

**RISK ADJUSTMENT IS NOT ENOUGH:
STRATEGIES TO LIMIT RISK SELECTION
IN THE MEDICARE PROGRAM**

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EXECUTIVE SUMMARY

Thirteen percent of Medicare beneficiaries are now enrolled in health maintenance organizations (HMOs). Compared with beneficiaries who have remained in traditional fee-for-service Medicare, HMO enrollees are a favorably selected group: they have less need for medical care than beneficiaries of similar age, gender, and other characteristics accounted for in the average adjusted per capita cost (AAPCC) formula used to determine HMO capitation rates.

This favorable selection and the mechanisms that lead to it create serious quality-of-care and financial concerns. If HMOs were to excel in providing high-quality care for beneficiaries who are chronically ill or severely disabled, or who have serious medical problems, they would attract an adverse selection. They cannot afford to do so under the present payment system, which adjusts for some demographic characteristics but not for health status. The most needy beneficiaries are thus poorly served in HMOs and faced with increasingly steep Medigap premiums (or high out-of-pocket payments) in fee-for-service care. Favorable selection results in the AAPCC paying plans more than would have been spent by Medicare if the HMO beneficiaries had remained in fee-for-service; this “overpayment” is estimated to be anywhere from 6 to 37 percent. Thus, Medicare and the public purse fail to benefit from the financial economies that managed care could bring.

The premise of this paper, supported by The Commonwealth Fund, is that the single most effective action the Health Care Financing Administration (HCFA) could take to limit the financial pressures and quality-of-care concerns created by risk-selection dynamics—adjusting payments to HMOs based on the health status of enrollees—is necessary, but not sufficient in itself to solve risk-selection problems.

EVIDENCE FOR RISK SELECTION

At least 20 studies have measured selection bias in Medicare HMOs using three sets of indicators: health status, mortality rates, and pre-enrollment service utilization or cost. The evidence overwhelmingly suggests substantial favorable selection, controlling for the AAPCC demographic adjusters. HMOs that have experienced adverse or neutral selection are a small minority. Most of the data used in these studies were collected from 1982 to 1990, but three new studies that examined 1994 data found similar results. Much less has been published comparing health-care quality and outcomes in fee-for-service and HMOs. The available findings suggest that most beneficiaries are as satisfied in HMOs as in fee-for-service, and quality of care and outcomes (to the extent that these have been measured) appear equally good for average beneficiaries. There is some evidence, however, that quality and outcomes for those most in need of care are wanting.

Little evidence exists on how risk selection occurs, or on the relative causal importance of consumer preferences and deliberate actions by plans. Consumer preferences are expected

to lead to favorable selection at enrollment, since reluctance to change physicians and concerns that access to some care may be difficult in HMOs deter high users of care from switching from fee-for-service to managed care.

Despite HCFA oversight of marketing, disenrollment, and complaints, plans have abundant opportunities to attract a healthier, lower-risk group and avoid adverse risk selection. Although their marketing actions have been little studied, it is clear that plans' mass-marketing materials are targeted toward healthy people. In addition, despite regulation prohibitions, some HMOs have screened potential enrollees. Little evidence has been found of other strategies that plans could use for favorable risk selection, such as discouraging the enrollment of high-risk patients by avoiding providers who specialize in serving the sick or who practice in low-income areas, or by tailoring their benefit packages to avoid the sick.

Favorable selection can also occur through selective disenrollment. Although only 3 percent of plan members disenroll and switch to fee-for-service each year, they tend to be in poorer health than other enrollees, and this is enough to cause significant favorable selection over time. Typical HMO utilization-review practices and barriers to limit specialist care (such as requiring repeated primary physician referrals) are especially burdensome to the chronically ill.

OPTIONS FOR CHANGING POLICY TO LIMIT RISK SELECTION

The forces restraining plans from acting aggressively to improve their risk mix—the drive to increase enrollment, the desire to avoid bad publicity or HCFA sanction, the professionalism of providers and staff, and medical liability concerns—are not enough. Policy changes are necessary to encourage HMOs to provide excellent care for the most needy and to compensate them fairly for their enrollee risk mix, and thus to help reduce the selection that currently segments the Medicare market, costs the program money, and undermines the quality of care. This paper discusses five complementary strategies that could help limit selection and encourage the development of delivery systems that provide high-quality care to those beneficiaries most in need.

1. Annual coordinated open enrollment for Medigap and Medicare HMOs. Selection is increased and beneficiaries' choices within Medicare are greatly complicated by three factors: the dearth of clear, unbiased comparative information on plan options; the primary role that plans have in marketing and enrollment; and differences in the rules under which HMOs and Medigap insurers operate—notably the right of Medigap insurers to refuse coverage to beneficiaries after their first six months of eligibility. Four changes would facilitate well-informed choices between managed care and traditional fee-for-service Medicare, and among competing HMOs and Medigap insurers:

- guaranteed annual open enrollment in Medigap policies as well as HMOs;

- widely available, timely, comprehensive, clear, and unbiased comparative information on HMO and Medigap options;
- an independent broker to provide information, answer beneficiary questions, and perhaps process enrollment; and
- a common premium rating system for HMOs and Medigap insurers.

People who were well informed of their options and the relative costs, benefits, and performance of different plans might be encouraged to enroll in HMOs, especially if they could later regain Medigap coverage if they wished. These measures would unify the Medigap and HMO markets, facilitate choice, and most likely reduce selection bias.

The U.S. General Accounting Office recently estimated that annual excess payments to HMOs nationwide could be as much as \$2 billion. The cost of a third-party broker to provide some of the services described above is estimated to be approximately \$12 per beneficiary per year, or approximately one-quarter of 1 percent of total Medicare expenditures. If coordinated open enrollment with better beneficiary information reduced favorable selection to HMOs, the brokerage process could potentially pay for itself.

2. Better beneficiary information. Information on the choices facing beneficiaries should be presented in the context of a basic explanation of how Medicare works, how managed care differs from fee-for-service, and the role of supplementary insurance. Focus group and survey research has revealed that beneficiaries give priority to comparative information on costs, coverage, and exclusions, and how different systems and plans operate. They want clear explanations of rules and procedures, especially in choosing providers and access to specialists and emergency, after-hours, and out-of-area care.

Information should also be collected and disseminated on consumer satisfaction, health plan quality, and disenrollment rates, with reports focused on the experiences of vulnerable patients. This information should be published together with comparable measures on fee-for-service, and presented in a way that facilitates easy assessment and choice. Risk-selection problems would be reduced to the extent that publicizing this information encourages HMOs to improve their performance, and makes beneficiaries—including those most in need of care—more likely to join HMOs that perform well on satisfaction and quality measures.

3. Simplify choice by partial standardization of benefits. Diversity in benefit packages makes it difficult for beneficiaries to compare and choose among plans, and facilitates market segmentation and risk selection. The Medicare population is too diverse and the geographic variation in the AAPCC too wide for a single benefit plan to be feasible, but HCFA should

establish a limited and well-defined set of supplemental benefit packages that HMOs would be allowed to offer.

These packages should be as similar as possible to the set of Medigap supplementary policies to facilitate comparison between HMOs and Medigap and simplify beneficiaries' comparisons and choices. Although a prescribed list of supplemental benefits would inhibit innovation and responsiveness to changes in consumer preferences, this system appears to have worked well for the Medigap program since 1990. It is possible that risk-selection dynamics would cause the more generous packages to attract an unfavorable risk mix, but more sensitive health-based payments would help ameliorate this problem. Further, at least in areas of the country where the AAPCC is well above the amount that HMOs need to provide basic Medicare coverage, risk selection would be a problem only with packages that are more expansive than those that efficient plans can offer for zero premium.

4. Increased oversight and credentialing of provider networks. HCFA currently has a set of requirements that HMOs applying to participate in the risk contract program must meet. These requirements could be augmented and standards raised to increase the likelihood that contracting plans would do a good job of caring for people most in need. A number of state Medicaid programs require HMOs that serve disabled recipients to meet certain criteria, which HCFA could usefully consider for Medicare plans. The criteria might include:

- HMOs must perform an initial assessment of all new enrollees to identify beneficiaries with chronic health problems;
- HMOs must produce a plan of care (preferably created by a multidisciplinary team), for all chronically ill enrollees, including for home health care, durable medical equipment (DME), and mental health services;
- plans must have a system in place for 24-hour telephone access to medical advice;
- plans must conduct and report to HCFA the results of a specified number (e.g., five) of quality improvement initiatives each year, some in areas chosen by HCFA and others chosen by the plans;
- plans must have health education and prevention programs that target the needs of the chronically ill;
- plans must report on the processes employed to decide on the use of home health and DME, the extent to which these services are used, and the number and disposition of beneficiary complaints about these services.

Requiring all contracting HMOs to satisfy these criteria would not guarantee that enrollees with heavy care needs and chronic problems will be well served in HMOs, but

would increase the likelihood of this outcome. Better monitoring and reporting on quality of care both in HMOs and fee-for-service are also important. The requirement that HMOs produce HEDIS reports is a beginning, but may have limited effects. A useful addition would be a systematic review of a sample of deaths of HMO and fee-for-service patients, with the goal of reducing preventable mortality.

5. Increased monitoring of disenrollment and publication of data on disenrollment and performance. The four strategies discussed above would primarily affect beneficiary decisions at enrollment. To deal with potential selection problems as a result of differential disenrollment, HCFA should:

- improve collection and reporting of data on rates of and reasons for disenrollment. This would give HMOs an incentive to improve enrollee satisfaction and reduce disenrollment rates, lest their attempts to gain new enrollees are undermined by a poor reputation; and
- systematically collect data on the post-HMO disenrollment expenditures of beneficiaries who enter fee-for-service arrangements. If, on average, post-enrollment expenditures are higher than the capitation the HMO was receiving, then corrective action would be required—perhaps making the HMO bear financial responsibility for its dissatisfied former enrollees.

These five strategies should make HMOs more attractive to the chronically ill and reduce the extent of favorable selection in HMOs. They cannot be effective, however, unless the strong financial incentives HMOs now have to avoid beneficiaries with greater than average health care needs are removed from the payment system. Plans cannot be expected to organize delivery systems to serve the chronically ill and others most in need of care if they are paid the same amount as for those with fewer health care needs. Capitation payment that is adjusted for the health status of enrollee groups is technically possible, and HCFA is developing proposals to test this option. An environment with the right incentives is essential to HMOs' achieving their potential of saving the Medicare program money and providing high-quality care to all beneficiaries.

PART 1: INTRODUCTION

Biased selection occurs when HMOs enroll groups of beneficiaries whose need for medical care differs significantly from the risk pool upon which the capitation payment is based. In the Medicare program, where the AAPCC payments are based on age, gender, geographic location, welfare status, and institutional status, biased selection occurs if HMO enrollees have different needs for medical care than average enrollees with similar age, gender, and other characteristics accounted for in the AAPCC. If HMO enrollees have less need for medical care than the average in the group on which capitation is based, then we say that the

HMO has a favorable selection of risk; if HMO enrollees have greater need for care than average, then the HMO has an adverse selection of risk.

There are serious financial and quality-of-care concerns associated with biased selection. If HMOs enroll a favorable selection of Medicare beneficiaries, then the AAPCC pays the plans more than would have been spent by Medicare if the HMO beneficiaries had remained in fee-for-service.¹ This wastes taxpayers' money and leads to increased financial pressure on the Medicare Trust fund and on the general revenues used to pay for Part B services: no one has suggested encouraging the growth of Medicare HMOs simply to pay more money to health plan administrators and providers than would have been paid under fee-for-service.

Of greater concern to many, however, is the effect of the dynamics that lead to biased selection on the quality of care for vulnerable Medicare beneficiaries: the chronically ill, the severely disabled, and those with a variety of serious medical problems. Part of the promise of managed care is that it will create health care delivery systems that are more responsive to the needs of consumers: HMOs are more likely to provide preventive care, to coordinate care for their enrollees, and to reduce overutilization. Since HMOs are competing for enrollees, in principle they have an incentive to provide high-quality care and strive for high levels of patient satisfaction.

In the current environment, however, an HMO that seeks to excel in providing care to beneficiaries with cancer, heart disease, or stroke, or that aggressively recruits the most respected subspecialists in the community, would likely cause its own demise. It would attract an unfavorable selection of risk, be paid less than the cost of providing care to enrollees, and be forced either to change its modus operandi or go out of business.²

The financial imperative for HMOs to avoid attracting an adverse selection of enrollees raises the concern that those most in need of care may not receive high-quality care. If they choose to stay in fee-for-service, these patients will be faced with increasingly steep Medigap premiums (or high out-of-pocket payments). The purpose of insurance is to spread risk between the healthy and the sick: the dynamic of risk selection defeats that purpose, and threatens the quality of care available to those most in need.

PURPOSE OF THIS PROJECT

Many analysts assert, and we agree, that changing the HMO payment system to adjust payments to HMOs based on the health status of enrollees is the single most effective action that HCFA could take to limit the effects of risk-selection. However, risk-adjusted payment—or the more appropriate term health-based payment—has been the focus of

¹ Further, if HMOs receive favorable selection, then the beneficiaries remaining in fee-for-service will be more expensive than average, and the AAPCC will increase in subsequent years, thus increasing the extent of overpayments.

² See Jones 1996 for a clear statement of this problem.

extensive policy discussion and debate. Health-based payments are necessary, but not sufficient, to create an environment that will limit risk selection and encourage the development of delivery systems that provide high-quality care to vulnerable beneficiaries. This study, which was supported by The Commonwealth Fund, therefore considers a range of complementary strategies.³ It is organized as follows:

Part 2 discusses the problem of risk selection, assessing its impact on cost and quality of care, and describing why and how it occurs. It also considers factors that limit the ability of HMOs to engage in favorable risk selection, and discusses the extent to which risk selection is likely to remain a problem in mature Medicare HMO markets.

Part 3 discusses policy responses to risk selection, including the likely benefits of adopting an annual coordinated open enrollment period for Medicare HMOs. It also reviews the kinds of information beneficiaries want and need to make informed choices among plans, and methods of communicating that information to beneficiaries. Part 3 also proposes partially standardizing the supplemental benefits offered by HMOs, discusses how better screening of plans that participate in Medicare might increase their likelihood of providing high-quality care for all beneficiaries, and points out how closer monitoring of HMO disenrollment might help limit the extent of risk selection and its effects. Part 4, the conclusion, summarizes and argues for the necessity and feasibility of implementing health-based payment as a complement to the other strategies considered for limiting risk selection in the Medicare program.

³ As part of this study, four additional papers were commissioned exploring aspects of the problems associated with risk selection and options that HCFA might consider for addressing them. This overview paper draws on the detailed discussions of these four papers, which may be obtained directly from their authors: Thomas Rice, Mark Merlis et al., Mark McClellan, and Gerard Anderson (see References).

PART 2: THE PROBLEM OF RISK SELECTION

The extent of risk selection in Medicare HMOs has been researched extensively. At least 20 studies have measured selection bias, using three sets of indicators: health status, mortality rates, and pre-enrollment service utilization or cost.⁴ Typically, HMO enrollees are compared with those in fee-for-service Medicare, controlling for the demographic adjusters included in the AAPCC. The overwhelming predominance of evidence is that substantial favorable selection exists.

A simple comparison of demographic characteristics between Medicare HMO enrollees and nonenrollees shows that the beneficiaries most likely to be in need of medical care—those under age 65 and disabled, and all those over age 75—are less likely to be enrolled in HMOs. Since the AAPCC adjusts payments based on these demographic characteristics, this is not evidence that HMOs receive favorable selection. However, it is clear evidence of the type of demographic subgroups most attracted to HMOs.

Controlling for demographic characteristics, Medicare HMO enrollees are found to be, on average, healthier than beneficiaries in fee-for-service: they have a lower prevalence of chronic conditions, better self-reported health status, and better functional health status. Lichtenstein et al. (1991) compared the mean functional health status and the proportions of very disabled and very able enrollees in 22 TEFRA HMOs in 12 cities with a control group of fee-for-service beneficiaries living in the HMO service areas. Data on a total of 10,035 beneficiaries were collected in 1988. The authors found no adverse selection to HMOs and strong evidence of favorable selection: nine HMOs had an enrolled population with better mean health status, and another ten had a better selection at one or both ends of the health status distribution. The HMOs appeared to have done particularly well in avoiding very disabled enrollees—18 out of 22 showed favorable selection.⁵

Most studies comparing age-adjusted mortality rates between HMOs and fee-for-service Medicare report 20 to 30 percent less mortality among HMO enrollees.⁶ Riley, Lubitz, and

⁴ Five useful articles that review the Medicare risk-selection literature are Rossiter et al. 1989; Davidson, Sofaer, and Gertler 1992; Helliger 1995; Physician Payment Review Commission 1996; and Riley, Feuer, and Lubitz 1996. Numerous others report analytic results: Eggers and Prihoda 1982; Garfinkel et al. 1986; U.S. General Accounting Office 1986; Kasper et al. 1988; Langwell and Hadley 1989; Porell and Turner 1990; Riley, Lubitz, and Rabey 1991; Lichtenstein et al. 1991; Lichtenstein et al. 1992; Brown et al. 1993; Dowd et al. 1994; Dowd et al. 1996; Riley, Feuer, and Lubitz 1996; Physician Payment Review Commission 1996; and Rodgers and Smith 1996.

⁵ If HMOs provide better access to care, or better quality of care, the better health status of their enrollees may be argued to be endogenous rather than the result of selection bias. The number of chronic conditions diagnosed, however, is more likely to increase with better access to care.

⁶ U.S. General Accounting Office 1986; Riley, Lubitz, and Rabey 1991; Brown et al. 1993; and Physician Payment Review Commission 1996.

Rabey (1991) estimated adjusted mortality in 1987 among 1 million Medicare enrollees in 108 HMOs at 0.8 of the “expected” level, and only 0.7 for persons newly enrolled in 1987. Brown et al. (1993) reported 25 percent fewer deaths among HMO enrollees in 1990 than among fee-for-service beneficiaries.⁷ As a result of the concentration of Medicare expenditures in the last year of life, even small differences between HMOs and fee-for-service in mortality rates have large effects on expected resource needs: if the age-adjusted mortality rate in HMOs is 25 percent lower than in fee-for-service, we would expect total HMO expenditures, other things being equal, to be approximately 5.7 percent below the fee-for-service level.⁸

Pre-enrollment costs and use of services are consistently found to be lower for HMO enrollees than for Medicare recipients who remain in fee-for-service.⁹ Brown et al.’s (1993) comparison of prior-year Medicare claims data for 1990 of 6,476 risk HMO enrollees and 6,381 fee-for-service beneficiaries remains the most comprehensive and influential study of selection. They found that in the year prior to enrolling, HMO enrollees’ health costs were 23 percent lower than those of fee-for-service beneficiaries, and they were about 25 percent less likely to have had certain high-cost hospitalizations that are associated with subsequent higher spending. The average predicted AAPCC for the HMO enrollees was estimated to be 11.3 percent higher than their average predicted cost of care using a richer set of explanatory variables.

The implication of these findings was that Medicare capitation payments, at 95 percent of the AAPCC, were 5.7 percent higher than the counterfactual fee-for-service cost would have been. The Physician Payment Review Commission (PPRC), analyzing fee-for-service spending from 1989 to 1994 during the six months prior to enrollment for a 5 percent sample of HMO enrollees, found even larger effects: pre-enrollment spending for HMO enrollees was 37 percent lower than spending for beneficiaries who remained in fee-for-service (PPRC 1996).

⁷ Earlier research found some HMOs where mortality rates were inconsistent with other indicators of selection bias. For example, Langwell and Hadley 1989 mention one HMO whose Medicare enrollees had higher prior reimbursements but lower mortality than comparable fee-for-service beneficiaries. However, this HMO’s enrollees had high service utilization, suggesting that mortality rates were not an accurate reflection of biased selection in this case. See also Kasper et al. 1988, and Porell and Turner 1990.

⁸ Approximately 5 percent of Medicare beneficiaries die each year, and last-year-of-life care for these decedents accounts for approximately 28 percent of total Medicare expenditures (Riley, Lubitz, and Rabey 1991; Langwell and Hadley 1989). Thus, decedents have a weight of 5.6, and survivors have a weight of 0.758. In fee-for-service, the overall weight is $(0.05*5.6) + (.95*.758) = 1.0$. If the HMO mortality rate is 25 percent lower, then the HMO overall weight is $(0.0375*5.6) + (.9625*.758) = .943$. While in theory lower mortality rates among HMO enrollees may be endogenous, resulting from higher-quality care, in practice it seems likely that almost all of the observed difference in mortality between HMO and fee-for-service beneficiaries is a result of selection effects.

⁹ Eggers and Prihoda 1982; Porell and Turner 1990; Lichtenstein et al. 1991; Brown et al. 1993; Dowd et al. 1994; and Physician Payment Review Commission 1996.

There are some contrary data and opinions on whether HMOs have favorable selection. There is evidence that “some HMOs have experienced adverse selection:”¹⁰ for example, Brown et al. (1993) found adverse enrollment in 1 of 17 plans studied, and inconclusive evidence for 2 others. Analysis commissioned by the HMO industry questions whether favorable selection persists as HMO enrollees age and the risk-contract market grows and matures.¹¹ Rodgers and Smith (1996) find mixed evidence of selection bias using the 1992 (round 4) MCBS: their sample of 371 HMO enrollees included more younger and healthy people, but also higher proportions of chronically ill and lower-income Medicare beneficiaries than a carefully matched fee-for-service group. They calculated that these selection effects canceled out to make overall average costs about the same in fee-for-service as in HMOs (after controlling for demographic factors in the AAPCC). However, these conclusions are undermined by small sample size and other sampling and methodological problems.¹² Moreover, Riley, Feuer, and Lubitz (1996) used comparable and more recent data from the 1994 (round 10) MCBS and estimated HMO enrollee costs as only 0.85 of the predicted costs of fee-for-service beneficiaries. The HMO sample had better self-reported and functional health status, and lower prevalence of chronic conditions (although only the result for chronic heart disease was statistically significant).

These results on risk selection primarily reflect selection in markets with relatively low levels of Medicare HMO penetration. However, the PPRC (1996) analysis found that favorable selection among new enrollees was just as strong in markets with relatively high Medicare penetration (25 percent or more of beneficiaries in HMOs) as in markets with low HMO penetration. Similarly, recent testimony from the U.S. General Accounting Office suggests that even in the more mature California market, where close to 50 percent of Medicare beneficiaries in some counties are enrolled in HMOs, substantial risk selection continues to exist among new enrollees.¹³ As discussed below, some theoretical evidence may suggest that the extent of selection will be somewhat reduced as the Medicare HMO market matures. However, strong evidence suggests that substantial risk selection will take place even in relatively mature markets unless HCFA implements strategies to limit it.

¹⁰ Physician Payment Review Commission 1995.

¹¹ The best study arguing against the consensus on favorable persistent risk selection is by Rodgers and Smith (1996) of Price Waterhouse, commissioned by the American Association of Health Plans.

¹² An “Issues Brief of the Center for Studying Health System Change” (November 1996) notes that the sample is very small—only 371 HMO enrollees. It was not designed to be representative of HMO risk contract enrollees; and it could be biased because it excludes people who died during the first nine months of the study period and does not capture the effects of switching between HMOs and fee-for-service. A U.S. Congressional Budget Office memorandum (July 17, 1996) is cited that argues that adjusting for these biases could more than quadruple the estimate of favorable selection in the Rodgers and Smith study.

¹³ Testimony by W. Scanlon on February 25, 1997, reported in U.S. General Accounting Office 1997.

The financial imperatives to obtain a favorable selection of risks (relative to the capitation) that threaten the quality of care are of greater concern than the financial implications of risk selection. Less has been published on this topic, and the evidence comparing health-care quality and outcomes between fee-for-service and HMOs is mixed. A variety of studies find that beneficiary satisfaction is similar in HMOs and fee-for-service, and that quality of care and outcomes for average beneficiaries is also similar.¹⁴

Results are not so positive, however, for beneficiaries most in need. Ware et al. 1996, for instance, found that health outcomes of elderly patients worsened under managed care compared to fee-for-service. Much more work is needed here, but the available evidence justifies a theoretical concern: HMOs, in the current environment, are not rewarded for excellence in providing care to the chronically ill. Many HMOs have responded to these adverse incentives as we would expect, and have not worked hard to develop systems of care that are responsive to those most in need.

In summary, the overwhelming evidence is that HMOs, on average, enjoy favorable selection, which has resulted in Medicare paying them more than the enrollees would have cost had they remained in fee-for-service. Enrollment data show that the most vulnerable subgroups—the elderly, the disabled, and the chronically ill—are less likely to join HMOs than are other Medicare beneficiaries. It is less clear whether the most needy are poorly served in Medicare HMOs, but some evidence suggests that they are.

In order to assure that rapidly growing Medicare HMO enrollment promotes the development of high-quality care for those most in need, the policy problems of risk selection and the dynamics that create it require solutions. Without them, HMO enrollment growth will undermine one of the great strengths of Medicare: its ability to spread risks across a large pool, treating all 37 million beneficiaries alike, and avoiding the costs of underwriting and differentiating risks.

HOW AND WHY RISK SELECTION OCCURS

Understanding how and why risk selection occurs is important in determining which policies may be effective in solving the problem. It is well known that among almost any group of people, approximately 20 percent can be expected to account for 80 percent of group expenditures. Some people need a lot of care; most need little or none. This gives plans a strong incentive to try to attract the healthy majority and avoid the sickest people. Selection bias can arise from deliberate or inadvertent actions by health plans, as well as from patterns of consumer choice. It can occur both at the time of enrollment, if the beneficiaries who join

¹⁴ Dubow (1996) in the Institute of Medicine study provides a good recent literature review. She cites the following studies of Medicare beneficiaries: Clement et al. (1994) found no significant outcome differences for Medicare HMO and fee-for-service beneficiaries with chest pain or joint pain on three of four measures, the exception being that HMO enrollees had less symptomatic improvement of joint pain. Carlisle et al. 1992 found no mortality differences for HMO and Medicare fee-for-service patients who had been hospitalized with acute myocardial infarction.

a plan have health care needs that are different from the group average, and at disenrollment, if those who leave a plan are different from the group average. It is important when evaluating potential policy responses to think of these mechanisms separately.

Selection at Enrollment

Beneficiary Preferences

In deciding whether to enroll in an HMO, beneficiaries weigh costs, benefits, and access to particular providers and facilities. They balance the potential for saving money, reducing paperwork, and having all care coordinated through one set of providers against the loss of freedom to choose their provider and concerns about lack of access to needed care (or increased hassles in obtaining this care). Consumer choice will cause risk selection if HMOs intrinsically appeal more to healthier people.

The main incentive for beneficiaries to join an HMO is to save money;¹⁵ in some areas of the country, HMOs offer a package of supplemental benefits for zero premium that might cost \$1,000 or more per year if purchased as a Medigap policy. The relationship between health status and financial benefit from joining an HMO is different for those with and without supplementary insurance. Among beneficiaries currently in fee-for-service Medicare with Medigap policies who are deciding whether to switch to an HMO, the financial benefit to joining an HMO is similar whether they are in good or poor health.¹⁶ However, for people choosing between fee-for-service Medicare without supplemental coverage and an HMO, the potential savings from joining a zero-premium HMO increase as health status deteriorates, because of the potentially large co-payments, deductibles, and uncovered services in fee-for-service.

The main disincentives to enrolling in an HMO are loss of freedom to choose a provider; obstacles that may be placed in the way of obtaining medically necessary care; and the potential denial of coverage for care that might have been paid for in fee-for-service. These considerations are much more important to those with high health care needs or risks. Sicker people tend to have strong established relationships with health care providers (especially their physicians), which they are reluctant to give up. A required switch to unfamiliar new providers is a strong deterrent to enrolling in an HMO (Berki and Ashcroft 1980; Wells, Marquis, and Hosek 1991; Billi et al. 1993). The greater a person's health care needs, the

¹⁵ Two other advantages of joining an HMO—better coordination of care and reduced paperwork—do increase as people get sicker, but they are minor compared with the monetary incentive. These were not mentioned among the most commonly cited reasons for joining plans in a recent survey of enrollees (Physician Payment Review Commission and Mathematica 1996), although the reduced burden of paperwork has been mentioned by respondents in other surveys cited by Dubow in Institute of Medicine 1996, p. 213.

¹⁶ This is true for beneficiaries whose Medigap policy has similar coverage to the supplemental benefits that the HMO offers.

greater the number of physicians who may be providing care, and the less likely that all physicians will be in a single HMO. Even if a particular HMO does include all the physicians, beneficiaries may worry that the HMO utilization-review process will make it hard for them to get the care they need, and the weight of these concerns is likely to increase as the expected need for care increases.

For beneficiaries with a Medigap policy, the drawbacks of managed care are higher for those with heavier needs, while the monetary benefits of joining do not differ for the healthy and the sick. Thus, it makes sense to expect that those with heavier needs are less likely to join an HMO than beneficiaries with fewer health care needs. For the 11 percent of beneficiaries without supplemental coverage, both the costs and benefits of joining an HMO are expected to be greater for beneficiaries with heavy needs; the net expected effect on the direction and extent of selection bias for these beneficiaries is ambiguous.^{17,18}

Since most beneficiaries do have supplemental coverage, we would expect favorable selection to HMOs from beneficiary enrollment decisions even if HMOs were trying as hard as possible to provide excellent care to those most in need. However, we have created a system in which it is not reasonable to expect plans to strive for excellence in the care of the chronically ill, and so the expected selection effects from consumer preferences will only be aggravated by HMO actions.

Actions by Plans

Attempting to attract a healthier, lower-risk group and to avoid an adverse selection of risk is sound business practice in a competitive managed-care market in which payments are not adjusted for enrollee health status. HMOs could use a variety of strategies to influence enrollment decisions: marketing to the healthy; tailoring benefit packages to attract low-risk people; designing provider networks to minimize involvement of the specialists who treat costly conditions; limiting service availability in very low income areas; requiring prior approvals that increase the “hassle factor” the most for those who use the most health care; and implementing utilization-review processes that target services, such as home health care and durable medical equipment, that are heavily used by the chronically ill. Although HCFA tries to prevent skimming by plans through its review process when an HMO applies for a risk contract, and through subsequent review and approval of marketing materials, HMOs still have many opportunities to influence the composition of their enrollment. There are

¹⁷ Analysis of the Medicare Current Beneficiary Survey shows that 11 percent of the community-based elderly do not have either Medicaid or private supplemental coverage (Chulis et al. 1995); however, the Current Population Survey finds 22 percent without supplemental coverage (Ways and Means Committee, Green Book), and the National Health Interview Survey finds 25 percent without supplemental coverage (CBO 1997). It is not clear why the CBS results are so different from the CPS and NHIS results.

many anecdotes about plan strategic behavior, most focused on marketing practices, but little systematic study. Thus, although there is much opportunity for plans to take actions to influence selection, we emphasize that there is relatively little evidence about the extent to which plans systematically engage in these actions.

Marketing

Both generic marketing strategies and specific enrollment techniques can be used to influence selection: the generic aim marketing materials at the healthy; the specific seek out healthy people and try to avoid the sick or disabled. Marketing opportunities to appeal to selected target groups remain despite HCFA reviews of all HMO marketing activities and rules intended to ensure that no groups of Medicare beneficiaries are systematically excluded or differentially courted. Pictures of active, healthy seniors in media advertisements might give the message to those who are sick that the HMO is not for them. We have seen many TV and print ads for Medicare senior products showing beneficiaries playing golf, or strolling hand in hand on a tranquil riverbank. We have seen few depicting victims of quadriplegia, heart attack, or stroke. Few advertisements trumpet an HMO as the best place to be if you are really sick. However, a study in 1987–89 of the marketing activities of 22 HMOs (including review of materials and interviews with HMO staff) concluded that it was unlikely that there was any systematic marketing or market segmentation responsible for the favorable risk selection that was found.¹⁹

There are hardly any marketing materials targeted at the under-65 Medicare disabled, and many Medicare products have names suggesting that the under-65 are not welcome: Health 65, 65 Plus, Secure Horizons, Senior Advantage, Senior Care, Senior Choice, Senior Plan, Senior Plus. The under-65 disabled are seriously underrepresented in HMOs.²⁰ Because the AAPCC adjusts for age (and thus, implicitly, for disability status), this is not, in itself, evidence of favorable selection (remember that selection is defined relative to the group upon which capitation rates are based), but does indicate a general tendency.

In addition to generic methods of attracting the fit and discouraging the sick, if plans are given the opportunity, they could subtly (or not so subtly) discourage enrollment of sick beneficiaries. Although HMOs are prohibited by Medicare from health screening, there have been reports of them providing potential enrollees with physical examinations one month before enrollment (billed to Medicare under fee-for-service), which is strongly suggestive of screening (General Accounting Office report on Florida, cited in Porell and Turner 1990). An

¹⁸ In the CBS data, approximately one-third of low-income beneficiaries do not have supplemental coverage; for these beneficiaries, in particular, those who are sick may be more attracted to HMOs than those who are healthy.

¹⁹ Lichtenstein et al. 1992.

²⁰ Only 4 percent of the Medicare disabled are enrolled in HMOs, compared to 12 percent of the over-65 beneficiaries. Given that approximately 50 percent of Medicare disabled also have Medicaid, perhaps a fairer comparison is among the disabled without Medicare. Even there, 4 percent penetration is well under the overall Medicare average.

HHS survey of nearly 3,000 Medicare beneficiaries in 1993 found “serious problems with enrollment procedures and service access”: 43 percent were asked about their health status when applying to a HMO, and 3 percent were required to have a physical before joining. The report did not cite direct contravention of the regulation, but noted that the survey suggests “the possibility of health screening and selective enrollment.”²¹ For many of the sick and chronically ill, subtle health-screening tools are not needed: a face-to-face meeting with a marketer would be enough to identify elevated levels of need. We would want marketers to present both pros and cons of joining; slight shading of the pros and cons when presenting to a person who is sick might be enough to create substantial selection effects.

HCFA discourages but does not prohibit marketing by providers, and in any case, providers are likely to be asked their advice and opinions about alternative health care options. Physicians are in a very powerful position to influence choice, and have extensive information on their patients’ health status. If providers participate in several plans or both fee-for-service Medicare and HMOs, maximizing their own compensation would likely mean steering high users to fee-for-service and healthier patients to HMOs. And even if they are acting entirely in their patients’ best interests, they may “advise patients with multi-system problems to avoid plans with limited choice of specialists” (Merlis et al. 1997) or believe that higher-risk patients will be better cared for under fee-for-service.

Benefits

Plans could tailor benefits to attract the healthy or deter the sick. For example, they could provide a broad array of preventive care and relatively little coverage of prescription drugs or long-term care. The medical director of one large health plan wrote that changes in its benefit packages had “been designed to attract and keep healthy people within the pool of the insured.”²² Discouraging unhealthy enrollees is a corollary of attracting healthy ones. One HMO trade publication carried an article explicitly recommending that health plans identify characteristics in groups that produce losses and reposition their products to discourage those people from enrolling.²³

However, coverage limitations in the basic Medicare benefit package and fierce competition among Medicare HMOs in many markets have led to HMO benefit offerings that, relative to fee-for-service, should be attractive to those in greater need. Many HMOs offer supplemental benefits, particularly prescription drug coverage, that should be attractive to high users. Further, in the markets with the highest Medicare HMO enrollment, competitive pressures have created an environment in which most plans offer similar supplemental benefits packages. In these markets, HMOs frequently tinker with benefits

²¹ *Modern Healthcare*, March 20, 1995.

²² Maurer 1990, p. 50.

²³ Edres and Gunter, in *Insurance Executive Reports* (New York: Ernst and Young), cited in Newhouse 1994.

packages as they jockey with one other for market share; for example, if one HMO improves its dental benefits, others in the area are likely to follow suit quickly. There is little direct evidence in this behavior of tailoring packages to make them less attractive to the chronically ill.

Indirect evidence of benefit package tailoring can be seen in the types of policies that are not offered at all. For example, most beneficiaries in HMOs have prescription drug coverage, usually up to a maximum of some amount (e.g., \$1,500 per year) after a relatively small deductible. We are not aware of any HMOs that offer an actuarially equivalent policy that has a very high deductible for prescription drugs (e.g., \$2,000 per year), but then pays for most of the costs beyond the deductible level. Given a hypothesis of risk-aversion among beneficiaries, a high-deductible catastrophic policy should be more attractive than an actuarially equivalent policy that leaves beneficiaries with unlimited exposure to catastrophic expenses. The absence of catastrophic policies may reflect HMO judgment about beneficiary myopia, but more likely reflects concerns about unfavorable risk selection. Similarly, many beneficiaries might prefer coverage of additional home health care services to an actuarially equivalent policy that covers preventive services, but concerns about adverse selection are, we suspect, part of the reason that such policies are not available.

In addition to concerns about the potential to tailor benefit packages to avoid people most in need of care, another concern is raised by the diversity of benefit packages: namely, that a plethora of choices is confusing to beneficiaries. It is difficult for beneficiaries to gather and assess information about their HMO choices in many markets. There are now some efforts to compile side-by-side comparison charts of HMOs, but even where these exist, they are not widely distributed and most beneficiaries do not know about them. Beneficiaries thinking about joining an HMO would have to know that they could call a toll-free number or an Independence, Counseling, and Assistance program to get a list of available HMOs in their area. Then they would have to call each HMO to request information. One of the authors attempted this for the San Diego and Los Angeles areas. It took at least two hours of phone calls, and then only about half of the information packages promised actually arrived. Those plans that did arrive were difficult to compare because formats, terminology, and level of detail are not standardized.²⁴ Older adults find it more difficult than younger people to process and assimilate unfamiliar, difficult material, and many Medicare beneficiaries are hampered by physical or mental frailty or poor vision or hearing.²⁵ Some beneficiaries will need written materials to be in a large typeface, or pitched at a sixth-grade reading level. The information problem is proportional to the number of plans on offer, differing in benefits,

²⁴ The GAO conducted a similar exercise in 1996 (see U.S. General Accounting Office, October 1996). It received information from only 10 of 14 HMOs, even after follow-up calls. The report shows an 8-inch stack of documents from the HMOs, which cover an entire wall, distilled into a 3-page side-by-side benefit comparison sheet compiled by HCFA.

²⁵ Institute of Medicine (1996) reports research results on Medicare beneficiary information needs, both content and form.

exclusions, and rules. The frailest and sickest may have the most difficulty gathering, comparing, and processing information. And since it is those with greatest need who are likely to be most reluctant to leave fee-for-service to begin with, high information cost is likely to have more effect on the decisions of the sick than on the decisions of the healthy.

Access to Care: Provider Networks and Facilities and Utilization-Review Practices

The composition of a plan's provider network and the places where that care is provided can have a powerful effect on who enrolls. Plans can avoid the providers who specialize in treating costly conditions.²⁶ They can avoid providers practicing in low-income areas, where the burden of illness is likely to be higher. They can recruit newly trained specialists with limited patient following rather than more experienced specialists who may bring with them large numbers of patients in need of specialized (expensive) care. Evidence of plans tailoring their networks to avoid high-risk members is limited. Academic health centers, inner-city physicians, and the occasional highly visible specialist complain about difficulty in joining HMO networks, but it is not clear whether there is a systematic problem that needs an aggressive solution.

We have stronger evidence that the barriers that HMOs set up to limit care disproportionately affect the choices made by the chronically ill and those most in need. If, for example, a primary care physician referral to a specialist needs to be re-authorized after every three visits to the specialist, then an extra hurdle is created for the chronically ill. There is strong evidence that HMOs provide much less home health care than recipients receive in fee-for-service, and that health outcomes suffer as a result.²⁷ Although a similar study of durable medical equipment (DME) has not been performed, we would not be surprised to find sharp reductions in access to DME in HMOs as well. Conversely, there are relatively few examples of HMOs making large investments in developing systems of care that are especially responsive to those most in need. Determining what to do about these problems is difficult—we turn to HMOs in an attempt to get better value for money, and this means that we expect that some services that are provided in fee-for-service will not be provided in HMOs. We want the services that are eliminated, however, to be those that do not improve beneficiary quality of life; there is some evidence that some of the services HMOs eliminate result in poorer outcomes, particularly for those most in need. We will return to this problem when we consider credentialing of health plans.

Risk Selection at Disenrollment

²⁶ Influence of provider networks can be seen in Kronick (forthcoming), which shows that an HMO in Colorado serving Medicaid patients that had contracted with a university hospital and a children's hospital had a massively adverse selection of recipients.

²⁷ Shaughnessey, Schlenker, and Hittle 1994. See also Physician Payment Review Commission 1996.

Risk selection can occur not only because those beneficiaries who enroll in HMOs are different from beneficiaries who do not enroll, but also because those who disenroll are different from those who remain.

On average, 2.8 percent of Medicare beneficiaries who were enrolled in an HMO for at least two months between March 1, 1995, and March 1, 1996, disenrolled and returned to fee-for-service by March 1, 1996, and an additional 4.7 percent switched from one HMO to another during this period.²⁸

This relatively small volume of voluntary disenrollment reflects a relatively high level of satisfaction with HMOs among the enrolled beneficiaries, and suggests, at first blush, that disenrollment is not likely to be a big source of concern. However, closer consideration suggests otherwise. The MPR survey shows that disenrollees are more likely to be in poor health than continuous enrollees (13.8 percent in poor health among disenrollees, compared to 3.9 percent among continuous enrollees), and much more likely to be dependent in one or more activities of daily living (13.3 percent needing help with

²⁸ Physician Payment Review Commission 1996. Nearly 20 percent of the disenrollment to fee-for-service was involuntary, most commonly because the beneficiary moved out of the plan service area. This leaves approximately 2 percent of HMO enrollees who choose to return to fee-for-service each year.

bathing, compared to 6.3 percent among continuous enrollees). These data are consistent in direction with other studies of disenrollees that have found that they tend to be significantly higher-risk than those who remain, measuring disability and health status, utilization, risk factors, mortality, and functional impairment.²⁹ Hogan and Cox (1996) found that spending in the six months after disenrolling from an HMO was 60 percent higher than for those in fee-for-service, and 42 percent higher when adjusted for factors included in the AAPCC.³⁰ If disenrollees have 42 percent higher expenditures than continuous enrollees, and comprise 3 percent of total enrollment, then selective disenrollment would improve the HMO case mix, relative to the capitation payments, by approximately 1.5 percent per year. Other things being equal, selective disenrollment of this magnitude would increase HMO profits by 1.5 percent per year. Over a period of a few years, this would clearly be a significant contributor to risk selection.

Consumer Preferences

Consumer preferences, unmediated by plan actions, are likely to have a mixed selection effect on disenrollment. Health plan enrollees who are sicker have more opportunities to “test” and be dissatisfied with the HMO, and thus may be more likely to disenroll. Similarly, enrollees with greater needs for care may be more likely to want care from a provider not in the HMO, and thus more likely to disenroll. However, the sick will also be using more health care, and should be forming stronger attachments to providers, as well as benefiting more from coordination and reduced paperwork, which should make beneficiaries more likely to stay enrolled when sick. Certainly the sick should be less likely than the healthy to switch to another HMO for a lower premium. But if the plan does not perform well, high-use beneficiaries will become dissatisfied more quickly and will be more likely to return to fee-for-service. There is a clear difference between the consumer-preference-selection effects at enrollment and disenrollment: disenrollment is likely to be selective of the sick only if the HMO performs poorly; but sick people are less likely to enroll in an HMO, almost regardless of how welcoming the plan is to them, because those who are already sick are more likely to have to change provider relationships or fear intrusive utilization review.

Plan Actions

If plan enrollees who are heavy service users receive systematically less attention or poorer care, or must contend with onerous grievance processes, this may cause substantial selective disenrollment, as those most in need of care disproportionately leave. Selective disenrollment is a potentially powerful device for selection, because enrollees’ health status is generally known to the plan and high-risk individuals can be targeted directly. There is no documented evidence of HMOs deliberately encouraging high-risk people to disenroll, but a

²⁹ Rossiter et al. 1989; Tucker and Langwell 1988; Langwell and Hadley 1989; Riley, Rabey, and Kasper 1989; Adams and Tyler 1995.

³⁰ “Risk Selection and Risk Adjustment in Medicare,” chap. 15 in Physician Payment Review Commission 1996. Some of this differential may reflect “pent-up” need for care that was denied by the HMO, but it surely also indicates substantial adverse selection of disenrollees.

number of standard HMO practices can be expected to selectively affect high users. A HICAP study of disenrollees from HMOs in Los Angeles (1992) found numerous examples of egregious practice, including denying or delaying care or services, until beneficiaries opted out of the HMO, sometimes as a last resort.

LIMITS ON HMO INCENTIVES TO SELECT RISKS

We have discussed a variety of actions that HMOs might take to influence the composition of their enrollment. But there are also forces that restrain plans from acting aggressively to improve their mix of risks:

- the marketing department may want to enroll as many beneficiaries as possible;³¹
- even if plans are relatively subtle about dissuading sick beneficiaries from enrolling, or encouraging the sick to disenroll, there is the chance that HCFA or the press might find out, and the threat of bad publicity or sanctions is serious;
- if a plan does not include hospitals with good reputations, it may have trouble attracting the healthy as well as the sick;
- if a plan consistently makes it hard for beneficiaries in need to obtain needed care, and beneficiaries are aware of this, then it will have a hard time persuading both the healthy and the sick to enroll; while those in need may be even less likely than the relatively healthy to enroll—leading to a favorable selection—if overall enrollment is low, a plan will not do well even with favorable selection;
- the culture of a successful organization is one that does a good job of serving its customers; it may be hard to run a well-functioning medical group or HMO if there is a countercurrent in the organization that doing an excellent job of serving those most in need is not part of the organization's mission;
- concerns about medical liability require HMOs to provide services that are “medically necessary” (defined by a community standard of care);
- most physicians, providers, and health plan administrators are professionals who want to do a good job of taking care of people.

Each of these factors will act as a partial restraint against the financial incentives that HMOs face to attempt to enroll a favorable selection of risks. In the current environment, however, the restraining influences are not enough to overcome fully the financial incentives. HCFA's task is to increase the power of the restraining influences.

RISK SELECTION IN MATURE MARKETS

The extent to which favorable selection is likely to persist in more mature HMO markets is uncertain, but it seems likely that even in relatively mature markets HMOs will receive a favorable selection of Medicare beneficiaries under current HCFA policy. Two factors reduce selection effects in markets in which HMO penetration is higher and in which larger numbers of beneficiaries have been enrolled for longer periods of time. First, beneficiaries who enroll in HMOs when they have particularly low utilization will have their expected health care needs increase over time.³² Second, when larger numbers of beneficiaries have enrolled in plans, if some enrollees with heavy care needs are well served in HMOs, word of this is likely to spread, and those with heavy care needs may be more likely to enroll than when penetration is low.³³ However, even at 40, 50, or 60 percent HMO penetration, it is likely, under current rules, that there would still be substantial differences in health status between enrollees and beneficiaries in fee-for-service: greater consumer preferences for HMOs among the healthy than among the sick, and the financial imperative that plans avoid an adverse risk mix while taking action to influence enrollment composition, suggest a continuation of favorable selection even in mature markets. Recent GAO testimony on the extent of risk selection in high-penetration counties in California provides some support for this expectation, although it should be noted that even in the counties with high penetration most of the HMO enrollment is quite recent.³⁴

³¹ Merlis et al. 1997 provide a good discussion of the tension between plan marketers and actuaries.

³² This “regression toward the mean” effect has been discussed by Welch 1985. An individual with expected annual expenditures of \$2,500 is more likely to enroll in an HMO following a good year, in which actual expenditures were only \$1,000, than following a bad year with expenditures of \$5,000 (because of the “attachment to physicians” arguments made above). The individual’s expected expenditures in the first year following enrollment might be \$1,800, but a few years later will be \$2,500. The extent of favorable selection decreases over time. However, if the individuals who do enroll are inherently healthier than those who do not, even after many years of enrollment, there will remain health status differences between the two groups: individuals regress toward their own mean, not toward the mean of a demographically defined group.

³³ Lichtenstein et al. (1992) hypothesize that the “favorable and stable image within the Medicare population” was responsible for the tendency of HMOs that had participated in risk contracts for longer to be less likely to show favorable enrollment than HMOs who were newer to the Medicare market. Their sample was only 22 plans.

³⁴ Scanlon testimony on February 25, 1997; see U.S. General Accounting Office 1997.

PART 3: POLICY RESPONSE TO RISK SELECTION

It is clear that in the current environment, health plans have both strong financial incentives to enroll a favorable selection of risks and a variety of strategies available to influence the composition of their enrollment. The weight of available evidence suggests that, whether as a result of health plan strategy or of innate consumer preferences, HMOs have received a favorable selection of risks. Given the current HMO payment policy, favorable selection costs the Medicare program money. Of even greater concern, the dynamics that lead to favorable selection also threaten the quality of care that HMOs offer to enrollees most in need of care. In the current environment, HMOs would be punished for doing what we would like them to do: organize the delivery system to provide high-quality care to those most in need of services.

WHAT SHOULD HCFA DO ABOUT RISK SELECTION?

The most powerful single tool to reduce the incentive to HMOs to avoid those most in need of care is to change the HMO payment system to pay more to plans that attract beneficiaries with greater needs. Although we don't know how to do this perfectly, we know how to do much better than the AAPCC in accomplishing this goal, and we should implement what we know. The final section of this paper will briefly discuss some of the main issues in the implementation of health-based payment systems (known more commonly as risk-adjusted payment).

Health-based payment is necessary, but not sufficient, to solve the problems created by risk selection. Available health-based payment systems would differentiate among groups of enrollees with particular health problems or health status, but pay the same for everyone within a particular risk or health/illness-status group. No group would be homogeneous, so there would still be an incentive to selectively enroll (and disenroll) some members of any risk group.

Imagine a group of beneficiaries, each of whom has congestive heart failure, diabetes, and arthritis. Then imagine that an HMO receives an identical payment for each enrolled member of the group. The plan will still be able to profit if it can somehow attract those beneficiaries who need less care than the average member of the group. However, it will be much more difficult for an HMO to figure out how to attract relatively low-need persons with CHF, diabetes, and arthritis while avoiding high-need beneficiaries who have all three of these problems than to avoid high-risk people altogether. HCFA can and should implement a variety of other strategies that will make it harder for plans to avoid the high-risk members of a particular risk group, and that will decrease the extent to which beneficiaries with high risk will want to stay away from plans.

A variety of actions in addition to health-based payment is needed to capture the potential financial and health care benefits of managed care for all Medicare beneficiaries, including the sickest. This paper discusses five ways that the “choice environment” for Medicare beneficiaries could be improved and opportunities for risk selection reduced.

Coordinated Annual Open Enrollment

There are several problems with the present enrollment system:

- a dearth of clear, unbiased, comparative information on options within the Medicare program;
- different rules regarding guaranteed issue, preexisting-condition exclusions, and premium-rating practices for HMOs and Medigap insurers that inhibit competition between these two parts of the Medicare market and leave beneficiaries (especially sicker ones) who want to try managed care at risk of being unable to get their Medigap policies back if they change their minds later; and
- because marketing and enrollment are carried out by plans themselves (or their agents), beneficiaries are presented with limited and selected information and are vulnerable to not having their best interests served.

The two most glaring needs are guaranteed open enrollment in Medigap policies as well as HMOs at least once a year; and timely, comprehensive, clear, and unbiased information that would be widely available to all Medicare beneficiaries, to facilitate well-informed choices between managed care and traditional fee-for-service Medicare, and among competing HMOs and Medigap insurers.

All Medicare beneficiaries have guaranteed open enrollment to Medigap policies for six months when they first become eligible for Medicare (although insurers may impose up to six-month restrictions on claims for preexisting conditions). After this one-time window of opportunity, insurers may (and do) refuse coverage at will. Disabled or chronically ill people may find it difficult to get coverage except perhaps from insurers offering the richest and most expensive packages. Annual open enrollment would make it less risky for beneficiaries to try managed care, and would help unify the two parts of the Medicare market.

Information on HMOs and Medigap coverage is currently difficult to assemble and compare, and many beneficiaries do not even know that HMO coverage is available in their area. Recent efforts by HCFA and ICAs in some areas to compile good side-by-side comparison charts about HMO plans are an excellent beginning, but these are not available for all regions, and not widely distributed. There is nothing comparable for Medigap policies, which are standardized by benefits, but may differ in the way premiums are calculated, and in

the costs. Most beneficiaries get little help in comparing available plans and Medigap policies, and there is virtually no information available about insurer performance. Since the main information sources are individual companies and their agents, there is too much opportunity for subtle (or blatant) filtering or shading of information, despite HCFA monitoring of marketing materials.

These problems could be addressed by an annual period of open coordinated enrollment with the following features:

- once a year, coordinated open guaranteed enrollment in Medicare HMOs and Medigap policies, with enrollment during the rest of the year at the insurer's discretion;
- coordinated with the open enrollment, wide distribution to beneficiaries of clear, unbiased information comparing all HMO and Medigap plans available to them;
- an independent broker whose role is to provide the necessary information, answer questions, and process enrollment for HMOs, at least as a second process for enrolling in addition to dealing directly with plans;
- a common premium-rating system for HMOs and Medigap insurers;
- enrollment at times other than the "open" month allowed for people whose current insurer goes out of business, who move out of their insurer's area, or whose employer or former employer terminates health insurance coverage.

Vested interests would be threatened by these changes. Many HMOs will resist losing direct control over the marketing and enrollment process. Medigap insurers will resist losing their right to refuse coverage and to choose how to set their premiums, and being put into more direct competition with HMOs. Medigap insurers might expect to lose market share to HMOs. At first glance, requiring Medigap to guarantee enrollment at least once per year might seem likely to increase adverse selection against Medigap policies, by increasing access to such policies by the sick. But since most of the sick already have such policies, the actual effect might well be the reverse: namely, to give peace of mind to the sick who want to join an HMO that they will be able to regain their Medigap coverage if they discover that they are dissatisfied with managed care. If political considerations were to dictate a second-best system of coordinated open enrollment for HMOs only, many advantages would be lost. However, the provision of timely, unbiased comparative information would still be greatly worthwhile.

The proposed system (including HMOs and Medigap insurers) should reduce favorable risk selection to HMOs for several reasons:

- to the extent that plans perform well and their enrollees are satisfied with the care they receive, word of mouth will increase HMO enrollment and make sicker people more willing to join;
- especially for low-income people without supplementary insurance, learning of the existence of HMOs in their area might make them consider managed care for the first time, especially if zero or low premium plans were available. Sicker people would especially stand to benefit from enrolling in an HMO;
- Medigap policy holders who see price/benefit comparisons with substantially cheaper managed care plans, perhaps even ones offering a richer benefit package, might well switch to HMOs. Even if their established provider relationships continue to make sicker people more reluctant to change, the switchers may well be a less favorably selected group than present HMO enrollees;
- sicker people who currently are unwilling to risk being denied Medigap coverage in the future if they give it up now would at least have the reassurance of knowing they could regain their coverage during the next annual open enrollment period. At worst, they would be “locked in” to the HMO for a year; alternatively, new enrollment rules might include a 90-day “free look” period, during which switchers could revert to their previous coverage without penalty.

A decision would need to be made whether to continue to allow people to disenroll from HMOs whenever they wish. Allowing disenrollment only during the “open” month (or when forced by geographic relocations or other circumstances) would further reduce risk selection, but it is not clear by how much. The risk-selection benefits of an annual lock-in are probably not great enough to confront the strong consensus that disenrollment should remain a basic right of Medicare beneficiaries and should provide a mechanism to safeguard against poor-quality care or access problems.

Many of the third-party information and enrollment functions suggested here were included in the proposed Denver Competitive Bidding Demonstration, with costs estimated at about \$12 per beneficiary per year. If costs were similar for a national effort, for 37 million beneficiaries this would amount to about \$450 million per year. This would be vastly more than the present level of funding for ICA activities of \$10 million in federal funds, with states about matching that amount, but would be only one-quarter of 1 percent of total Medicare

expenditures.³⁵ Risk selection is costly to HCFA, and if coordinated open enrollment reduces favorable selection to HMOs, it could potentially easily pay for itself, as well as increasing quality and access for those beneficiaries most in need.

Presenting Information to Beneficiaries

There is research that points to the kinds of information that beneficiaries need and want, and optimal ways to deliver it. Information on the choices facing beneficiaries must be presented in the context of a basic explanation of how Medicare works, how managed care differs from fee-for-service, and the function of supplementary insurance. Focus group and survey research has revealed that beneficiaries give priority to comparative information on costs, coverage, and exclusions, and how different systems and plans operate. They want clear explanations of rules and procedures, especially with respect to choosing providers and gaining access to specialists, emergency, after-hours, and out-of-area care. Some information on plan performance would be valued, especially with regard to access to care and services and the interpersonal and technical skills of providers.

Most beneficiaries are interested primarily in information that is specifically relevant to them. In order to get this, it must be easy for them to seek more specific information than it would make sense to provide to everyone. Beneficiaries also want to know whether plans are approved by HCFA. Information also needs to be presented in ways that facilitate assessment and choice.

Information should be collected and disseminated on consumer satisfaction, health plan quality, and disenrollment rates, with reports focused on the experiences of the vulnerable (some of which HCFA is planning to do or has under way). It is important to publish this information together with similar measures on experiences in fee-for-service.

Publicizing this sort of information, particularly with respect to treatment of beneficiaries who are frail or have chronic conditions, should help reduce risk-selection problems for two reasons:

1. If HMOs in a market perform well on these measures, particularly for those who are most in need of care, knowledge of this performance is likely to encourage those with higher need to switch into plans, reducing the extent of favorable selection; and
2. Publicizing information on satisfaction and quality, particularly focused on the sick, should encourage HMOs to improve their performance, which will then further reduce selection bias. The extent to which HMOs will want to look good depends in part on successful implementation of health-based payment, and in part on questions about HMO and beneficiary choice behavior for which we do not have definitive

³⁵ Some economies of scale would be expected for a national effort.

answers. Although plans may not want to gain a reputation as being the best plan in town for beneficiaries who are really sick, they will also want to avoid getting a reputation as the worst. Even relatively healthy Medicare beneficiaries are more likely than younger persons to understand their own vulnerabilities, and are likely to be reluctant to enroll in a plan with a middling to poor rating on quality and access for those most in need. Given a desire to avoid being seen as a poorly performing plan and uncertainty about rankings, we would expect that better information to beneficiaries on the performance of plans in caring for the vulnerable would encourage plans to improve their performance.

Stronger Oversight of Marketing

Medicare plans are currently prohibited from door-to-door and other direct marketing to individuals unless invited, and HCFA reviews plan marketing material before it is distributed. The present focus of oversight is to ensure that beneficiaries are not enticed or induced unreasonably to join (enrollment gifts, for example, are prohibited). We make two additional fairly minor proposals to monitor whether plans are trying to discourage enrollment of high-risk beneficiaries, which could have a significant impact on risk selection. These are:

- adding to current oversight efforts of marketing materials through research using focus groups to understand what messages beneficiaries are absorbing and the impact of marketing on different types of beneficiaries—for example, comparing high- and low-risk people; and
- conducting periodic surveys of people who make contact with plan representatives but decide not to enroll, to understand their decisions and whether sicker people are being actively or subtly discouraged.

Additionally, HCFA should require that in their marketing materials, plans provide specific standardized information about benefits, costs, exclusions, and rules in a consistent format, and using specified terminology. This would greatly simplify comparison and facilitate compilation of comparative material.

If one believed that HMO marketing activities were a primary cause of favorable selection, there would be grounds for arguing that plans should be prohibited from marketing altogether, as some states have done for Medicaid. However, the evidence is insufficient. Some analysts propose federal standards and requirements for training and licensing of plan marketing employees, but we are not convinced that the cost would be justified by the benefits.³⁶

Benefits Package Diversity

If a beneficiary is choosing among HMOs that offer highly varied benefits packages, two kinds of problems are created. First, it is difficult for beneficiaries to make an informed choice among plans, since price differences may reflect variations in quality and efficiency as well as variations in covered benefits. Uncertainty about judging value will likely reduce the rewards to those provider groups that in fact are good at creating value. Second, allowing diversity in benefit packages invites plans to attempt to segment the market and select risks.

Many large employers require each HMO to offer virtually the same set of covered benefits, including the same co-payment structure. This facilitates comparison across plans, and is thought to have sharpened competition among HMOs and led to restraint in price growth. Private employers will typically have a different co-payment structure for their PPO option(s) than for their HMO options, but otherwise increasingly offer uniform benefits packages.

Although theoretically an option for HCFA as well, a uniform HMO benefits package is not likely to be a practical option in the short run. Consider, for example, the extent of prescription drug coverage. If HCFA mandated that all HMOs offer only one package to Medicare beneficiaries, and that package included prescription drug coverage at, for example, the level of Medigap policy J,³⁷ then in many areas of the country HMOs would need to charge a relatively high premium for this plan. This premium might price out of the HMO market low-income beneficiaries, who would be forced to stay in fee-for-service and pay co-payments and deductibles when they might prefer a lower-option HMO plan; further, it would discourage some from switching from Medigap policy C—which does not cover drugs—into the HMO, even when the HMO might be a better buy for them if it excluded drug coverage. Conversely, if the HCFA-mandated package did not include prescription drugs, then beneficiaries living in Southern California and other areas where drugs are included today in zero-premium plans would be worse off.

An alternative is to establish a limited and well-defined set of supplemental benefits packages that HMOs would be allowed to offer. The set of packages should be as close as possible to the set of Medigap supplements, to facilitate comparison between HMOs and Medigap. The set of packages could be established by HCFA, after consultation with beneficiaries, the HMOs serving Medicare beneficiaries, and the NAIC. This would leave the choice environment more confusing than the environment facing many of the privately insured, but substantially less chaotic than the current environment. If the supplemental benefits offered by HMOs were limited to a set of packages from a predetermined list, then beneficiaries would be able to compare prices more easily across plans, and more easily compare prices and benefits between HMOs and Medigap policies.

³⁶ Merlis et al. 1997.

³⁷ Option J covers 50 percent of the cost of prescription drugs after a \$250 deductible, up to an annual limit of \$3,000.

The main disadvantage of a prescribed list for supplemental benefits compared to the status quo is that it inhibits innovation and responsiveness to changes in consumer preferences: if an HMO were to figure out a new benefit that it wanted to offer and that beneficiaries might value highly, it would be prohibited from doing so. However, we have had a prescribed list of supplemental benefits for Medigap policies since 1990, and there is little evidence or suggestion that this has caused problems.

The disadvantage of a prescribed list compared to a single benefit package is the concern that risk-selection dynamics will cause the more generous packages on the list to be priced at well above their actuarial value if enrollment were unbiased. More sensitive health-based payment (as discussed below) will ameliorate this problem to some extent. Further, at least in areas of the country where the AAPCC is well above the amount that HMOs need to provide basic Medicare coverage, this will be a problem only for those benefit packages that are more expansive than the packages that efficient plans can offer for zero premium.

Additional Requirements to Assure that Plans Provide Good Care to Those Most in Need

A number of state Medicaid programs have established selection criteria for HMOs that seek to serve Medicaid recipients with disabilities that are designed to increase the likelihood that the plans will actually do a good job of serving those recipients most in need. These criteria include requirements in the following areas:

- HMOs must perform an initial assessment for all new enrollees to identify beneficiaries with chronic health problems;
- for all chronically ill enrollees, a plan of care must be produced (preferably by a multidisciplinary team) that should include discussion of anticipated needs for home health and durable medical equipment and consideration of the need for mental health services;
- a system must be in place for 24-hour telephone access to medical advice;
- HMOs must conduct (and report to the Medicaid agency) the results of a specified number (e.g., five) of quality-improvement initiatives each year; some of these might be in areas chosen by the agency and uniform across plans, others might be chosen by the plans;
- HMOs must conduct health education and prevention programs that target the needs of the chronically ill;

- HMOs must report on the processes employed to decide on the use of home health, DME, and mental health services, the extent to which these services are used, and the number and disposition of beneficiary complaints about these services;
- HMOs must have a member services representative to help link beneficiaries with community-based organizations.

HCFA already has licensing and other requirements that HMOs participating in Medicare risk contracts must fulfill. We think that carefully devised additional requirements could help ensure that participating HMOs are more responsive to the needs of disabled and chronically ill beneficiaries. However, it would be no easy task to decide which requirements would be most effective, nor to find a single set of requirements appropriate for all Medicare HMOs.

In addition, it is important that HCFA increase its efforts to monitor and report on quality of care, in both HMOs and fee-for-service. There is a long way to go, especially in producing good comparative information on quality of care in FFS. The standardized satisfaction surveys of HMO enrollees (the Consumer Assessment of Health Plans Study, or CAHPS) to be administered in 1997 and the requirement that HMOs produce HEDIS reports are a beginning on the managed care side. A useful addition would be a systematic review of a sample of deaths, both among HMO enrollees and from fee-for-service. Established protocols could be used to determine whether the death was preventable, and health care organizations should be monitored to determine what percentage of deaths are judged preventable, and required, as part of quality-improvement efforts, to work at reducing the number of preventable deaths.

Monitoring Disenrollment

The strategies discussed above—coordinated open enrollment, provision of unbiased and timely information to beneficiaries, partial standardization of benefits packages, more stringent credentialing of plans, and implementation of health-based payments—will primarily affect beneficiary decisions at time of enrollment. After beneficiaries have enrolled, it will be easy for the HMO to determine which members are using more resources than provided for in the health-based capitation; further, with a bit of additional analysis and judgment, reasonably good estimates can be made by the plan of which enrollees are likely to continue to use more resources in the coming year than are provided for in the capitation. Although it will be less easy for plans or providers to act on this information without fear of violating either professional ethics or public trust, the financial temptation to do so is so strong that it would be worthwhile for HCFA to raise the cost of encouraging selective disenrollment.

First, and most simply, HCFA should collect and publicize data on rates of and reasons for disenrollment.³⁸ An HMO that experiences consistently higher disenrollment rates than its competitors will likely have a harder time generating new enrollment; similarly, a plan whose disenrollees are disproportionately unhappy with access to or quality of care will likely suffer further in attempting to gain new enrollees.

Further, HCFA should systematically collect data on the post-disenrollment expenditures of those beneficiaries who disenroll from a plan to fee-for-service, and compare these expenditures to the amount of capitation payment the HMO would have received if the beneficiary had stayed enrolled. If, on average, post-enrollment expenditures are higher than the capitation, then corrective action will be required. More information on the extent of the problem is needed in order to develop sensible solutions. If post-disenrollment expenditures are consistently higher than the capitation, however, a strong argument can be made that the HMO should pay for what would have been its financial responsibility if the beneficiary had remained enrolled.

³⁸ At present, HCFA collects data on disenrollment. The Social Security Disenrollment Form asks beneficiaries why they are disenrolling, but the reasons are not captured by HCFA's data system. Some HCFA regional offices publish data on disenrollment rates by HMO, and the central HCFA office has plans to put disenrollment data on the Internet. It is recognized that the way the data are presented and analyzed could be improved. For example, "rapid disenrollment" (within three months) is now shown as a percentage of total enrollment instead of as a percentage of new enrollment for that period. (Personal communication, Rae Lowen, Julia Cohen, HCFA.)

PART 4: CONCLUSION

If HCFA implements the five strategies discussed above, it is likely that HMOs, on average, will be more attractive to the chronically ill in the future than they are today, and that HMOs will receive a less favorable selection of recipients than they have to date.

However, if the payment system continues to give HMOs strong financial incentives to avoid beneficiaries with expected health care needs that are greater than average for their age/gender rate cell, none of the strategies suggested here will be likely to be sufficient to materially reduce the extent of favorable selection, or to assure that the most vulnerable beneficiaries have high-quality care available to them. We want plans to organize delivery systems to be attractive to the chronically ill and those most in need; however, we cannot expect plans to do so if they are paid the same amount for the chronically ill as for those with fewer health care needs. Health-based payment, by itself, is not enough to solve the risk-selection problem, but it is a necessary component of any solution.

In response to evidence about risk selection, the Clinton administration has proposed reducing payments to HMOs from 95 to 90 percent of the AAPCC by the year 2000. This would be a sensible response if four conditions were satisfied:

- 1) we had reasonably good evidence that, on average, risk selection was at the 5 percent level;
- 2) we had reasonably good evidence that each HMO enjoyed selection that was at this average level;
- 3) we had no interest in creating an environment that encouraged plans to attract and enroll beneficiaries with greater than average needs; and
- 4) there were no feasible alternative payment methods that would protect the federal treasury if HMOs were to receive a favorable selection while simultaneously encouraging plans to attract those recipients with greater than average levels of need.

The first condition is the only one with much evidence in support: it does appear that HMOs, on average, have received a favorable selection to date, and an estimate that the favorable selection is at least 5 percent is reasonable. However, it seems likely that the extent of selection varies across HMOs, and an across-the-board cut would not be fair to those HMOs with a less favorable, or even an adverse, selection. More important, an across-the-board cut will increase the pressure on HMOs to attempt to select favorable risks; rather than

foster the development of HMOs that do a good job of serving beneficiaries in need of care, a flat, across-the-board cut will further encourage HMOs to avoid those most in need.

It would make much more sense to implement a payment system that adjusts payments to HMOs to reflect the health status of their enrollees. We introduce the term “health-based payment” to replace “risk adjustment,” which has little intuitive meaning for most readers. Rather than pay 90 percent of the AAPCC for all beneficiaries, it would make much more sense to pay 30 percent for the many beneficiaries whose expected health care needs are light and 300 percent (or more) for the few whose expected needs are heavy.

Capitation payment that is adjusted for the health status of enrollee groups is technically possible, and is scheduled for implementation soon in the Medicare Choices demonstration and in Maryland, Colorado, and other state Medicaid programs. As discussed in Newhouse, Beewkes, and Chapman 1997, the state of the art has developed sufficiently over the last few years to make widespread implementation of diagnostically adjusted payment systems a feasible and sensible option. In order to move from potential to reality, HCFA must require that HMOs provide encounter-level diagnostic data. We can anticipate resistance from some HMOs to such a requirement, but the advantages of a health-based payment system for beneficiaries, plans, and taxpayers will far outweigh the disadvantages of being required to report diagnostic information.

The cost of providing encounter-level data would be small for plans that already collect encounter information with diagnoses (this is true of all plans that pay providers on a FFS basis and most plans in which physicians are salaried). Plans that pass on a percentage of the capitation to large provider groups do not typically get encounter data from these providers, some of whom may not have the data systems to collect them. However, providers and plans should be able to produce the requisite data given enough lead time and the incentive (or sanction) of lower payments. Plans and their enrollees would clearly benefit from having diagnostic information on health care encounters: this basic information should enable plans and providers to improve care management.

HCFA would require modest additional resources to implement and operate a health-based payment system.³⁹ It would need an auditing program (similar to the auditing of discharge diagnoses in hospitals) to monitor and sanction systematic over-reporting.⁴⁰ We

³⁹ HCFA’s main tasks would be to produce county-level estimates of case mix; estimate and adjust for the increased intensity of diagnostic reporting that is expected when HMOs are paid based on diagnoses (including auditing HMO-reported diagnostic information); process the HMO-generated encounter data; and produce case-mix weights for each plan.

⁴⁰ A different technical problem is raised by the increased intensity of diagnostic reporting that is expected when plans are paid based on diagnosis. Just as adjustments for “DRG creep” were needed after the introduction of the DRG system, adjustments for “diagnosis creep” or “diagnosis discovery” will be needed and should be expected after HMOs start getting paid based on diagnosis.

imagine that under-reporting would soon be corrected by plans. To avoid large discontinuities, a phase-in schedule would be sensible, in which only part of the plan's payment would initially be based on its health-based case-mix.

HCFA has the statutory authority to implement health-based payment under current law: the Secretary is authorized to adjust the AAPCC to reflect the risk-mix of HMO enrollees. The age, gender, institutional status, and welfare status adjusters to the AAPCC are not in statute, but in HHS regulations; the regulations could be amended to incorporate diagnostically based health status adjusters as well. However, given the possibility of opposition from some parts of the HMO industry to the requirement of submitting encounter data, and modest additional HCFA resource needs to implement the system, it would be desirable to have an expression of Congressional intent to go forward.

Increased enrollment of Medicare beneficiaries in HMOs has the potential to improve quality of and access to care for Medicare beneficiaries, as well as to reduce the rate of growth of Medicare expenditures. This potential will be realized only if HMOs are rewarded for quality and efficiency, and not for risk selection. It is widely recognized that implementation of a health-based payment system is necessary to create the right environment, but the other actions described here are also needed. HCFA is discussing, planning, or beginning to implement some of the actions proposed. The present rapid growth of Medicare HMO enrollment argues for bolder, faster action to reduce risk selection and the associated negative dynamics.

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