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PROLOGUE: After a prolonged debate, Congress enacted legislation several years ago that authorized Medicare to negotiate contracts with health maintenance organizations (HMOs) that would enable them to enroll elderly beneficiaries. The history of HMOs’ courting of the vast Medicare market was long and tortured, dating as it did to the earliest days of the program and even before its enactment. For more than fifteen years, Medicare refused to deal with HMOs on the same payment basis that HMOs dealt with private purchasers. Not until 1982, a full decade after the government began promoting HMOs as a good value for the private sector, did Congress finally agree to authorize Medicare to negotiate prospective, per capita arrangements with organized medical plans. In this article, Paul Ginsburg and Glenn Hackbarth, respected Washington health policy analysts, report on the status of the current relationship between Medicare and HMOs and recommend future policy changes. As the chief health policy analyst of the Congressional Budget Office (CBO) for six years (1978-1984), Ginsburg established a solid reputation as a nonpartisan participant in policymaking. Ginsburg, who holds a Ph.D. in economics from Harvard University, was an associate professor at Duke University before joining CBO. Ginsburg departed the budget office in mid-1984 to join the Rand Corporation. At Rand, Ginsburg has worked on a study of preferred provider organizations and has consulted with the Health Care Financing Administration on Medicare’s prospective hospital payment system. Hackbarth, who holds a master’s degree in public policy and a law degree from Duke University, worked at the Department of Health and Human Services during the Reagan administration’s first term. Hackbarth was centrally involved in developing the legislation that now authorizes Medicare to negotiate risk contracts with HMOs. Hackbarth became the Washington counsel of Intermountain Health Care, Inc. in 1984 to advise the organization on changes in federal policy and assist it in deciding whether or not to seek a Medicare HMO contract.
During the early 1980s, the Reagan administration and Congress agreed on important changes in Medicare, indeed, the most important changes in the program’s twenty-year history. To slow the increase in Medicare expenditures, the administration and Congress launched a two-pronged attack. The two lines of attack are conceptually different but not mutually exclusive. The nation therefore has the luxury of experimenting simultaneously with both approaches.

Under the first method, which we will call the “federal approach” or “fee-for-service Medicare,” the federal government continues to serve as the primary health insurer for senior citizens. The federal government bears the insurance risk and manages assorted cost-containment efforts. The goal is to make Medicare a “prudent purchaser” of health care services.

In its effort to make Medicare a more effective purchaser, the federal government has established the prospective payment system for hospitals (PPS), subjected medical decisions to scrutiny by peer review organizations (PROs), established a “participating physician” program which encourages physicians to reduce their fees, and expanded coverage for potentially lower cost “substitute” services (for example, hospice care). At Congress’s request, the administration is now studying further changes in physician reimbursement. We call this series of reforms “the federal approach” because of the federal government’s extensive role in deciding what to pay for and how much to pay.

The other approach, which we will call “the alternative delivery system (ADS) approach,” shifts responsibility for underwriting financial risk to private health plans. Under the ADS approach, the federal government gives Medicare beneficiaries the opportunity and incentive to use their Medicare entitlement to enroll in a private health plan. Along with the financial risk, the federal government shifts responsibility for decisions about how to spend health care dollars, including decisions about appropriate medical practice and provider payment. The essence of the ADS approach is to decentralize those complicated and often subjective decisions.

Although Congress authorized the ADS approach in 1982, regulations implementing it were not published until January 1985. In February 1985, the federal government actually began making capitation payments to health maintenance organizations (HMOs) and competitive medical plans (CMPs).1 Medicare beneficiaries are not required to enroll in an HMO or CMP; all beneficiaries retain the right to remain in the fee-for-service Medicare program or to return to it on short notice.

In exchange for Medicare’s capitation payment, the HMO or CMP agrees to provide all Medicare-covered benefits as medically necessary. If the government’s payment exceeds the HMO or CMP premium for non-Medicare enrollees (after adjusting for differences in coverage and the greater use of health care by the elderly), the health plan must pass on
the difference to the Medicare beneficiary in the form of increased benefits. The HMO or CMP is fully at risk if actual costs exceed the government’s capitation payment plus any premium charged to the enrollee.

The ADS approach may, in the long run, prove more effective than the federal approach, at least for a substantial proportion of the Medicare population. By paying capitation payments to HMOs and CMPs, the federal government harnesses private innovations in health care finance and delivery for the benefit of senior citizens and taxpayers. Capitation is a useful tool because it grants private health plans maximum flexibility to organize the delivery of health care, subject to an overall resource constraint. Arrayed against this, however, are the frictions of adding another element to Medicare—the choice of a private health plan by 29 million beneficiaries.

The federal government need not choose between the federal approach and the ADS approach, at least not now. The two approaches are not mutually inconsistent and may prove mutually reinforcing. If alternative delivery systems succeed in changing how their physicians practice, there will be competitive and spillover effects on physicians serving patients under fee-for-service Medicare.

To remain competitive with ADSs, physicians in traditional fee-for-service practice may try to reduce the out-of-pocket costs incurred by Medicare patients—for example, by more frequently accepting Medicare’s payment as payment in full. Although roughly 60 percent of Medicare patients supplement their Medicare coverage with private insurance, that insurance often pays only the deductibles and coinsurance built into the Medicare program. When the physician does not agree to accept assignment (that is, accept Medicare’s payment as payment in full), even a beneficiary with supplemental coverage must pay out-of-pocket the portion of the physician fee exceeding Medicare’s fee limits.

Growth of alternative delivery systems may also provide spillover benefits for the traditional Medicare program. Spillover benefits occur when physicians care for both ADS patients and non-ADS patients. If an ADS persuades a physician that a less expensive form of practice is also good medicine, the physician will likely adopt that style of practice for all of his or her patients, including those not enrolled in the ADS.

Not only may the federal approach benefit from the growth of ADSs, but it may in turn encourage their growth. As will be discussed later, the federal approach is inherently more rigid and arbitrary than the ADS approach, an inevitable result of applying national payment rules in a diverse nation. Given the nation’s diversity, it simply is not possible to write rules that are both generally applicable and generally fair.

The ill effects of the rigidity and arbitrariness are compounded when the government squeezes Medicare payments to reduce federal spending. As the squeeze continues, health care providers may find ever more
appealing the flexibility of the alternative delivery systems approach, which vests more control in local organizations.

Defining “Alternative Delivery System”

Rather than confine this discussion to HMOs and CMPs—the private health plans currently permitted to enroll Medicare beneficiaries—we will use a more generic concept: alternative delivery systems. The essence of an ADS, as we use that term, is that it provides services through health care providers under contract. ADS enrollees therefore must seek health care services from a select group of providers or suffer some financial penalty. In the extreme case, the enrollee might be liable for the entire cost of services rendered by nonparticipating providers—a “lock in.”

The nature of the provider/ADS contract may vary. Physicians, for example, need not be employees of the ADS; they may even be paid on a fee-for-service basis, perhaps subject to some sharing of financial risk or agreement to seek prior approval from the ADS before nonemergency hospital admissions or prescribing major procedures. Physicians and other providers may contract with more than one ADS.

For our purposes, we need not define how much a “true” alternative delivery system restricts the enrollee’s free choice of provider. A concrete definition would be necessary only if all other private health plans were to be denied Medicare capitation contracts. We do not favor such a limitation. We focus on ADSs only because they are the most promising vehicle for delivering low-cost but high-quality services. We believe traditional insurance plans offering an unrestricted choice of provider would likely prove ineffective competitors. These “free choice plans” would probably find it difficult, if not impossible, to hold their per capita costs below the level incurred by Medicare. But consumers, not the government, should decide whether traditional insurers offer an appealing product.

Notwithstanding our support for the ADS approach, we do not favor “privatization of Medicare” for its own sake. It would be a mistake to force senior citizens to enroll in private plans offering fewer benefits at a higher cost than under Medicare. For the foreseeable future, senior citizens should be given the option of remaining in the traditional Medicare program. Prudence dictates that alternative delivery systems be required to prove their appeal and effectiveness. By permitting, but not requiring, senior citizens to enroll in ADSs, the government has granted ADSs a market test.

Rationale For The ADS Approach

The rationale for the ADS approach is based on the subjective and personal nature of many medical decisions. That is not to say that mod-
ern medicine is a primitive art, as some of the profession’s sharpest critics would have it. Much has been done to assure that day-to-day medical practice is based on the best available scientific information. Nevertheless, physicians will never be free of the shackles of uncertainty. Medicine is inevitably a probabilistic science, and the best course of treatment often depends on the personal preferences and circumstances of individual patients.

Because of medicine’s uncertain, subjective, and highly personal character, health care providers and their patients should be granted maximum flexibility to determine the appropriate course of treatment. Political institutions are ill-equipped to make such decisions, either directly or indirectly through prescriptive payment rules. Of course, government, as a third-party payer, is reluctant to grant providers and patients complete freedom to determine which services are needed. Taxpayers are unwilling to pay the resulting bills. Therefore, a balance must be struck. Discretion must be granted but exercised within a broad economic constraint. By making capitation payments to ADSs, Medicare establishes such a framework.

Making capitation payments to ADSs is a starkly different approach from the federal approach as embodied in Medicare’s prospective payment system for hospitals. Both use economic incentives to influence behavior, but the prospective payment system risks a deeper intrusion into medical practice. By classifying patients into diagnosis-related groups (DRGs), the prospective payment system requires federal decisions that directly affect medical practice—for example, whether to adjust the DRG weights and classifications to accommodate changes in technology or medical practice.

Political pressures, budget concerns, and a lack of first-hand information may push the federal government toward yes/no decisions on complicated issues—for example, a new therapy may be covered in all cases or no cases. More discriminating judgments, judgments based on knowledge of individual patients, would be preferable. While peer review organizations may provide some guidance, their purview is best limited to issues where physicians have reached a consensus on appropriate medical practice. Being somewhat removed from the patient, peer review organizations may also assume patient preferences are uniform—or worse yet—irrelevant.

By decentralizing decisions, the ADS approach may also help assure that the amounts paid to individual physicians and hospitals are fairer than under the federal approach. The Medicare prospective payment system, for example, bases payment on broad diagnostic and hospital categories for the sake of simplicity and because the information needed for finer adjustments is not available. The system’s premise is that variation in patient costs within the diagnostic categories will average out,
with adjustments made by hospital type—for example, for teaching hospitals or hospitals having a disproportionate share of low-income patients. There is reason to doubt, however, that the existing categories are adequate.

By making capitation payments to ADSs, the federal government can delegate the responsibility for allocating available resources. Alternative delivery systems may have access to information about their patients and participating providers, much of it subjective, that is unavailable to the federal government. ADSs may also adjust the payment to reflect local market conditions—for example, paying less to physicians in a particular specialty because of a local glut.

Decentralizing decisions on appropriate medical practice and payment cannot assure that every patient and provider will be satisfied. As crude as the government’s information is, many ADSs have even less. But decentralization may grant patients and physicians some added protection. If, for example, a hospital believes an ADS is unfair or not meeting minimum quality standards, it may refuse to deal with the ADS. Under the federal approach, that may not be a realistic option. Medicare accounts for such a large share of the market that few providers can afford to refuse to participate. Each ADS, in contrast, has but a fraction of Medicare’s current market share, making withdrawal a more realistic option. From the provider’s perspective, the ADS approach is thus less coercive and more consensual than the federal approach. Similarly, patients who are dissatisfied with an ADS decision may complain directly, always with the implicit threat of disenrollment.

Of course, health care providers and patients may find it difficult to judge the quality of an ADS. But that difficulty is not unique to the ADS approach, as illustrated by the heated, but inconclusive, debate over quality of care under PPS. The chief advantage of further decentralizing decisions about appropriate medical practice and payment is that dissatisfied providers and patients need not wait for the government to change its payment rules. The ADS approach expands their range of choices, and permits them to act unilaterally.

Assessing The Potential Of Alternative Delivery Systems

To further analyze the merits of ADSs, we discuss their likely success in specific aspects of cost containment: reducing hospital admissions, reducing resources per hospital admission, reducing price paid per unit of hospital resources, reducing use of physician resources, and reducing amount paid per unit of physician resources. The potential of ADSs will be compared to what is likely to be achieved through the other approach to Medicare cost containment: the federal approach comprising a mixture of prospective payment for hospitals, PROS, and
potential physician payment reforms.

**Hospital admissions.** Many ADSs significantly reduce hospital admissions compared to the rate under traditional insurance plans. Prepaid group practice HMOs, in particular, have a well-established track record. The extensive literature on prepaid group practice suggests they have admission rates about 40 percent lower than traditional insurance plans. The Rand Health Insurance Experiment, though including only one HMO, found a comparable experience for a group of randomly selected families.

One explanation of HMOs’ success is that physicians in prepaid group practice are paid in ways that do not promote, and may discourage, excessive hospitalization. Another factor may be that some HMOs limit the supply of available hospital beds, or of surgeons. Still another factor might be self-selection by physicians; physicians electing to practice in an HMO may be predisposed to the “conservative” practice style used by such plans.

Less is known about HMOs that are not prepaid group practices. Research in the 1970s suggested that independent practice association (IPA) HMOs were less successful in reducing hospital admissions. More recent evidence, however, suggests IPAs have made considerable progress. The Boston Consulting Group, using federal data, estimates that IPA hospitalization rates have dropped nearly 30 percent during the last six years.

Competition from other HMOs, including prepaid group practices, is forcing IPAs to reduce hospitalization in order to remain competitive. To reduce hospitalization, many IPAs are abandoning fee-for-service payment to primary care (“gatekeeper”) physicians in favor of making a capitation payment to the physician. Many IPAs also require prior authorization for all nonemergency hospital admissions and some expensive outpatient tests. Unless the admission or test is approved in advance, the IPA will not pay the resulting bill. Many IPAs also require some surgical procedures to be performed on an outpatient basis unless otherwise authorized.

The federal approach currently does not use economic incentives to discourage hospital admissions. On the contrary, many observers believe that Medicare’s prospective payment system for hospitals and its physician payment system encourage hospital admissions. Physicians tend to be paid more for inpatient visits than for outpatient visits. Similarly, a hospital often receives more for inpatient surgery than it would for the same surgery performed on an outpatient basis, though the surgeon’s reimbursement is usually the same. Neither physicians nor hospitals are at financial risk for excessive admissions.

Fee-for-service Medicare attempts to offset these incentives by making payment for many admissions contingent on prior authorization by PROS. PROS are descendants of the professional standards review organizations (PSROs) that were not highly effective. PROS, however, do have clearer
direction and an easier job: since prospective payment establishes strong incentives to reduce the average length-of-stay, PROS can concentrate their efforts on reducing admissions.

Contrary to what many expected, Medicare admissions have declined since the advent of PPS, with the decline accelerating in the fourth quarter of fiscal year 1984. Admissions in fiscal year 1984 were 1.7 percent lower than in fiscal year 1983—in contrast to an average annual increase of 4.6 percent from 1978 to 1983. For fiscal year 1985, admissions declined another 5.6 percent, leaving Medicare admissions 15 percent below where they would have been if earlier trends had continued. While it is difficult to identify the causes of this reversal, PROS, which began operation toward the end of fiscal year 1984, may have been a factor. Nevertheless, we doubt that PRO review can be as effective as ADSs in reducing hospital admissions for Medicare beneficiaries, since ADSs can establish for their physicians more stringent standards which are not subject to the same legal and political constraints as the federal approach.

Another reason ADSs are likely to be more effective than PROS in reducing admissions is that ADSs, unlike PROS, are subject to continuous competitive pressure. The marketplace is littered with the hulks of ADSs gone bankrupt or disbanded because of their failure to reduce admissions. Medicare’s PROS, on the other hand, face a less immediate threat: that they will lose their Medicare contract if they do not perform. Given the federal government’s record at disciplining poor suppliers (for example, defense contractors), some skepticism may be warranted. We conclude that PROS will almost certainly be more effective in reducing hospital admissions than the predecessor PSROs, yet not so effective as well-managed ADSs.

One other potential tool for reducing hospital admissions bears mentioning: patient cost sharing. In theory, this tool is available to both ADSs and fee-for-service Medicare, but in neither case is it likely to be important. Congress has shown a strong disinclination to increase Medicare deductibles and coinsurance. Even if this were to change, a large portion of any increase (roughly 75 percent) would be paid not directly by the patient but by private Medicare supplemental insurance (“Medigap” insurance) or Medicaid.

ADSs generally do not use large deductibles or coinsurance to deter utilization. Indeed, they do the opposite. Most ADSs attract enrollees by offering a combination of comprehensive benefits and low out-of-pocket costs.

Hospital resources per admission. It is not clear whether the ADS approach or the federal approach has the greater potential for economizing on hospital resources per admission. Both have substantial tools.

The chief tool under the federal approach is an administered-price
system, which pays hospitals a fixed amount per admission based on the patient’s diagnosis. This system gives hospitals a strong incentive to reduce costs under their control (including the costs of nursing, dietary services, and housekeeping) and to pressure physicians to order fewer ancillary services.

Thus far, PPS appears to have been very effective in reducing costs per admission. Hospitals have cut lengths-of-stay sharply. The increase in hospital operating margins has encouraged the administration and Congress to set payment rates for 1986 far lower than had been expected when the program was enacted.

But constraints may limit the degree to which costs can be driven down in the long run. First, if the scheduled transition toward national rates is completed, a significant minority of hospitals are likely to find it hard to break even. Their complaints may cause at least a pause in the pressure to squeeze rates. The crudeness of the DRG classification system will also limit the pressure that can be applied to rates, though refinement is likely over time. Second, nonprice competition among hospitals remains an important force, and may preclude hospitals from reducing costs below PPS rates. To increase its market share, a hospital must do what is has always done: increase the quality of service and amenities offered to physicians and patients. In other words, the prospective payment system does not promote price competition; quality/amenity competition remains a dominant force.

Medicare’s fraud and abuse prohibitions reinforce the tendency toward quality/amenity competition among hospitals. According to most experts, the fraud and abuse laws prohibit hospitals from making cash payments to patients and physicians in order to attract more business. The fraud and abuse laws establish, in effect, a small-scale barter economy in which services and amenities serve as the mode of exchange. By restricting direct sharing of profits, the fraud and abuse laws inhibit the free flow of resources out of the hospital sector, promoting inefficiency.

The Medicare fraud and abuse laws may also prevent hospitals from using their profits under PPS to pay cash rewards to physicians who reduce costs through judicious use of ancillary services. This restriction would also make it more difficult for hospitals to control the resources going into each case. As the resulting quality/amenity competition runs its course, the resources consumed per hospital admission may rise or at least fall less rapidly than they would have otherwise. Potential “profits” from efficiency will be spent on more services and amenities, thus increasing costs.

The net effect of PPS on resource consumption will depend on how hard the government pushes down on the prospective payment rates. If the government squeezes the rates, resources per admission may fall, notwithstanding the quality/amenity competition. But even then, the
decline may not be as great as would have occurred under a price competitive system. Furthermore, the government’s ability to squeeze the prospective payment rates will be constrained by the quality/amenity competition. As new services are adopted, they will become intertwined in prevailing notions of what constitutes appropriate hospital care. Once that occurs, government may find it difficult to muster political support for squeezing them out of the system.

ADSs do not face the same constraints. ADSs control costs per admission by directing patients to hospitals with low costs and through the actions of ADS physicians who order the ancillary services for ADS patients. Direct incentives to physicians may be more effective at changing practice patterns than indirect pressure through hospitals.

As the aggregate market share of ADSs grows, hospitals will have strong incentives to reduce costs relative to the competition. The competition among hospitals for ADS contracts will be self-perpetuating. At least in theory, this competition would not even be slowed by increases in the capitation amount paid by Medicare. Since ADSs may use savings on hospital costs to finance nonhospital benefits, competition among ADSs may result in money being shifted out of the hospital sector if it can be better used elsewhere. Under prospective payment, on the other hand, competition among hospitals results in savings from efficiency being plowed back into new hospital services or amenities.

**Hospital price per unit of resource.** Both fee-for-service Medicare and ADSs are able to obtain a favorable price from hospitals (relative to amounts normally charged) for each unit of service. Medicare accounts for almost 40 percent of total hospital revenues. Medicare’s enormous market power permits it to obtain favorable prices simply by offering hospitals an “all or nothing” deal: either serve Medicare patients at this price or do not participate in the program.

Until 1983, Medicare’s all or nothing deal was based on Medicare’s definition of “reasonable costs;” The federal government forced hospitals to grant discounts by excluding certain items from the definition of “reasonable costs”—for example, a return on the equity invested by not-for-profit hospitals. By the early 1980s Medicare’s “reasonable costs” were 23 percent lower than hospital billed charges.

Under the prospective payment system, the government may be able to extract an equivalent or greater discount relative to billed charges. During the system’s first year, however, Medicare payments actually increased as a percentage of billed charges. For the program’s third year, the Reagan administration has proposed a freeze on the prospective payment rates. The freeze is, at least in part, a response to Medicare’s payments increasing relative to charges (and costs).

An ADS’s ability to obtain discounts stems from its power to channel patients to particular providers, not from its overall market share. Where
the supply of excess beds is large, the ADS's ability to command discounts is greatest. It is difficult to determine whether the market power of ADSs will ultimately approach the government's. In some areas, principally rural areas and small cities, hospital competition may be too weak for ADSs to negotiate low prices. In areas with three or fewer hospitals, it may not be feasible for an ADS to threaten a hospital with a significant loss of patients if it does not agree to a low payment rate. Even in large areas, it remains to be seen whether ADSs can achieve lower rates through selective contracting than Medicare can with an administered price.

In the short run, limited market power does not reduce an HMO or CMP's ability to offer an attractive alternative to Medicare patients. Current law permits (but does not require) HMOs and CMPs to use Medicare's prospective payment system to pay hospitals for care given to senior citizens, giving HMOs and CMPs the best of both worlds.

**Physicians' services.** ADSs will probably be more effective than the federal approach in reducing the volume of physicians' services per Medicare enrollee. Since the mid-1970s Medicare has experienced large increases in services per enrollee. A recent analysis of Health Care Financing Administration (HCFA) data found that services per enrollee grew at about a 7 percent average annual rate from 1975 to 1983.

The Medicare payment reforms now under consideration probably will not solve this problem. If any changes occur, the most likely is to replace the current system of "reasonable, customary, and prevailing charges" with a fee schedule, perhaps one that pays relatively more for cognitive services such as history taking and physical examinations and less for technical procedures such as endoscopy. While a change in relative fees might improve the fairness of the payment system and remove some of the distortion in signals sent to medical students selecting specialties, there is no evidence that a change in relative fees would reduce the overall volume of services. Like the current system, moreover, a fee schedule would be susceptible to unbundling—that is, the volume of billed services could increase as physicians begin to bill separately for services previously included under a single fee.

An alternative reform would be to pay for inpatient physician services on a per case basis, as is done for hospital care. Per case payment may reduce services per inpatient case, although it would not reduce outpatient services. The chief problems with per case payment are the amount of financial risk imposed on individual physicians and the need for major changes in the policy on assignment of claims. Per case payment for physicians, like per case payment for hospitals, would depend on high-cost and low-cost cases averaging out for any given provider. For costs to average out, a provider must have a large volume and broad array of patients, and that may pose a problem for physicians. A physician has far fewer patients than the typical hospital, and may be more likely to treat
an unrepresentative sample of patients within any given payment category.

To avoid causing financial hardship, a per case payment method must protect the individual physician from the huge potential loss associated with high-cost patients. One possible modification would be to blend per case payment with fee-for-service payment, with the proportions varying according to the homogeneity of cases within each DRG. Another proposal is for Medicare to stop paying individual physicians for their services, making payments instead to hospital medical staffs. The medical staff would pool payments, thus spreading the risk of high-cost patients. The medical staff would also assume responsibility for determining how much each physician should receive. Granting the medical staff such power would, of course, be very controversial among physicians. Either of these modifications would dilute the incentives for efficiency resulting from per case payment.

To make per case payment effective, Medicare would also need to change assignment policy, possibly going so far as to prohibit physicians from billing patients (except for any deductibles and coinsurance). In other words, the government would require physicians to accept Medicare payment as payment in full. Otherwise physicians might simply bill patients on a fee-for-service basis and let patients collect the per case payment from Medicare. Requiring physicians to accept assignment might be even more controversial than per case payment itself—a case of the tail wagging the dog.

ADSs will also have difficulty in controlling the volume of physicians’ services, but do have more options and operate under fewer constraints. Physicians may be willing to enter into an arrangement with an ADS that would arouse vehement opposition if imposed by the government. If a physician decides an ADS’s system is unfair, he or she can simply withdraw from the ADS. Experimentation therefore poses relatively few risks. As discussed earlier, refusing to participate in fee-for-service Medicare poses a different problem. Medicare’s market share is so large that many physicians have little choice but to participate. Physicians are therefore understandably risk averse about changes in Medicare’s fee-for-service payment system and thus far have been able to prevent experimentation.

Among the payment options available to ADSs are salary arrangements, profit sharing, and capitation. ADSs will likely prefer payment systems that reward primary care physicians for appropriate medical management. Effective case management may take the form of improved medical recordkeeping, more appropriate use of referrals, more careful monitoring of medical regimens, and training family members to perform some medical functions, obviating the need for health care professionals. These activities are especially important for chronically ill patients, a group that includes many Medicare beneficiaries. Medicare’s current physician reimbursement system pays little, if anything, for these important services.
Physician fees. Both alternative delivery systems and the government are able to obtain a discount from physicians’ regular fees. Medicare has long limited the fees paid to physicians, though physicians may hold the patient responsible for the full charge. In 1983, Medicare reduced 83 percent of the claims filed by an average of 23 percent. Through its new participating physician policy, Medicare is better able to pay low rates without shifting the burden to patients. In exchange for a physician’s agreement to accept Medicare’s payment as payment in full for all Medicare patients, Medicare includes the physician’s name in its directory of “participating physicians.” Medicare may also grant participating physicians greater fee increases in future years, increasing the incentives of physicians to agree to participating status.

Many, though not all, ADSs pay less than billed charges for physicians’ services. By channeling patients to participating physicians, ADSs are in a strong bargaining position. It is unclear whether ADSs pay more or less than Medicare on average. Again, however, ADSs have more flexibility. For example, ADSs may demand especially large discounts for those services in most abundant supply.

In summary, ADSs have the potential to serve Medicare patients at a lower cost than fee-for-service Medicare and will likely be competitive with the reformed Medicare program now taking shape. ADSs biggest advantage appears to be controlling the volume of services. Their ability to contain the price paid per unit of service may be comparable to Medicare’s in some areas, but may be weaker in others.

Potential Problems

This article has emphasized the promise of ADSs. Potential problems exist as well. Perhaps the three most important are meeting appropriate quality standards, coping with adverse selection, and absorbing the marketing costs incurred by ADSs.

Quality. For years, the nation’s health policy has been founded on the premise that more health care is better. Provider efforts to reduce services thus prompt concern about the quality of care. This instinctive and understandable bias in favor of more services has been reinforced by anecdotal evidence of poor quality in some ADSs. Perhaps the most frequently cited examples arose out of California’s ill-starred effort in the early 1970s to enroll Medi-Cal beneficiaries in prepaid health plans.

Researchers have begun to examine systematically the assumption that more services are better. There is growing evidence that the assumption is unfounded. The Rand Health Insurance Experiment found that adults significantly reduce their use of services when they must pay large deductibles and coinsurance, yet the decline in utilization has little effect on health status. The only exceptions were people with poor vision and...
low-income people with high blood pressure. For those groups, increased
cost sharing and reduced utilization were associated with a slight deterio-
ration in health status. Children’s use of outpatient services (but not
inpatient services) were affected by insurance, but no health effects were
observed for typical children. At-risk children had some differences of
clinical importance, but were not statistically significant. Population-
based studies of variations in medical practice patterns likewise suggest
that higher utilization does not necessarily result in improved health
status. Such evidence suggests that costs can be reduced without sacrifices
in quality.

The available evidence on HMOs is mixed but generally indicates that
HMOs provide care of comparable quality to the fee-for-service sector.
Conclusions about quality often depend on the measure of quality se-
lected: structural measures (How many board-certified specialists?), proc-
ess measures (How good are patient records? Are appropriate referrals
made to specialists?), outcome measures (How well is hypertension con-
trolled?), access to care (How long must a patient wait for an appoint-
ment?), or consumer satisfaction. Conclusions on specific measures may
also be affected by the type of ADS being analyzed—for example, an
IPA may offer easier access to physicians than a staff model HMO but
may not coordinate use of specialists as effectively.

For better or worse, practice patterns in alternative delivery systems
and under more traditional arrangements can be expected to converge in
the long run. Narrowing of the differences will be the inevitable by-
product of the rapid growth in the number of providers and patients
electing to participate in ADSs. To continue their rapid growth, ADSs
must appeal to an ever broader array of providers and an ever broader
array of potential patients. As enrollment grows, ADSs must deal with
providers and patients who did not join sooner precisely because they
are concerned about quality. The successful ADSs will be the ones who
assuage those doubts.

While the typical ADS is likely to provide services of acceptable qual-
ity, there may be instances of plans with low quality just as there are low
quality fee-for-service providers. Under current law, the government
addresses this problem by making it easy for Medicare beneficiaries to
disenroll and by limiting the number of Medicare and Medicaid benefici-
aries an HMO or CMP may enroll. Whether these devices are sufficient,
in conjunction with the threat of malpractice suits and physician ethical
standards, remains to be seen. Particularly worrisome is the possibility
that limited access to care would become apparent to enrollees only
when illness strikes, and that the low-quality plan would benefit from
the resulting disenrollment.

**Biased selection.** Another concern with the ADS approach is biased
selection—that is, an ADS may enroll a sample of Medicare beneficiaries
whose use of services under the traditional program would have been higher or lower than average. Biased selection could result from either patient decisions or from ADS efforts to attract relatively low users of services.

Published studies of the earliest Medicare HMO demonstrations showed three of four HMOs enrolling beneficiaries with lower than average rates of service use in prior years. One hypothesis is that those with chronic illness are less willing to change providers to participate in an ADS. It is not clear whether different results would be obtained if a larger sample of ADSs were studied over a longer period or in a situation other than a demonstration, especially where the possibility of having to change providers again after the demonstration concludes is not present.

Substantial biased selection poses risks to the Medicare trust funds. If capitation payments are based on the experience of the average beneficiary using traditional Medicare, but the average ADS enrollee would have used less than the average amount of services, then this approach will cause Medicare to overpay the ADS.

Another problem with biased selection is that its financial impact on ADSs could overshadow the results of good or poor management of health care costs. If ADSs must risk drawing a population that has a use rate 20 percent higher or lower than average, this will increase the business risk involved in serving the Medicare population, and induce management to devote its energies to selective marketing, or to avoid Medicare risk contracting altogether. Fortunately, methods to refine the Medicare mechanism of setting capitation payments are available and hold out the hope of reducing the magnitude of the problem. An example is incorporation of data on preenrollment use of health services. However, biased selection is unlikely to be eliminated, and will remain a liability of capitation systems, perhaps even the “Achilles heel.”

Of course, the problem of biased selection is not unique to capitation. In hospital prospective payment, for example, hospitals may draw a sample of beneficiaries that have treatment needs that are above or below average for their DRGs. Biased selection is an affliction of all options in which payment is not based on incurred costs, and the relative severity of the problem in different payment modes is an important subject for research.

**Marketing costs.** A private health plan strategy involves costs for marketing to beneficiaries that are not present under the federal approach. They may offset a portion of the cost and other advantages of the ADS approach.

Whether their magnitude will be substantial is not yet clear. To some extent it will depend on federal policy towards marketing. In private insurance, the marketing of plans to individuals and small groups is very expensive. Marketing costs of 30 percent of premiums is common. On
the other hand, marketing costs in the Federal Employees Health Benefits Program, which are for the most part borne by the government, are much lower. Each year the Federal Employees Health Benefit Program supervises the preparation of uniform brochures by health plans and informs employees of which plans are operating in their locale. Another option that is being demonstrated by Medicare in a few areas is to have a consumer organization function as a broker to market all of the qualified plans in the area, with support from the plans and from Medicare. Unless private health plans can be marketed at low cost, much of the advantage of the strategy could be lost.

Conclusion

By allowing Medicare beneficiaries to enroll in HMOs and CMPs, the federal government is giving the ADS approach a well-deserved market test. We believe ADSs will do well in the long run. The ADS approach harnesses private innovations in health care delivery for the benefit of senior citizens and taxpayers. One of the most appealing aspects of the ADS approach is that it decentralizes medical decision making, subject to a resource constraint. We believe decentralization is appropriate given the scientific uncertainty about appropriate medical practice and highly personal character of the service.

We do not favor privatization for its own sake—that is, forcing Medicare beneficiaries to enroll in private health plans by eliminating fee-for-service Medicare. For the foreseeable future, Medicare beneficiaries should have the option of remaining in the fee-for-service program. If private health plans are more efficient than Medicare, they will gain enrollees in due course.

The ADS and federal approaches to cost containment can be pursued simultaneously. In fact, the two approaches may prove mutually reinforcing. If ADSs succeed in changing medical practice for the better, physicians serving patients under fee-for-service Medicare will eventually follow suit. Meanwhile, the inherent arbitrariness of the federal approach will likely encourage more providers to participate in ADSs.

The twin threats of declining quality and adverse selection lurk wherever providers are put at financial risk for costs exceeding some predetermined amount. These threats are common to both the ADS and federal approaches, although the threats manifest themselves differently under each.
NOTES

1. A CMP is a term used for all private health plans that qualify under the provision, but
are not federally qualified HMOs. CMPs must be at risk and provide physicians' services
“primarily” through employees of the organization or through contracts with individual
physicians or groups of physicians.


Controlled Trial of the Effect of Prepaid Group Practice on Use of Services,” The New


5. E.S. Schlesinger, “Renaissance of the HMO” (Boston Consulting Group, 1985).

6. Congressional Budget Office, The Effects of PSROs on Health Care Costs: Current Findings
and Future Evaluations (June 1979).


Hospital Prospective Payment System: 1984 Annual Report” (November 1985), 6-43

10. An early study of California PPOs indicated that a wide distribution of discounts from
charges, with some much lower and some much higher than the average for Medicare. See:

Holahan and L. Etheredge, ed., Medicare Physician Payment Reform: Issues and Options
(in press).

Policy Fellows Meeting, American Enterprise Institute, 23 November 1985.

13. Ibid.

14. U.S. House of Representatives, Committee on Ways and Means, Background Material
and Data on Programs within the Jurisdiction of the Committee on Ways and Means, Com-

15. R.H. Brook, J.E. Ware et al., “Does Free Care Improve Adults Health?,” The New England
Journal of Medicine 309 (8 December 1983): 1426-1434

(May 1985): 952-971.

Health Affairs (Summer 1984): 6-33.

18. P. Eggers and R. Prihoda, “Preenrollment Reimbursement Patterns of Medicare Beneficiaries