectations may, however vary among enrollees. Some individuals may prefer to spend a long time discussing their care with their provider; others may prefer more matter-of-fact, business-like interactions; one person might be very satisfied with a 10 minute visit that started on time, focused on a routine condition, and ended with a renewed prescription; another might be very satisfied with a thirty minute discussion, even if it began somewhat late and resulted in a follow-up consultation rather than a clear-cut treatment plan. Specific information on factual issues (“how long did your last visit last?” or “how long did it take to get a follow-up visit with a specialist?”) may, therefore, provide more useful information to people trying to select a plan that general

16 The prudent layperson definition specifies that emergency care is warranted if a person with average knowledge of health and medicine would reasonably expect that without immediate medical attention, a medical condition manifesting itself by acute symptoms of sufficient severity (including acute pain) would result in placing the health of a person in serious jeopardy, or in serious impairment or dysfunction of bodily functions or bodily parts or organs (139).

satisfaction information. Generalized satisfaction measures, however, could be useful to policy makers or regulators, who can use this information for general monitoring purposes, or to flag plans that are generally achieving below average ratings for more in-depth review or oversight (90).

HCFA's work with the CAHPS project and requirements for standardized plan level surveys of enrollees and disenrollees should provide a sound foundation for collecting standardized information on consumer satisfaction. The module format also provides the flexibility to add optional modules that could address local or regional issues. A plan might, for example, want to add a module designed to focus on a particular medical condition for quality improvement purposes, or on a special problem such as coordination of out-of-service benefits in areas where many beneficiaries spend part of the year in warmer climates. Analysis of the information from these surveys should not only be useful for beneficiaries, but for health care plans and providers, who need to know more about how aspects of enrollee satisfaction relate to other aspects of quality of care across different populations.

Both the private and public sectors are working to develop methods for measuring the clinical quality of care provided in health care organizations and communicating that information to beneficiaries in ways that are useful in choosing health plans. HCFA is working with NCQA on clinical performance measures appropriate to the population (153),¹⁷ JCAHO is developing an "Indicator Measurement System" for health care networks and hospitals and on a performance

measurement system for use in accreditation reviews, and the Foundation for Accountability (FACCT) is working collaboratively with HCFA and AHCPH to develop a measurement system that can be used by beneficiaries to access clinical performance of health care providers (90). HCFA plans to put comparative information on plan performance on the internet (133). States have also devised initiatives to measure and compare provider performance. Florida and Maryland are developing state-wide standards for indicators for comparing health plans (90). The Institute of Medicine has recommended the creation of a private, non-profit agency that would identify and refine state-of-the-art methods for providing information to Medicare beneficiaries and coordinate many of these functions, working with regionally-based centers that build on the experience of existing consumer groups such as the ICAs (69).

Available research indicates that consumers want valid, impartial information on both the effectiveness of medical procedures and treatments, and on how well providers perform, e.g., conduct appropriate tests and implement the right treatments at the right times (125). Palmer and Chapman, for example describe a *Consumer Reports* approach that would include both the consumer information and the performance data that could help a beneficiary determine if a plan would be right for someone with his or her particular health care needs. This would include clearly written text information, for a particular condition, about what types of care are recommended (based on professional recognized standards based on valid outcomes and effectiveness research), what outcomes can be

17 HCFA currently requires Medicare HMOs to report data on a set of HEDIS quality indicators. As of July 1997, 273 HMOs had provided this data to HCFA (68).

expected, and what the beneficiary should do to contribute to achieving the best outcomes, along with charts summarizing ratings of how plans actually perform in relation to established standards in the diagnosis, management or treatment of the condition (90).

Experts generally believe it take 10 to 15 years to develop a comprehensive set of valid and reliable clinical performance measures (125, 90). The cost will be significant.

Collaborative efforts such as the FACCT initiative and effectiveness, work with NCQA on performance measures, and outcomes and clinical performance measurement efforts spearheaded by AHCPR¹⁸ will address some of the critical research and evaluation gaps. The data that HCFA will be collecting from health plans should also provide the foundation for much of the needed research and development.

CONCLUSIONS AND RECOMMENDATIONS

In a restructured Medicare program where beneficiaries choose among competing health plans, consumer information and protection are critical. As discussed in Chapter 3, in

benefits systems such as FEHBP and CalPERS, comparative information on plans is developed locally, using standardized questionnaires as well as administrative data from plans. Successful systems such as the Pacific Business Group on Health and the Buyers Health Care Action Group are engaged in sophisticated quality measurement and improvement activities. For Medicare, however, the tasks of providing information and protecting beneficiaries are more complicated, because it is responsible for enforcing regulations designed to protect beneficiaries and the Medicare program from fraud, abuse, deceptive practices, and discriminatory practices as well as for ensuring access to and quality of care.

The Medicare reforms enacted in 1997 significantly expand Medicare's responsibilities for obtaining and disseminating a wide range of information that should help beneficiaries made good choices about health plans. Collecting, validating, collating, and disseminating this information to beneficiaries in understandable and useful formats will require significant skill as well as cost.

18 AHCPR is working with a range of professional, research and industry groups on three related projects designed to advance clinical performance measures: the Evidence-based Practice Centers funded by the AHCPR that are developing methods for synthesizing what is known about effectiveness and outcomes of care for specific sets of conditions; the Guidelines Clearing House being set up jointly by the American Medical Association, the American Associations of Health Plans, and AHCPR; and CONQUEST, a relational data base that includes a comprehensive set of performance measures for a wide range of health care conditions and populations (126).

RECOMMENDATION:

The Medicare program should require all participating plans to provide standard information on plan benefits, availability of services, policies, and cost-sharing to beneficiaries in formats that are understandable and allow enrollees to make comparisons across plans. Non-proprietary information on management and operational issues that are directly subject to review under the terms of contracts between Medicare and the plans (e.g., data from enrollee and disenrollee surveys, data on provider-to-enrollee ratios for primary care providers and specialists, policies and administrative or judicial rulings regarding appeals and disputes about coverage or payments; provider incentive programs) should also be collected and made available to enrollees upon request. If regional entities are established to help to promote innovation in systems of structured Medicare competition (under demonstrations discussed below), they should be authorized to request waivers from national data collection or dissemination standards for special purposes, provided that such data collection is consistent with Medicare goals and standards.

Medicare's responsibilities with regard to ensuring and improving quality of care are also unique. In addition to establishing and regulating quality review standards for plans, Medicare supports a large external peer review system. Medicare is, moreover, the largest single force shaping national conceptions of what is appropriate and necessary

medical care. Decisions about Medicare's coverage of medical technologies, procedures, or treatment regimens have national consequences.

The basic standards for the types of information that need to be obtained from plans for quality oversight and for informing consumers should be national Medicare standards. National standards for ensuring meaningful choice are also needed in a restructured Medicare program. The standards should be designed to ensure equity in protections for all Medicare beneficiaries, including the right to obtain health care that is needed, when it is needed, at affordable costs.

RECOMMENDATION

Medicare "conditions of participation" should be nationally consistent across Medicare choice entities. Appropriate standards should be adopted in the areas of marketing; access to care (including specific rules regarding access to specialty care), continuity of care, and adequacy of provider networks; confidentiality; non-discrimination; performance measurement and reporting, quality review and sanctions; utilization review and systems for appeals and grievances; and criteria for non-allowable physician incentive payment arrangements and disclosure of such arrangements. Regional entities should be authorized to institute additional or alternative requirements (that conform to national standards) with the approval of the Secretary of the U.S. Department of Health and Human Services (DHHS).

Creating an infrastructure to assist consumers is essential. HCFA has the foundations of a consumer information infrastructure in place, but some components, such as the ICAs, do not currently have sufficient resources to provide beneficiaries with the help they will need to deal with the complexities of the new Medicare marketplace. Under the provisions of the Balanced Budget Act of 1997 (P.L. 105-33), HCFA can use revenues collected from plans for developing and disseminating consumer information. It is not yet clear that these funds will be adequate to support all the requirements set out in the legislation.

RECOMMENDATION:

Administrative funding for Medicare choice should include adequate resources to support local consumer information and counseling services that can provide individual counseling to Medicare beneficiaries about plan options. The Panel also believes that the system for assessing fees to support this work from health plans should be equitable, and should reflect the special information needs that will be generated by the entry of new plan and provider arrangements into the Medicare market. New Medicare+Choice organizations should be allowed to fully participate in the process of developing complete and accurate consumer information.

Chapter 6

Preparing for Structured Choice in Medicare

The Academy Study Panel on Capitation and Choice believes that building the infrastructure that can support a system of structured choice that will work well for beneficiaries will require careful experimentation and analysis of options. Issues that need to be addressed are discussed throughout the report. A number of these issues are controversial, and designing demonstrations of major program changes will raise difficult political as well as technical problems. The Panel believes, however, that these issues need to be addressed now.

COMPETITIVE PRICING DEMONSTRATIONS

The Balanced Budget Act of 1997 (P.L. 105-33) provides a starting point for this work. The Act calls for the Secretary of The Department of Health and Human Services to establish a demonstration project in which payments to different "Medicare+Choice" organizations in defined payment areas would be paid under a system of competitive pricing. A newly established Competitive

Pricing Advisory Board is to make recommendations to the Secretary regarding the designation of the areas for the demonstration. Three urban areas and one rural area are to be named on a schedule that would permit the first two demonstrations to begin payments to plan in the demonstration on January 1999, and the next two on January 1, 2000. Up to three other sites are to be designated later for inclusion in the demonstration. In consultation with the Advisory Board and area advisory committees, the Secretary is charged with establishing the design, method for selecting plans to be offered, methods for setting prices, mechanisms for rewarding plans for meeting or failing to meet quality standards, and establish systems for collecting and disseminating plan information to beneficiaries, and evaluating the results of the demonstration. A second demonstration project calls for a third-party contractor to conduct Medicare Choice enrollment and disenrollment functions in an area, separate from the competitive pricing demonstrations.

RECOMMENDATION

The Panel believes that the Medicare Competitive Prepaid Pricing Demonstrations should expedite the development and evaluation of alternative models for organizing local public/private consortia to manage group purchasing of Medicare health insurance, e.g., competitive or negotiated bidding administered by Medicare, or other entities or coalitions (public or private) contracting with the Health Care Financing Administration (HCFA), to provide combined Medicare/Medigap managed care options to retirees in local markets. These demonstrations should be designed to provide useful comparative information to beneficiaries on choices available to them, the effects of benefits design (including the composition of alternative benefits packages and their effects on utilization, continuity of care, beneficiary satisfaction) and financial implications, including out-of-pocket costs. The demonstrations should be designed to test alternative approaches to competitive bidding and methods of establishing payment rates to plans, including the application of different methods for adjusting for the health risk of enrollees. The demonstrations should also build on current research to include tests of promising payment methodologies incorporating partial capitation, reinsurance or stop loss provisions.

PREMIUM SUPPORT DEMONSTRATIONS

To determine whether competition will result in more efficient and effective health care for the Medicare population, the Panel believes that demonstrations need to evaluate options for redesigning beneficiary choices regarding traditional fee-for-service Medicare as well as capitated Medicare+Choice plans. In this redesign, beneficiaries would be financially accountable for the choices they make when their costs exceed defined Medicare payment limits. At the same time, the restructured system must provide full protection to most vulnerable groups in that population — chronically ill and low income beneficiaries. The Panel believes that focused research and evaluations should explore whether this could be accomplished by offering Medicare fee-for-service as a plan with a premium that competes on the basis of cost (premiums, co-payments and deductibles), benefits, access and quality of care, analogous to the Federal Employees Health benefits Programs' nationwide Blue Cross/Blue Shield options. This could be one or more Medicare fee-for-service products that include supplemental benefits, point-of-service arrangements, and health plan options now available in the private sector marketplace.¹

Evidence from existing structured choice systems has shown that maintaining a competitively-priced fee-for-service option in a managed competition environment is very difficult. For Medicare, some of these problems are even more daunting. The beneficiary population has greater health care needs and fewer financial resources than the working population, making the issues of risk

¹ These options are discussed in detail in the National Academy of Social Insurance *Study Panel on Fee-For-Service Medicare Final Report*, issued in January 1998.

adjustment more important, and possibilities for cost-shifting to beneficiaries more constrained than in private markets. The beneficiary population also includes people who, because of the increasing incidence of frailty, cognitive impairment and chronic illness that comes with aging, may have more difficulty mobilizing the resources necessary to make informed decisions about their health care. While the demonstrations mandated by the Balanced Budget Act of 1997 (P.L. 105-33) should yield important information about the strengths and weakness of alternative approaches to structuring competition among Medicare+Choice options, determining the feasibility of more fundamental restructuring of Medicare fee-for-service options would require more far-reaching experimentation that will require additional legislation.

The NASI Panel on Capitation and Choice concluded that a structured choice approach to restructuring Medicare may also require integrating the fee-for-service component into a market structure so that it becomes more compatible with a defined premium support system. In such a system, the Medicare program would contribute a fixed proportion of the premium costs of an appropriate benefits package defined in statute. The contribution would be capped at an established level within the range of participating plan premiums. Plans offering the Medicare benefits package would compete on price and quality; beneficiaries selecting more expensive plans would pay more; those selecting less expensive plans would pay less.

The Panel believes that for such a system to work, Medicare benefits would need to be expanded. The expanded Medicare coverage would more closely approximate the cover-

age that beneficiaries seek through supplemental insurance now, i.e., some, if not complete coverage of prescription drugs, catastrophic coverage for total Part A and Part B and a somewhat lower Part B copayments. The Panel acknowledges the complexity of designing and implementing an enhanced benefits package that would supplant a significant portion of supplemental insurance. The Panel believes, however, that the additional costs would be less than the cost of purchasing that coverage in the private market. It is also possible that a better-designed benefits package could reduce incentives for beneficiaries to seek out supplemental coverage, then select first-dollar coverage options, which are believed to contribute to higher utilization rates. Medicare fee-for-service coverage that looks more like insurance available in the employment-based market might actually “level the playing field” among plan options, encouraging beneficiaries to compare costs and benefits of managed care and fee-for-service plans directly, without having to factor in additional supplemental coverage. At the same time, the Panel recognizes that an expanded benefits package could trigger significant changes in employment-based supplemental coverage, and in state and federal responsibilities for beneficiaries eligible for Medicaid. The demonstration would indicate whether the increased costs of enhanced benefits could be offset by the greater efficiencies expected in a competitive market system.

Ideally, public policy should be based on sound information about what is required (resources, time, data, etc.) to implement major changes, what the likely implementation problems will be and what steps can be taken to alleviate those problems. Even with the changes introduced in the Balanced

Budget Act of 1997 (P.L. 105-33), the Medicare Part A Trust fund will not be able to cover the health care costs incurred by the Baby Boomers when they become Medicare beneficiaries. More fundamental reform of the Medicare program will be necessary. Restructuring Medicare as a premium support model would affect tens of millions of Americans. Before implementing such a program, policymakers need better information

to help determine if such a system can work well for beneficiaries and for the Medicare program. An aggressive, focused research and demonstration program should begin now. In such a program, Congress would need to enact legislation granting HCFA the authority, and adequate resources, to plan and implement a demonstration of fully operational models for structuring choice among managed care and fee-for-service options.

RECOMMENDATION

In conjunction with the implementation of the Competitive Pricing Demonstrations, defined contribution demonstrations based on a premium support model that includes Medicare fee-for-service as a component should be established in several regions. In these demonstrations, traditional Medicare fee-for-service coverage would be offered as one of a limited number of “full replacement” fee-for-service insurance options provided (or, in the case of Medicare, administered) by insurance carriers, in addition to qualified managed care options. The basic Medicare benefit package would be enhanced, and would include a modest prescription drug benefit. A small number of standardized optional supplemental benefits plans offered by approved carriers could also be purchased in addition to the enhanced Medicare fee-for-service plan, or in conjunction with other plans. Other supplemental policies would be precluded. The demonstration would be limited to beneficiaries who do not have employer or other third party-sponsored supplemental retiree health insurance.

— Total payments to plans would be established by local entities contracting with HCFA in the demonstrations, in consultation with the Competitive Pricing Advisory Board, through a process that takes account of bids submitted by plans as well as general economic conditions. All plans would bid based on the assumption of providing services to all Medicare beneficiaries in the demonstration area. The bids would be broken down to show estimates of the costs of providing the basic Medicare benefits package, enhanced benefits provided under the demonstration, and additional benefits offered by each plan. Medicare would determine a fixed contribution toward the cost of premiums for all participating plans. Actual payments to plans would then be adjusted using an appropriate risk adjustment method based on individuals' expected use of services; retrospective adjustment of payments for some portion of care would be permitted. Medicare payments to plans would therefore vary by the risk category of each enrolled beneficiary. The premiums paid by individual beneficiaries within each plan, however, would not vary with an individual's health status. Beneficiary costs (in the form of increased premiums and copayments) or savings (in the form of reduced premiums and added benefits) would be determined based on the difference between a plan's bid premium price and the Medicare contribution. Beneficiaries would pay more for plans that were more expensive due to differences in practice style or efficiency, but would not pay more because they enroll in a plan with sicker than average enrollees.

— The demonstration would be designed to guarantee that beneficiaries would be “held harmless” in terms of premium costs and coverage under the demonstration. The actuarial value of the enhanced benefits package could, for example, be paid for by an increase in Social Security payments for demonstration enrollees. Premium payments would be deducted from beneficiary Social Security checks (as Part B premiums are for all beneficiaries); the premium amount to be deducted would vary, depending on the cost of the plan in which the beneficiary enrolls. For beneficiaries in the demonstration electing the traditional program, no additional deduction would be made. For beneficiaries selecting lower-cost plans, any difference between the premium for the selected plan and that for traditional Medicare would be reflected in an increase in the monthly Social Security payment; for those selecting higher price plans, monthly checks would be reduced to cover the higher premium costs. Qualified and Specified Low-income Medicare Beneficiaries would retain the same Medicaid supplemental coverage and the same level of protection as under current law, and would be allowed to select from all participating plans, including fee-for-service options.

■ Demonstration sites would be given the authority to coordinate enrollment and funding of Medicaid, Veterans Health Administration, and Department of Defense health programs and other federal and state resources and to establish a fund to provide income-related assistance to cover basic Medicare premium costs, the increased cost of the enhanced supplemental benefits provided under the demonstration, and any copayments and deductibles not covered by the enhanced benefits.

■ All beneficiaries in the region would be provided with the same comprehensive information on benefits (including translated materials for non-English-speaking beneficiaries), plan characteristics, consumer rights, information on quality and access to care, and beneficiary cost sharing as is required for other Medicare+Choice options, including information on access, utilization, quality of care, enrollee and disenrollee satisfaction, and costs to enrollees in the fee-for-service options.

The Panel believes that planning the demonstration would require three years, with appropriated funding to support planning studies and the development of requisite data, administrative and consumer education systems. The demonstrations should be structured to run for five years, and should include a comprehensive evaluations. If plan-

ning and development activities began in 1999, five year demonstrations would be completed in 2007, in time to guide the fundamental reform of Medicare that will have to take place before the Medicare Part A Trust Fund can no longer support the growing costs of the beneficiary population.

Appendix C

Report Recommendations

STRUCTURING MEDICARE MARKETS (CHAPTER 3)

The models used by government and private organizations to structure insurance choice for their employees, retirees and dependents should be studied closely so that their successes and failures can inform decisions with respect to Medicare. Examining approaches to offering both capitated and fee-for-service options within structured choice systems is particularly important.

Reconsidering the Medicare benefits design in the light of the health care needs of the current and future beneficiary populations is essential for successful Medicare reform. Legislatively prescribed Medicare benefits should maintain or improve upon current Medicare benefits.

In the long-term, Medicare should adopt annual open enrollment and information periods that are coordinated with enrollment and lock-in for Medicaid, other federal health care programs (e.g., Medicaid and the Department of Veterans Affairs managed care), and Medigap policies. To protect beneficiaries and ensure appropriate opportunities for choice, there should also be periodic opportunities for beneficiaries to opt out of choices that are unsatisfactory for them. Provisions for retroactive disenrollment protections in current law, e.g., for beneficiaries who were enrolled through deceptive or fraudulent practices, should be maintained.

HCFA should use its demonstration authority to assess options for standardizing the ways in which benefits are described to facilitate comparisons among plans, and to also explore options for developing and evaluating the marketing of a small set of basic plus supplemental standardized benefits sets through the Medicare+Choice program, analogous to the standardized supplementary benefits packages created under provisions of Omnibus Budget Reconciliation Act of 1990.

PAYING FOR MEDICARE MANAGED CARE (CHAPTER 4)

The Panel endorses HCFA's ongoing efforts to meet the requirements in the Balanced Budget Act of 1997. HCFA should work aggressively, on a fixed timetable, to design and recommend to Congress a system for assessing and adjusting for risk in payments that is based on the best available encounter/diagnosis-based method. HCFA should also develop (with adequate funding) the infrastructure to administer this risk adjustment system. In collaboration with other public and private sector research organizations, HCFA should support a broad-based research and evaluation program to use these data to examine issues of cost effectiveness, outcomes and quality of care.

The extreme case, full risk capitation for all services applied to individual physicians or other providers, should be prohibited in the Medicare program. The Panel also believes that there will need to be close monitoring and full disclosure of arrangements in which individual physicians

or other individual providers are substantially at risk, particularly for services that are not directly under their control.

HCFA should also design experiments to determine what level(s) of risk sharing, in a blended partial capitation rate, can protect against biased selection (avoiding or under serving high cost-cases) without inducing unacceptable reductions in treatment efficiency.

INFORMATION NEEDS AND BENEFICIARY PROTECTION (CHAPTER 5)

The Medicare program should require all participating plans to provide standard information on plan benefits, availability of services, policies, and cost-sharing to beneficiaries in formats that are understandable and allow enrollees to make comparisons across plans. Non-proprietary information on management and operational issues that are directly subject to review under the terms of contracts between Medicare and the plans (e.g., data from enrollee and disenrollee surveys, data on provider-to-enrollee ratios for primary care providers and specialists, policies and administrative or judicial rulings regarding appeals and disputes about coverage or payments; provider incentive programs) should also be collected and made available to enrollees upon request. If regional entities are established to help to promote innovation in systems of structured Medicare competition (under demonstrations discussed below), they should be authorized to request waivers from national data collection or dissemination standards for special purposes, provided that such data collection is consistent with Medicare goals and standards.

Medicare “conditions of participation” should be nationally consistent across Medicare choice entities. Appropriate standards should be adopted in the areas of marketing; access to care (including specific rules regarding access to specialty care), continuity of care, and adequacy of provider networks; confidentiality; non-discrimination; performance measurement and reporting, quality review and sanctions; utilization review and systems for appeals and grievances; and criteria for non-allowable physician incentive payment arrangements and disclosure of such arrangements. Regional entities should be authorized to institute additional or alternative requirements (that conform to national standards) with the approval of the Secretary of the U.S. Department of Health and Human Services (DHHS).

Administrative funding for Medicare choice should include adequate resources to support local consumer information and counseling services that can provide individual counseling to Medicare beneficiaries about plan options. The Panel also believes that the system for assessing fees to support this work from health plans should be equitable, and should reflect the special information needs that will be generated by the entry of new plan and provider arrangements into the Medicare market. New Medicare+Choice organizations should be allowed to fully participate in the process of developing complete and accurate consumer information.

PREPARING FOR STRUCTURED CHOICE IN MEDICARE (CHAPTER 6)

The Panel believes that the Medicare Competitive Prepaid Pricing Demonstrations should expedite the development and evaluation of alternative models for organizing local public/private consortia to manage group purchasing of Medicare health insurance, e.g., competitive or nego-

tiated bidding administered by Medicare, or other entities or coalitions (public or private) contracting with HCFA, to provide combined Medicare/Medigap managed care options to retirees in local markets. These demonstrations should be designed to provide useful comparative information to beneficiaries on choices available to them, the effects of benefits design (including the composition of alternative benefits packages and their effects on utilization, continuity of care, beneficiary satisfaction) and financial implications, including out-of-pocket costs. The demonstrations should be designed to test alternative approaches to competitive bidding and methods of establishing payment rates to plans, including the application of different methods for adjusting for the health risk of enrollees. The demonstrations should also build on current research to include tests of promising payment methodologies incorporating partial capitation, reinsurance or stop loss provisions.

In conjunction with the implementation of the Competitive Pricing Demonstrations, defined contribution demonstrations based on a premium support model that includes Medicare fee-for-service as a component should be established in several regions. In these demonstrations, traditional Medicare fee-for service coverage would be offered as one of a limited number of “full replacement” fee-for-service insurance options provided (or, in the case of Medicare, administered) by insurance carriers, in addition to qualified managed care options. The basic Medicare benefit package would be enhanced, and would include a modest prescription drug benefit. A small number of standardized optional supplemental benefits plans offered by approved carriers could also be purchased in addition to the enhanced Medicare fee-for service plan, or in conjunction with other plans. Other supplemental policies would be precluded. The demonstration would be limited to beneficiaries who do not have employer or other third party-sponsored supplemental retiree health insurance.

— Total payments to plans would be established by local entities contracting with HCFA in the demonstrations, in consultation with the Competitive Pricing Advisory Board, through a process that takes account of bids submitted by plans as well as general economic conditions. All plans would bid based on the assumption of providing services to all Medicare beneficiaries in the demonstration area. The bids would be broken down to show estimates of the costs of providing the basic Medicare benefits package, enhanced benefits provided under the demonstration, and additional benefits offered by each plan. Medicare would determine a fixed contribution toward the cost of premiums for all participating plans. Actual payments to plans would then be adjusted using an appropriate risk adjustment method based on individuals’ expected use of services; retrospective adjustment of payments for some portion of care would be permitted. Medicare payments to plans would therefore vary by the risk category of each enrolled beneficiary. The premiums paid by individual beneficiaries within each plan, however, would not vary with an individual’s health status. Beneficiary costs (in the form of increased premiums and copayments) or savings (in the form of reduced premiums and added benefits) would be determined based on the difference between a plan’s bid premium price and the Medicare contribution. Beneficiaries would pay more for plans that were more expensive due to differences in practice style or efficiency, but would not pay more

because they are at greater risk of needing health care, or because they enroll in a plan with sicker than average enrollees.

—The demonstration would be designed to guarantee that beneficiaries would be “held harmless” in terms of premium costs and coverage under the demonstration. The actuarial value of the enhanced benefits package could, for example, be paid for by an increase in Social Security payments for demonstration enrollees. Premium payments would be deducted from beneficiary Social Security checks (as Part B premiums are for all beneficiaries); the premium amount to be deducted would vary, depending on the cost of the plan in which the beneficiary enrolls. For beneficiaries in the demonstration electing the traditional program, no additional deduction would be made. For beneficiaries selecting lower-cost plans, any difference between the premium for the selected plan and that for traditional Medicare would be reflected in an increase in the monthly Social Security payment; for those selecting higher price plans, monthly checks would be reduced to cover the higher premium costs. Qualified and Specified Low-income Medicare Beneficiaries would retain the same Medicaid supplemental coverage and the same level of protection as under current law, and would be allowed to select from all participating plans, including fee-for-service options.

- Demonstration sites would be given the authority to coordinate enrollment and funding of Medicaid, Veterans Health Administration, and Department of Defense health programs and other federal and state resources, and to establish a fund to provide income-related assistance to cover basic Medicare premium costs, the increased cost of the enhanced supplemental benefits provided under the demonstration, and any copayments and deductibles not covered by the enhanced benefits.
- All beneficiaries in the region would be provided with the same comprehensive information on benefits (including translated materials for non-English-speaking beneficiaries), plan characteristics, consumer rights, information on quality and access to care, and beneficiary cost sharing as is required for other Medicare+Choice options, including information on access, utilization, quality of care, enrollee and disenrollee satisfaction, and costs to enrollees in the fee-for-service options.

The panel believes that planning the demonstration would require three years, with appropriated funding to support planning studies and development of requisite data, administrative and consumer education systems. The demonstration should be restructured to run for five years, and should include comprehensive evaluations. If planning and development activities begin in 1999, five year demonstrations would be completed in 2007, in time to guide the fundamental reform of Medicare that will have taken place before the Medicare Part A Trust Fund can no longer support the growing cost of the beneficiary population.

Appendix D

Acknowledgements

The National Academy of Social Insurance and its Study Panel on Medicare Capitation and Choice gratefully acknowledges the assistance provided by the following individuals to the Panel's work. However, any errors or omissions the report may contain are the responsibility of the Study Panel and staff.

John Bertko
PM Squared, Inc.

Chris Brown
U.S. Office of Personnel Management

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Agency for Health Care Policy and Research

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DxCG, Inc.

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Pacific Business Group on Health

Cary Sennett
National Committee for Quality Assurance

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Managed Risk Medical Insurance Board

Cynthia Smith
Washington State Health Care Authority

Margaret Stanley
CalPERS

Sarah Thomas
Payment Assessment Commission
(formerly Prospective Payment Assessment
Commission)

Cynthia Tudor
Health Care Financing Administration

Steve Wetzell
Buyers Health Care Action Group

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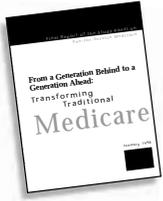
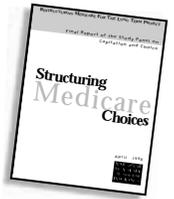
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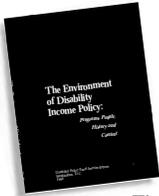
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