New Directions and Developments in Managed Care Financing

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This overview discusses articles published in this issue of the Health Care Financing Review, *entitled "Managed Care: Advances in Financing." Articles cover the cutting-edge developments in payment methods for managed care organizations and their providers; new approaches to financing managed health care services for Medicare and Medicaid beneficiaries and special subpopulations; and the financing challenges presented by new managed care delivery models and industry consolidation.*

Many people believe that managed care is a relatively recent phenomenon. In fact, the concept is nearly 100 years old, dating to the creation of a prepaid health clinic for workers by railroad mogul Henry Kaiser. The seminal year for managed care is 1929, which saw the establishment of a rural farmer's cooperative health plan in Elk City, Oklahoma, a community of some 6,000 persons.

Today, managed care is one of the most common—and rapidly expanding—forms of health insurance. More than 100 million Americans are now enrolled in some form of managed care, be it through health maintenance organizations (HMOs), preferred provider organizations (PPOs), or provider-sponsored networks—a quadrupling in enrollment since the early 1980s (American Managed Care and Review Association, 1995). More than 70 percent of Americans who receive their health care coverage through their employer are now members of some type of managed care organization (MCO) (Foster-Higgins, 1996).

Medicare and Medicaid are also experiencing growth in managed care enrollment. During calendar year 1995, Medicare enrollment in risk-bearing HMOs grew by more than 26 percent. More than 4 million beneficiaries—over 10 percent of all Medicare enrollees—are now enrolled in managed care plans. As of March 1, 1996, Medicare was contracting with 289 MCOs—202 of them on a risk basis (Health Care Financing Administration, 1996a).

From June 1994 to June 1995, Medicaid managed care enrollment grew by more than 50 percent, reaching 11.6 million individuals—more than 32 percent of all program beneficiaries. Forty-nine States employ managed care in their Medicaid programs, 46 through waivers approved by HCFA (Health Care Financing Administration, 1995a).

The incentives in managed care are very different than those of traditional fee-for-service (FFS). In traditional FFS, the provider can make more by providing more services. In capitated managed care arrangements, a provider of care receives a fixed payment regardless of the amount of care delivered. In theory, by providing care in a more coordinated and cost efficient manner, prepaid capitation can lead to curbs on unnecessary services and more appropriate utilization. However, it can also lead to undertreatment, particularly since capitated payments are not currently adjusted to reflect the health status of the enrolled population. Thus, the challenge for the future of managed care is to test payment systems that minimize these

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potentially negative inducements and, where possible, build in incentives for MCOs to ensure the provision of high-quality services, particularly to those patients that need them the most.

HCFA represents the Nation's largest managed care purchaser on behalf of Medicare beneficiaries and as a partner with the States in the joint venture of Medicaid. As we mentioned, Medicaid is becoming a managed care program at a much faster pace than Medicare as States attempt to reduce program costs while expanding coverage to new populations. The vast majority of States have indicated their intention to enroll their Aid to Families with Dependent Children (AFDC). A growing number of States are also including related populations, and many chronically ill and disabled in MCOs within the next 4-5 years.

The challenge of modernizing payment methods in Medicaid is complicated by the fact that while AFDC and related populations represent about 70 percent of program beneficiaries, they account for only one-third of program vendor payments (Health Care Financing Administration, 1995b). Of all Medicare and Medicaid beneficiaries, "mothers and children" are the most similar to commercial managed care enrollees from an actuarial perspective, therefore representing a logical initial foray for the managed care industry into government program populations. It is the chronically ill and disabled populations, such as those with AIDS or behavioral health problems, whose non-long-term care medical costs account for another one-third of Medicaid vendor payments while making up 15 percent of program beneficiaries (Health Care Financing Administration, 1996b). If policymakers wish to move these populations into managed care, appropriate methods of paying for their managed health care services will be a central consideration of any approach.

The article by Kronick, Dreyfus, Lee, and Zhou examines methods of risk-adjusting reimbursements for disabled Medicaid beneficiaries, looking specifically at one of the most promising approaches: diagnostic cost groups. The authors analyze claims data from a number of States and then apply their "predictive diagnostic categories" to that data, looking at the distribution of disabled beneficiaries by condition and the estimated effects on subsequent-year costs of various types of disability and illness. The merits and challenges of implementing a diagnosis-based risk-adjustment system are explored.

Several articles in this issue of the *Review* examine the adjusted average per capita cost (AAPCC)—the payment methodology that HCFA currently uses to pay its risk plans serving Medicare beneficiaries. Put in place by the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982, this methodology is designed to pay HMOs that risk-contract with the Medicare program 95 percent of the average annual cost of serving Medicare beneficiaries in the FFS sector. This methodology was designed to ensure that Medicare costs for HMO enrollees would be reduced by 5 percent—if the AAPCC accurately reflects what Medicare costs for enrolled beneficiaries would have been had they remained in FFS. However, while the AAPCC adjusts for the demographic status of enrollees in terms of age, sex, Medicaid eligibility, and institutional status, it does not adjust for health status differences within these categories. If HMO enrollees within a demographic category systematically differ from non-enrollees in terms of health status, selection bias results and payments to the HMO will be inaccurate. Medicare currently pays HMOs a capitated amount for each enrollee based on average FFS spending in the enrollee's demographic group. HCFA's selection studies showed

that HMO enrollees tend to be healthier than average, indicating that capitation amounts may be too high (Mathematica Policy Research, Inc., 1993).

Since the AAPCC is based on costs for Medicare beneficiaries in the FFS sector, any payment inaccuracies that are a result of selection bias may be exacerbated in areas that exhibit a high degree of managed care penetration. If HMOs are enrolling the healthiest beneficiaries in these areas, overpayment to the plans will be magnified as penetration increases and payments are increasingly based on a sicker-than-average population remaining in FFS. Alternatively, if HMOs are enrolling individuals who are sicker than average, increased penetration may lead to payments being based on an increasingly healthier population remaining in FFS. This would result in decreasing HMO payments.

Dowd, Feldman, Moscovice, Wisner, Bland, and Finch directly address this issue in their examination of selection bias in the AAPCC, using data from Minneapolis and St. Paul—one of the most active markets in Medicare managed care—where five risk HMOs were competing for Medicare beneficiaries. The authors examine possible payment bias to Medicare TEFRA-risk HMOs in the Twin Cities in 1988.

Gruenberg, Kaganova, and Hornbrook's article looks at how health status measures derived from the Medicare Current Beneficiary Survey can be used to improve the AAPCC. The authors examine the efficacy of a comprehensive model incorporating demographic, diagnoses, perceived health, and disability variables.

Weiner, Dobson, Maxwell, Coleman, Starfield, and Anderson in their article and Ellis, Pope, Iezzoni, Ayanian, Bates, Burstin, and Ash in theirs address the use of diagnostic-based risk adjusters in Medicare capitation payments—as Kronick et al. do in theirs for Medicaid disabled populations. Weiner et al. developed two diagnosis-based methodologies for setting risk-adjusted Medicare capitation rates, using data from over 600,000 beneficiaries and the previously developed Ambulatory Care Group algorithm to categorize diagnoses. Ellis et al. developed and evaluated two models that utilize diagnostic data and account for multiple coexisting medical conditions. The models examined by Weiner et al. and Ellis et al. appear to predict Medicare beneficiary costs far more accurately than the AAPCC.

Farley, Carter, Kallich, Lucas, and Spritzer analyze modifications to HCFA's current methods for reimbursing HMOs for services provided to beneficiaries with end stage renal disease (ESRD). The authors developed a payment method consisting of risk-adjusted capitated payments for individuals on dialysis or with functioning kidney grafts, lump-sum payments for costs of kidney transplants or graft failures, and outlier payments for the most expensive patients. ESRD patients represent the sole group among Medicare beneficiaries that are prohibited from joining HMOs if not already enrolled at time of diagnosis. Yet over 6,400 beneficiaries with ESRD remain in HMOs, having been diagnosed after enrollment in the plan. These 6,400 beneficiaries accounted for more than $270 million in payments to HMOs in 1995.[1]

Modernizing payment methods for Medicare and Medicaid beneficiaries is not the only area of inquiry and experimentation in managed care. The commercial sector is experimenting with alternative payment approaches. Hanchak, Schlackman, and Harmon-Weiss, of the multi-State HMO U.S. Healthcare, discuss their company's newly implemented quality-based compensation model. This is a system that

[1]Unpublished data from HCFA's Office of Managed Care.

provides adjusted capitation rates to U.S. Healthcare physicians on the basis of quality and outcomes indicators. If a U.S. Healthcare physician meets the top tier of quality indicators, he or she can substantially enhance their capitation rate.

Some managed care markets are maturing to the point where competition among plans for the remaining non-enrollees has led to a narrowing of premium differences among plans. To illustrate, in Los Angeles, more than 70 percent of the total population is enrolled in some form of managed care, and there is only a $7-8 difference in commercial premiums for the two leading plans in the area (UCLA Center for Health Policy Research, 1996). With premium differences narrowing to this extent, purchasers and consumers may increasingly look to quality of care to choose among plans. Plans that provide incentives for their providers to offer continuously improving quality of care may be at a competitive advantage.

As important to the future of managed care financing as market penetration rates and the growing emphasis on quality improvement is the introduction of new types of managed care delivery models and the proliferation of mergers and acquisitions in the managed care industry. The PPO industry began in the mid-1980s as a strategy of insurance companies to compete with HMOs, especially for employer group contracts. PPOs now number more than 1,000, with more than 60 million members (American Association of Preferred Provider Organizations, 1996). Verrilli and Zuckerman examine trends in physician fee discounts in this increasingly popular managed care model. Managed care plans that rely on discounted payments have increased from about 10 plans in 1981 to more than 700 in 1994; their article looks at two large national insurers' experiences with discounts across types of service and geographic areas.

Beyond new managed care delivery models are the effects of consolidation in the marketplace on managed care financing. Nationwide, 40 percent of managed care enrollment is in the 10 largest HMOs; at the same time, 40 percent of the enrollment is in HMOs with under 50,000 enrollees (American Association of Health Plans, 1995). This illustrates how ripe the managed care industry is for consolidations and mergers—and dozens, large and small, have happened already. As of April 4, 1996, Aetna and U.S. Healthcare have merged to form the largest MCO in the Nation. In 1994, Metropolitan Life and Travelers merged their managed care operations into another massive company, MetraHealth, which was in turn acquired in 1995 by United Healthcare. Additionally 1994 saw the merger of Health Net and QualMed Plans to form Health Systems International, FHP's acquisition of Takecare, and Physician Corporation of America's purchase of Southeast Health Plan (*New York Times*, April 2, 1996). Obviously, these trends will have effects on how MCOs operate and compete, on how they pay their providers for services rendered, and on consumer and purchaser decisionmaking. Feldman, Wholey, and Christianson look at two critical issues in their article: whether HMO mergers increase or decrease premiums; and whether the effect of mergers differs according to the degree of competition among HMOs.

Clearly, the body of scholarly inquiry represented here and the number of research projects on HMO payments that HCFA is engaged in will facilitate the maturation and modernization of managed care financing. Purchasers and the industry are actively engaged in developing appropriate payment methodologies that adjust for differences in health status among enrollees, and reward the provision

of quality care. The success of these efforts, as characterized by the articles in this issue of the *Review*, will impact on the future of managed care.

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