

# Paying for HMO Care: Issues and Options in Setting Capitation Rates

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**D**URING THE FIRST HALF OF THE 1980S THE number of individuals enrolled in capitated health care systems such as health maintenance organizations (HMOs), prepaid group practices (PGPs), and competitive medical plans (CMPs) has grown at an average annual rate approaching 20 percent. This rapid rate of growth is projected by some analysts to continue until at least the year 2000, when an estimated 63 percent of the population may be enrolled in HMOs (Salomon Brothers 1985). Most of the recent growth in enrollment has been fostered by a belief in both the public and private sectors that capitated systems offer the potential for lower costs and more comprehensive coverage than is available in the fee-for-service sector.

With the increased tendency of employers to offer a capitation option as part of employee benefit packages, many employed individuals now have the choice of joining a capitated system or remaining in traditional health insurance programs (Anderson and Studnicki 1985). In addition, the Medicare program has recently begun offering beneficiaries the option of remaining in the traditional fee-for-service system or selecting an HMO or CMP (U.S. Congress 1984). Many Medicaid programs similarly are offering their beneficiaries HMO options and managed care programs in addition to the fee-for-service program.

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The increased opportunities for individuals to choose freely from among capitated and noncapitated health insurance options have made the prices at which such options are offered an increasingly important public policy issue. Inadequate attention to pricing policies, for example, could lead to adverse and favorable risk selection, and thus to increased medical care expenditures for the Medicare and Medicaid programs and corporate payers, to windfall profits for certain health care providers, and to increasingly limited access to comprehensive health insurance for individuals who are poor health risks. The pricing issue is particularly important for the Medicare program, since the Health Care Financing Administration (HCFA) establishes the rates it pays to HMOs and CMPs (hereafter collectively referred to as HMOs) for Medicare beneficiaries based upon a formula, rather than relying on traditional market forces to establish the payment rates.

The purpose of this article is to review the methods which have been used by governmental and private enterprises to establish payment rates for capitation systems, define the circumstances under which improper pricing could lead to adverse and favorable risk selection, and propose capitation pricing strategies that could be employed to decrease the likelihood that risk selection will occur. The body of the article is divided into six sections. In section I we define risk selection and clarify the circumstances under which risk selection is most likely to occur. In section II we discuss the problems that arise when risk selection occurs. In section III we define the attributes of an ideal capitation pricing system. These attributes provide a useful framework for evaluating the way HMOs and the Medicare program actually set their prices. In section IV we briefly describe how capitation rates are established by HMOs and various insurers, including the federal government. Special attention is given to the methodology employed by HCFA to establish capitation rates for HMOs and participation in the Medicare program. In section V we consider potential modifications to the way the Medicare program establishes capitation payment rates. In the final section we summarize our findings, suggest ways to improve the methodology that the federal government uses to establish capitation rates, and outline actions that corporations can take to avoid the economic costs that might otherwise result from risk selection under multiple health insurance option benefit plans.



## I. Risk Selection

Risk selection can occur whenever individuals can freely choose among competing insurance plans. Adverse selection occurs when an individual or group of individuals enrolling in a health plan has predictable expenses that are greater than the premium charged to enroll in that plan. Favorable selection occurs when predictable expenses are less than the premium.

Adverse and favorable selection can occur because of actions taken by either providers or consumers. To achieve favorable selection, providers might locate facilities in geographic areas that have lower than average utilization rates; advertise in locations that are more likely to attract good health risks; selectively market to employer groups with low health risks; establish hours that are convenient to working populations; offer services, such as preventive dentistry, that are attractive to a healthy population; or make it difficult for individuals in poor health to subscribe, for example, by requiring applicants to climb stairs in order to reach the enrollment office (Luft 1982; Berki and Ashcraft 1980). Providers can also achieve favorable selection by implementing practices that encourage poor health risks to disenroll (Des Harnais 1985). Plans might also limit access to certain specialties or limit coverage for certain services, such as psychiatric care.

Favorable selection also may occur "naturally" in capitation systems that offer a closed panel of physicians. Individuals who have established relationships with nonplan physicians—as is likely to be the case, for example, for individuals with a history of medical problems—are unlikely to be interested in severing an established relationship with a physician in order to join a closed-panel HMO (Berki et al. 1980). Alternatively, individuals with no prior disease history, such as healthy young adults without established care patterns would tend to be less averse to enrolling in closed-panel capitated health plans (Luft 1981).

Adverse selection, in contrast, could occur because enrollees have more information about their health status than do potential insurers or providers (Pauly 1974). Individuals, for example, select plans based upon their self-perceived health status. A number of studies have suggested that self-perceived health status may be a better predictor of subsequent health risk than is any of the information that is available to a plan administrator (Thomas et al. 1984).

Adverse selection may also occur as a result of political or legal barriers to the establishment of actuarially fair rates. It is extremely unlikely, for example, that providers would be able to use race in a pricing formula, even if race were discovered to be a good predictor of health care utilization. When prices do not reflect anticipated utilization, either providers or consumers can take actions that will result in adverse or favorable selection. They may, for example, locate their HMOs in locations where certain races tend to live. Numerous pricing restrictions have been imposed by state regulatory agencies on capitated systems and by the federal government on federally qualified HMOs.

## II. Problems Caused by Risk Selection

Risk selection can cause a number of problems for insurers or benefit managers who offer both capitation and noncapitation insurance options. One potential problem is that total medical care expenditures can increase for organizations offering multiple-choice options when risk selection occurs. This is a special problem for Medicare, which establishes payment rates using a formula rather than accepting prices determined by the marketplace. Under the Medicare program, beneficiaries have the choice of joining an HMO or remaining in the traditional fee-for-service system (U.S. Congress 1984). For those beneficiaries who enroll in an HMO, Medicare currently pays the enrolling HMO 95 percent of the annual adjusted per capita cost (AAPCC) of Medicare beneficiaries in their local area. The AAPCC is an estimate of what Medicare would have spent to care for a beneficiary in the fee-for-service sector. Medicare's intention is thus to save 5 percent of what its costs would have been in the fee-for-service sector. This intention may not be achieved, however, if risk selection occurs. In fact, if HMOs experience favorable selection among Medicare beneficiaries, Medicare would likely spend more than it would have spent under its traditional insurance program.

Consider, for instance, the following extreme example. Currently approximately half of the beneficiaries in the Medicare program do not use any covered services in a given year (Anderson and Knickman 1984a). If HMOs enrolled a disproportionate share of these low-cost individuals, they would be paid 95 percent of the AAPCC to care

for individuals who would likely engender a minimal amount of expenditures. If the remaining Medicare beneficiaries who had a history of generating health care expenditures tended to remain in the traditional fee-for-service program, aggregate Medicare expenditures would be larger than they would have been without the HMO option. Medicare would be paying HMOs more than fee-for-service costs to care for healthy individuals while still paying full fee-for-service costs for the treatment of sicker beneficiaries.

In addition, under such a scenario the AAPCC would increase over time. Since average Medicare fee-for-service costs would increase as low-cost beneficiaries opted for HMO coverage rather than fee-for-service coverage, the AAPCC would, by definition, increase. The amount HMOs would be paid to care for Medicare beneficiaries (i.e., 95 percent of AAPCC) would thus also increase over time, resulting in even greater expenditures for the Medicare program. The extent to which Medicare expenditures will actually increase or decrease under an HMO option plan will depend on the extent to which adverse and favorable selection is experienced by HMOs and on the extent to which the amount paid to HMOs for care of Medicare beneficiaries reflects the enrolled population's health risks (U.S. Congressional Budget Office 1985).

Health care expenses, similarly, could increase for corporations that offer their employees both traditional insurance and an HMO option. If healthier employees and their families preferentially select HMOs over traditional health insurance, then employers will tend to pay HMOs capitation fees for employees who would have engendered little if any health care expenses under a traditional health insurance plan. In addition, the cost of the same corporation's traditional health insurance coverage plan will tend to increase over time as a result of the higher experience profile of the less healthy employees who opt for traditional insurance rather than an HMO. As a result, total corporate health care costs may increase.

A second problem that could arise when adverse and favorable selection occur is that the insurance market for comprehensive coverage for high-risk individuals could evaporate (Pollack 1985; Akerlof 1970; Pauly 1974; Rothschild and Stiglitz 1976; Williamson 1975; Wilson 1980). Consumers tend to select insurance programs that offer them the best combination of price, quality, and other factors. In general, individuals who anticipate using a particular service select a benefits

package that offers that service. Insurers, by contrast, find it very difficult to anticipate which potential enrollees will use a particular service. Consequently, insurers tend to charge all beneficiaries the same premium. To compensate for the problems associated with not basing premiums on anticipated risks, many insurers offer insurance that does not cover preexisting conditions at all or that covers them after a mandatory "lag period" following enrollment.

Low-risk individuals tend to find this single-price insurance excessive and tend to choose alternative plans that offer less comprehensive coverage at a lower price. High-risk individuals, in contrast, tend to choose comprehensive coverage. The tendency for high-risk individuals preferentially to choose comprehensive coverage increases the price of comprehensive coverage and tends to induce more low-risk individuals to choose plans which offer less comprehensive coverage. Ultimately, in such a situation the market for comprehensive health insurance evaporates as the price of the comprehensive coverage desired by an increasingly small number of high-risk individuals becomes prohibitively high. An alternative scenario might be that new firms who think they could make a profit by offering comprehensive coverage would enter the market and fail, creating a continuous cycle of entry and exit of insurers. In either scenario, the market for comprehensive insurance would be unstable and high-risk individuals would have difficulty obtaining comprehensive coverage. In addition, restrictions on coverage for preexisting conditions would limit the ability of high-risk individuals to change health insurance coverage even under an open enrollment period. To date, comprehensive coverage is still available, principally because insurers have imposed restrictions that exclude coverage for prior conditions. As multiple-choice insurance options become increasingly widespread, and open enrollment periods during which restrictions on preexisting conditions are lifted, however, the theoretical concerns we have raised regarding the disappearance of comprehensive coverage are more likely to occur.

The third problem that could arise when risk selection occurs is that certain providers can earn excessive profits by attracting low-risk individuals. For example, since approximately half of Medicare beneficiaries do not use any covered services during a given year, an HMO which attracts these individuals preferentially will be able to earn a substantial profit that is unrelated to clinical or managerial efficiencies. Resources may be used inefficiently by providers able to earn "easy

profits," and excessive amounts may be spent on marketing efforts designed to attract low-cost enrollees.

### III. Attributes of an Ideal Capitation Pricing System

Adverse and favorable selection can be minimized in a number of ways, including mandating open enrollment periods, other forms of regulation, and more accurate pricing. Probably the most effective mechanism for reducing the problems of risk selection is careful attention to pricing decisions. In this section we outline five attributes of an ideal capitation pricing system.

The first attribute is that the price should accurately reflect the predictable cost of providing care to an individual or group of individuals. According to Luft, "the major difficulty with any competitive approach is that the effective premiums of the sick must be above those for the healthy; otherwise plans will develop strategies to avoid enrolling people whose expected costs exceed the premium" (Luft 1982).

A second attribute is that the predictable costs upon which payments are based should vary as a function of the characteristics of the individual or group of individuals being enrolled rather than of the pattern of practice of the person or plan providing the care (McClure 1984). It is generally agreed that health care providers have some control over utilization rates (Wennberg 1984) and that HMOs and other capitated systems are able to reduce utilization (Luft 1981; Manning et al. 1984). Capitation rates should neither penalize providers who control costs and lower utilization rates nor reward inefficient providers who provide inappropriate care.

A third attribute is that the system should be capable of being used for all potential participants. Consequently, whatever data regarding potential enrollees are deemed to be pertinent must be available for all the potential enrollees. Fourth, the system should be administratively feasible. Information pertinent to pricing decisions, therefore, must be available on a timely basis and at a reasonable cost. Finally, the pricing system should be resistant to manipulation by both providers and beneficiaries.

#### IV. How Capitation Prices Are Set Currently

A wide variety of methods are used to establish capitation rates. Most of these methods are modifications of two methods insurance companies have used to set premiums—manual rating and experience rating.

Manual rating uses demographic and other data to calculate payment rates for different classes of enrollees. Published tables provide actuarial adjustments for factors such as age, sex, geographic location, size of insurance plan, etc. Manual rating is generally used by insurance companies only for small groups or new clients for whom experience rating is not feasible. Manual rating requires numerous calculations and is generally considered by most insurers to be a poor predictor of actual costs (Trapnell, McKusick, and Genuardi 1982).

Experience rating, in contrast, relies on other factors to determine premium rates. These include the actual historical health care costs of a specific group of individuals, as well as a projection of the rate of inflation, an allowance for profits and reserves (called a loading charge), and adjustments for changes in the pool of eligible individuals and the level of coverage from year to year. Experience-rating systems are based upon group rather than individual enrollee experiences. Experience-based rate-setting systems are considered to be more accurate predictors of actual expenditures than are manual-rating systems.

Capitation prices are established using modified versions of these two premium-setting methodologies. HMOs use a form of experience rating in setting their capitation rates, while the federal government uses a modified form of manual rating in establishing the rates it will pay HMOs for providing care to Medicare beneficiaries. The prices offered by HMOs to the private sector also reflect market conditions in the local area.

##### *Methods Used by HMOs to Establish Capitation Rates for Non-Medicare Beneficiaries*

HMOs employ several different variations of experience-rating methods in determining the capitation rates they charge. All of these variants draw on the actual experience of groups of individuals enrolled in the HMO rather than on community norms. Two such experience-rating variants used by HMOs are the integrated budget-pricing method and the actuarial-pricing method (Sutton and Sorbo 1983). Both



methods provide estimates of future utilization and expenditures, which are based upon utilization norms that exist within the organization (Leighton 1978). The integrated-budgeting approach, for example, might use a standard that one physician is required for each 1,000 enrollees, and that three other clinical staff are required for each physician. Personnel cost estimates are combined with estimates of the costs of other "inputs" to project total expenditures. In the actuarial method, HMOs project utilization and per unit costs by functional unit, such as laboratory. These functional unit costs are combined to project total expenditures.

After projecting total expenditures, HMOs employ one of three methods for allocating projected revenue requirements across projected enrollees: community rating (CR), experience rating (ER), or community rating by class (CRC). Under a CR system, an HMO charges the same rate to all groups electing the same benefits, regardless of differences in the actual or projected service utilization of each group. Under an ER system, the rate charged to a particular group is based on the actual or projected service utilization of the group. CRC is a rating system that permits rates to vary by certain factors, such as age, that are thought to predict differences in utilization of health services.

Increasingly, HMOs are responding to competition in the marketplace when they establish capitation prices. Only a few years ago, when most markets had only one or two HMOs, the primary competition faced by HMOs was traditional insurance plans. In order to be competitive, HMOs had only to offer either additional services or lower prices than the fee-for-service sector. With the proliferation of HMOs, many market areas now have several competing HMOs. In this new environment, the prices charged by HMOs are in many instances based more on the anticipated prices offered by their competitors than on the price-setting methodologies just described.

### *Capitation Rates for Medicare Beneficiaries*

The Medicare program uses a modified manual-rating system to establish the price it will pay an HMO for providing care to a Medicare beneficiary. The price paid by Medicare, called the adjusted average per capita cost (AAPCC), is calculated in several steps. First, the projected national average per capita cost for all Medicare beneficiaries in the coming year is calculated. This average national cost is then

adjusted for variations in local area costs. Next, the rates are adjusted on the basis of four factors thought to be relevant to variations in expenditures—age, sex, institutional status (e.g., in a nursing home), and welfare status (i.e., Medicaid or non-Medicaid). The result is a single payment to an HMO, which is based both on national and local Medicare costs per beneficiary in the fee-for-service sector, adjusted for the demographic characteristics of the group that actually enrolls in the HMO (Kunkel and Powell 1980). This method assumes that “all beneficiaries in a given community having the same institutional status, age, sex, and welfare characteristics will require approximately the same level of health expenditures” (Beebe 1984).

*Criticisms of AAPCC.* The current method of calculating the AAPCC has been criticized from several perspectives. First, the AAPCC is very similar to the manual-rating techniques that private insurers have generally found to be poor predictors of health care costs. A number of studies have found that the AAPCC is a poor predictor of both health care expenditures and utilization (Hornbrook 1984; Anderson, Resnick, and Gertman 1983; Beebe, Lubitz, and Eggers 1985). These studies suggest that additional factors should be included in the calculation of the AAPCC.

A second criticism of the AAPCC is that the current geographic adjustment may be perpetuating regional differences in health care costs that are based upon inefficient medical practices in local areas. By basing the AAPCC on the fee-for-service costs in the local area, all of the inefficiencies of the fee-for-service system, as well as geographic variations in utilization rates, are incorporated into the AAPCC (Galbaum and Trieger 1982).

A third criticism of the AAPCC is that the present method for calculating it assumes that no interactions exist among AAPCC geographic and demographic factors (Trapnell, McKusick, and Genuardi 1982). The same nationally derived demographic-adjustment factors are used in all areas of the country. There is considerable regional variation in certain demographic variables, however. For example, states have widely varying eligibility standards for the use of Medicaid funds in paying for the Medicare Part B premium. These different standards could affect the AAPCC adjustment for welfare status.

Finally, certain factors in the AAPCC formula have been criticized for the incentives they create. The institutional factor, for example, has been criticized because it rewards providers that institutionalize patients (McClure 1984).

## V. Potential Modifications to the AAPCC

Several investigators have suggested ways in which the AAPCC could be improved. The first suggestion is based on the observation that the use of prior-utilization information in addition to demographic adjustments substantially improves the predictive accuracy of the AAPCC. Anderson and Knickman (1984b), for example, found that the most statistically important variable in generation of cost-related groups of Medicare beneficiaries was prior utilization, not demographic characteristics (Anderson and Knickman 1984b). In another study, the same authors showed that prior utilization was the most important predictor of future expenditures for individuals with high prior expenses, and that age and other demographic variables were not good predictors of expenditures (Anderson and Knickman, 1984a). Beebe, Lubitz, and Eggers (1985) found a similar result using a different methodology.

Other researchers have shown that modifying the prior-utilization model by including only certain diseases can improve the overall predictive accuracy of the model. Anderson, Resnick, and Gertman (1983) found that by incorporating only prior high-cost diagnoses the predictive accuracy of the model was improved. Ash, Anderson, and Gertman (1983) have shown that separation of Medicare individuals into three broad classes of individuals—(1) those with no prior utilization, (2) those with Medicare-reimbursed expenses but no high-cost admissions, and (3) those with high-cost Medicare admissions—is a much better predictor of future utilization than is the current AAPCC.

An alternative to the prior-use model is the incorporation of specific health-status adjustments into the calculation of the AAPCC. Such adjustments could be based on self-reported or functional health status. Thomas et al. (1983) have shown that a self-perceived health-status score is highly correlated with ambulatory care use. The same researchers also demonstrated that use of a self-reported health-status adjustment to the AAPCC significantly enhances the accuracy of cost predictions (Thomas et al. 1984).

Adjustments for functional health status—another possibility—would adjust for a beneficiary's ability to perform the activities of daily living (ADL)—personal care tasks (e.g., bathing) and various physical activities (e.g., walking one-half mile). Thomas et al. (1983) used the current Medicare survey to examine the relation between ADLs and the use of Medicare services. They found that an ADL index was a better

predictor of Medicare expenditures than were demographic variables (Thomas et al. 1984).

A fourth potential adjustment to the AAPCC that has been suggested by researchers is an adjustment in the amount paid to HMOs based on enrollees' mortality rates in a given year. Medicare beneficiaries use a disproportionate share of resources in their last year of life. Two separate studies have shown that the current AAPCC formula overpays HMOs that have lower than average mortality rates (Lubitz and Prihoda 1984; Manton and Tolley 1985). The authors of both studies suggest adjustments to the AAPCC rates based upon actual mortality rates.

Analytically, there is a growing consensus that some modification to the AAPCC would be beneficial. Unfortunately, all of the potential modifications that have been suggested have their own limitations. Use of prior-utilization data to determine subsequent payments may reward inefficient providers who are unable to control utilization, while penalizing providers who control utilization effectively. If HMOs control utilization more effectively than other providers, for example, they would be penalized unfairly under a prior-utilization payment scheme when caring for enrollees who remain in the HMO for several years. An adjustment for prior utilization could also create perverse economic incentives. There may be certain circumstances, for instance, in which it would be in the best economic interest of an HMO to increase an individual's utilization in one year in order to insure a higher payment for that individual in a subsequent year. One final problem with using prior utilization to determine subsequent payments is that the data necessary to make an adjustment for prior utilization are lacking for beneficiaries at the time they first become eligible for Medicare coverage, and it would also require HMOs to change their record-keeping systems.

It may also be difficult to make adjustments in the AAPCC for beneficiaries' health status. For one thing, there is no consensus about the most appropriate measure of health status. One potential measure, self-reported health status, could be affected by biased responses from enrollees encouraged by providers to report a lower than actual health status in order for the HMO to receive a higher payment rate. In addition, problems associated with patient confidentiality and invasion of privacy could arise if health-status measures are used to set payment rates for Medicare beneficiaries.

The other proposed modifications have even greater problems. Func-

tional health-status adjustments would require massive data-collection efforts and frequent monitoring. If the data were collected on a sample basis, the cost would still be prohibitive. Giving higher payments to providers whose enrollees experience higher mortality rates could reward providers for poor quality of care.

## VI. Summary and Suggestions for Change

In this article we have discussed the circumstances under which risk selection is most likely to occur, the problems that arise when risk selection does occur, and the attributes of a capitation pricing system that would be least likely to promote risk selection. We have also reviewed the methods HMOs actually use to establish capitation prices, as well as the price-setting methodology employed by HCFA to establish payment rates to HMOs for providing care to Medicare beneficiaries under risk contracts. Our analysis suggests that organizations, such as HCFA or corporations, that offer beneficiaries or employees a choice among competing health plans face the prospect of increased health care expenditures as a result of risk selection. This is particularly an issue for the Medicare program, which uses its monopsony power and the regulatory authority granted by Congress to set payment rates. In addition, certain providers may receive windfall profits if capitation prices are not established appropriately. In the process, total health care expenditures would increase. In order to minimize the probability of any of these events occurring, capitation prices should be set to reflect the expected costs of providing care to specific individuals or groups of individuals.

Corporations and the Medicare program could undertake several actions to avoid the economic costs that might otherwise result from adverse and favorable selection under multiple health-insurance option-benefit plans (Luft 1985). Corporations, particularly large ones with substantial negotiating leverage, for example, could pressure HMOs to use experience rating (ER) or community rating by class (CRC) rather than community rating (CR), when defining capitation rates for corporate employees. ER or CRC would better reflect the expected costs of providing care to corporate employees than would CR, and, thus, would partially offset the costs of favorable selection. To the extent that HMOs were experiencing favorable selection from corporations, price competition among HMOs for corporate enrollees also

should reduce the problems associated with risk selection. A movement to ER or CRC, or to negotiated capitation rates, would also help large national corporations to avoid paying a single national premium or capitation rate to all providers or insurers in instances in which regional offices are located in regions with varying health care costs.

Corporations could also revise the standard benefits offered to employees in traditional insurance options, e.g., by including well-baby visits under coverage for obstetrical care, in order to decrease the likelihood that "healthy" families would opt for HMOs rather than traditional insurance. To the extent that preferential selection of HMO options by "healthy" families and preferential selection of traditional insurance options by higher-risk families is thereby decreased, such expanded traditional insurance-option coverage could reduce rather than increase total corporate health care costs.

In the case of the Medicare program, we suggest that further analysis concentrate on ways to modify prior-utilization models. In particular, we advocate that a distinction be made between prior utilization for chronic versus self-limited conditions, and between prior utilization for conditions that involve minimal versus substantial physician discretion in the decision to hospitalize. By distinguishing between chronic and self-limited conditions, one can discount types of prior utilization that likely correlate poorly with future utilization, thereby improving the accuracy with which future expenditures are predicted. Future expenditures, for example, are likely to be higher for a beneficiary hospitalized with chronic uremia than for a beneficiary hospitalized with acute appendicitis. Current measures of prior use do not differentiate between these types of illnesses.

In addition, by focusing on conditions involving minimal physician discretion in hospitalization decisions, capitation payment rates can be based on utilization experiences without penalizing efficient providers or rewarding inefficient ones. Research by Wennberg (1984) suggests that certain diseases can be identified that involve significantly more physician discretion in the decision to hospitalize. By identifying a set of conditions in which physician discretion regarding hospitalization or treatment is minimal, payments can be based more on the medical condition of enrollees than on the practice patterns of providers.

Another alternative is to decide that pricing problems are too difficult to solve. In an accompanying article, Luft (1986) suggests that trying to adjust capitation payment rates so that they accurately

reflect the expected cost of caring for a specific patient will not be successful. He suggests that accurate pricing cannot be done on a national basis and that Medicare should try a demonstration program of locally based insurers that are willing to accept 95 percent of the AAPCC payment for all Medicare beneficiaries. These locally based insurers would be more able to cope with adverse selection.

This concept, generally known as intermediary at risk, raises several concerns. The administration is concerned that it is anticompetitive since it gives a monopoly to a single insurer. Consumer groups are concerned that the insurers will save money by severely restricting access or controlling the number of hospital days. Many providers are concerned that an insurer without any political constraints will lower payment rates substantially. Finally, there are no data that suggest that insurers can solve the adverse-selection problem any better than the federal government.

There are great risks associated with moving forward with a multiple-choice insurance program that includes both a traditional insurance and a capitated system option before many of the pricing problems we have elucidated have been resolved. High-risk beneficiaries may have difficulty obtaining coverage that meets their needs, certain providers may achieve windfall profits, and total costs may increase. Given the growing tendency of government programs and corporations to offer multiple health care insurance and delivery options, as well as the increasing prevalence of capitated systems of payment, it is time that the methods by which capitation premiums are established be given the careful attention they deserve.

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