Mandatory HMO Enrollment in Medicaid: The Issue of Freedom of Choice

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MEDICAID WAS ESTABLISHED IN 1965 TO GIVE poor Americans access to mainstream medicine (Starr 1982, 370). This concern over access and the fear of a "two tier" (or two class) medical system is in many ways a concern over quality of care. The only way to ensure that the poor have quality of care, the argument goes, is to give them access to the same system that serves the middle class. Access and choice of physician are major concerns, because they implicitly serve as proxies for quality of care in the technical sense.

Access to mainstream medicine in 1965 meant access to the fee-for-service system. Since 1965, however, escalating costs in the health care sector have brought fee-for-service medicine under critical scrutiny, generally, and as a payment mechanism for public programs, in particular. In addition to problems of cost, owing to, for instance, use of the emergency room for nonemergency care, Medicaid has been criticized for failure to provide adequate access to primary care and for failure to ensure continuity of care (Freund and Neuschler 1986; Hurley 1986). Health maintenance organizations (HMOs) have been proposed as a solution to both cost and continuity of care problems. Several states, indeed, now require certain Medicaid beneficiaries to enroll in HMOs.

The Milbank Quarterly, Vol. 66, No. 4, 1988

Not everyone welcomes the entrance of HMOs into the Medicaid program, however. Critics of Medicaid HMOs maintain that mandatory HMO enrollment greatly limits beneficiaries' choice of physicians and that since HMOs are a small part of the American health care system, this forces beneficiaries out of the mainstream. This concern has led federal law to treat mandatory HMO enrollment for Medicaid beneficiaries as a special case. A state that makes HMO enrollment mandatory for its Medicaid beneficiaries must obtain an exemption, called a waiver, from the Health Care Financing Administration. A state that does not contract with HMOs for its Medicaid program—thereby, in effect, requiring its Medicaid beneficiaries to participate in the fee-for-service sector—needs no exemption. This differential treatment of fee-for-service and HMO sectors is based on the belief that a mandatory HMO system runs the danger of substantially reducing beneficiaries' freedom of choice of physician and site of care.

To date there has been little effort to submit to any empirical test the belief that mandatory HMOs restrict freedom of choice. It is a very policy-relevant issue, however, because of the potential advantages of the HMO form of medical care delivery. If it can be shown that mandatory HMO enrollment does not unduly restrict freedom of choice, a major argument against Medicaid HMO expansion will have been removed. The data available to perform such a test are limited, but they are adequate to begin the task.

This is the objective of our article. The first section sets the framework for the discussion by briefly reviewing the history of Medicaid HMOs, recent changes in the HMO industry, and the reasons why major expansion of Medicaid HMOs is unlikely unless enrollment is mandatory. (Voluntary HMO enrollment presumably does not run the risk of restricting freedom of choice precisely because it is voluntary.) The second section discusses the data used and their limitations. The third and fourth sections compare freedom of choice and site of care, respectively, between the HMO and fee-for-service sectors. The fifth section presents our conclusions.

Medicaid HMOs

Enrolling Medicaid beneficiaries in HMOs is not a new idea. It was tried in the early 1970s and was unsuccessful. More recent experiments

with Medicaid HMOs have, however, been promising, and projected changes in the HMO industry are even more promising.

History

For many years the perception of Medicaid HMOs was determined by the Medicaid scandals in California in the early 1970s, and this legacy is still with us, whether justified or not. In 1972 California enacted legislation allowing the state to contract with HMOs—called prepaid health plans—for comprehensive care of its Medicaid population. Beyond requiring the plans to be less costly than fee for service, the legislation placed little control on the organizations with which the state contracted. The same legislation embodied an incentive for Medicaid beneficiaries to enroll in HMOs by imposing copayment requirements on enrollees remaining in the fee-for-service sector. The goal of the program was for one million Medicaid eligibles to enroll voluntarily in such plans by the end of 1974.

The number of plans expanded from 21 in 1972 to 54 in 1974. The number of enrollees grew from 148,000 in 1972 to 252,000 in 1974. Even though the enrollment target was not reached, this rapid growth, combined with a lack of operating controls, led to a number of serious problems that have been well documented in congressional hearings and in scholarly articles (e.g., Chavkin and Treseder 1977). The state set no criteria for contracts submitted, failed to monitor the quality of care rendered, set no standards on the number of providers in an area, and incorrectly estimated payment rates. Consumers complained about unethical marketing tactics and denial of care. The prepaid health plans, for their part, had excessive administrative costs and profits, failed to keep proper records of utilization, and did not establish grievance and disenrollment procedures.

These problems led to a public outcry which was widely covered in the media. In 1973 California passed the Waxman-Duffy act, which (1) set marketing standards, (2) prohibited the HMOs from having a majority of their enrollment being from Medicaid, and (3) required public hearings for any potential contract. These regulations were insufficient to bring the situation under control, however, in large part because of poor administration. In 1975 a new governor put a moratorium on HMO contracts.

The Medi-Cal scandals made an impression on federal policy makers. In 1976 amendments to the HMO act limited federal Medicaid pay-

ments only to federally qualified HMOs. At that time only one California plan met the new federal criteria.

HMOs were not again seriously considered for Medicaid until 1981, when Congress passed the Omnibus Budget Reconciliation Act (OBRA) of 1981, which allowed states greater flexibility in establishing reimbursement practices and encouraged HMOs for their Medicaid populations. Under section 1915(b), the secretary of the Department of Health and Human Services was authorized to grant waivers of certain program requirements in order that states could establish case-management systems within their Medicaid programs. For instance, the secretary may waive the requirement that the Medicaid beneficiary must be able to choose his provider and the requirement that the same set of services must be available to beneficiaries statewide.

The OBRA of 1981 also introduced three other provisions significant to HMOs. First, states were permitted to establish their own standards for HMOs serving Medicaid beneficiaries, instead of being restricted to federally qualified HMOs. Second, the limit on public enrollment (Medicare and Medicaid) was raised from 50 to 75 percent. (Under Medicare rules, however, public enrollment still cannot exceed 50 percent.) Third, beneficiaries enrolled in federally qualified HMOs could be locked in (i.e., not permitted to seek care elsewhere and still have their health care expenses covered by Medicaid) for six months. No legislation since the OBRA of 1981 has been as important for Medicaid HMOs.

This legislation produced much experimentation and stimulated seven states to set up mandatory HMO enrollment for at least some areas in the state. In 1982 when Arizona became the last state to participate in the Medicaid program, it required all beneficiaries to enroll in HMOs. The program had serious administrative problems for the first two years. Under a new director, however, these have been corrected. Relative to traditional Medicaid programs, it is cheaper (Trapnell et al. 1986) and may have a better quality-assurance program (Schaller, Bostrom, and Rafferty 1986).

In portions of six other states, Medicaid beneficiaries are also required to enroll in HMOs. The Medicaid competition demonstration has sites in four states: Santa Barbara, California; Kansas City, Missouri; Monroe County, New York; and three counties in Minnesota (Hurley 1986). Wisconsin has mandatory HMO enrollment for all

aid to families of dependent children beneficiaries in Milwaukee, Dane, and Eau Clair Counties (Rowland and Lyons 1987), and Pennsylvania has mandatory HMO enrollment for all Medicaid beneficiaries in sections of Philadelphia. Although the OBRA of 1981 did not lead to large-scale enrollment in HMOs, it did produce evidence that a Medicaid HMO policy is feasible, and that California's experience in the early 1970s can be avoided through careful planning and good administration. Anderson and Fox (1987) expect these programs to expand in the future.

Building on this experience, in 1987 the Reagan administration proposed fiscal incentives for states that enroll Medicaid beneficiaries in HMOs. To qualify, a state program must have all eligible beneficiaries in a particular geographic area (such as a county) enrolled in HMOs or other capitated programs, and must have certain provisions that protect quality and access to care (U.S. Office of Management and Budget 1987). This proposal, although unlikely to be enacted in the near future, suggests that mandatory HMO enrollment may become part of the policy debate. Even more recently, Massachusetts enacted universal health care legislation in April of 1988. Although best known for mandating employer-provided health insurance, this law will also strongly encourage the enrollment of Medicaid beneficiaries in HMOs. Medicaid HMOs—having been tarnished in the early 1970s, ignored in the late 1970s, and nurtured in the early 1980s—now have the track record to be placed on the national policy agenda in the late 1980s.

The Changing HMO Industry

When most people think of an HMO, they think of any capitated program. In fact, there are at least three distinct forms. The first is the prepaid group practice (PGP), typified by Kaiser. PGPs provide medical services only at designated clinics. Most of their physicians are employed full time by the PGP, and consumers must switch their physician in order to enroll. The second is the individual practice association (IPA). Its defining characteristic is that its physicians maintain their own offices and can continue to have fee-for-service patients as well as patients who come under the group's capitation scheme. In essence, the PGP is much more of a unitary organization, whereas the IPA has two very separate parts: the administrative or

insuring arm, and the providers (individual physicians or small groups of physicians). A third type of HMO is the health insuring organization (HIO). Under an HIO, a Medicaid beneficiary selects among physicians with contracts with the HIO, but the beneficiary cannot select among HIOs. Although not always considered an HMO, the HIO is best conceived of as an IPA with a monopoly position with respect to patients.

When reality is changing rapidly, as in the HMO industry, perceptions typically are out of date. The general perceptions of HMOs come out of the 1970s, when the industry was dominated by PGPs and there was a clear line between fee-for-service medicine and HMOs. In the 1980s enrollment in IPAs has grown several times faster than in traditional HMOs. By 1987 IPAs had one-half of all HMO enrollment and are likely to dominate the HMO industry in the 1990s (Welch 1988).

This growth of IPAs blurs the line between HMO and fee for service. Upon joining an IPA, physicians continue to practice in their offices and see the same patients. A physician can bring his patients with him when he or she joins, and a consumer can generally enroll in an IPA without switching physician. This flexibility is a major reason for the growth of IPAs.

Another reason for their growth is that utilization rates of IPAs, which used to be above those of traditional HMOs, are now commensurate with rates in traditional HMOs. Most IPAs are giving their physicians financial incentives to control costs. These incentives, probably in conjunction with utilization review and other mechanisms, have resulted in a drop in hospital days per 1,000 enrollees, such that the performance of these modern IPAs is similar to that of traditional HMOs (Welch 1987). (This drop in utilization does not appear to be due to differential health status, since IPA enrollees have roughly the same level of health expenditure prior to enrollment as nonenrollees [Welch 1988].)

We should note that the incentives to underutilize are stronger in modern IPAs than in traditional HMOs. This may have adverse implications for quality of care in the absence of safeguards. In an evaluation of the Wisconsin Medicaid HMO program, for example, traditional HMOs were found to have higher quality of care than IPAs (Schramm et al. 1986, 40). The quality of care in IPAs should be further investigated.

If this growth of IPAs continues, the line between fee-for-service physicians and HMO physicians will be increasingly blurred. In some parts of the country, the two groups are already overlapping to a substantial degree. For instance, one-half of all physicians in California participate in an HMO (California Medical Association Bureau of Research and Planning 1986). To the extent that California is a bellwether, there may soon be little distinction between fee-for-service and HMO physicians.

The Importance of Mandatory Enrollment If Medicaid HMOs Are to Expand

When facing a choice between fee-for-service medicine and HMOs, the nonpoor have an incentive to enroll in HMOs because HMOs can offer enrollees lower health care cost and wider coverage that compensate for some restrictions on choice. The restrictions are greater for traditional HMOs, whose physicians are typically full-time employees, than for IPAs, as noted above.

The Medicaid poor do not generally have an incentive to enroll because the disadvantages of HMOs are not compensated for Medicaid beneficiaries by lower cost or wider coverage (Ashcraft and Berki 1983; Anderson and Fox 1987). Some states with voluntary HMO programs have tried to encourage Medicaid beneficiaries to enroll by offering either additional coverage or lower copayment than available through fee-for-service Medicaid coverage. Some have also offered the inducement of guaranteed HMO coverage for six months, even if Medicaid eligibility is lost in the interim. But there is little evidence that these inducements are leading to substantial proportions of Medicaid beneficiaries voluntarily enrolling in HMOs.

To get some idea of the potential scale of voluntary HMO enrollment by Medicaid beneficiaries, we looked at six states with the highest voluntary HMO enrollment, focusing on the Medicaid markets in the metropolitan areas in those states with populations exceeding one million. Seven states—California, Florida, Illinois, Maryland, Michigan, Ohio, and Pennsylvania—had voluntary HMO enrollment of at least 10,000 in 1986 (Freund and Neuschler 1986, tables 1 and 2). Pennsylvania was dropped from our analysis of voluntary enrollment, because Philadelphia has both mandatory and voluntary enrollment in different sections of the city. We excluded counties with

TABLE 1
Market Share in Voluntary HMO Programs in 1986

State/Metropolitan area	Eligible populations	HMO enrollees (1000s)	Eligibles (1000s)	Market share
Calif. Anaheim	All	13	103	13%
Calif. Los Angeles	All	163	944	17
Calif. Oakland	All	16	181	9
Calif. Riverside and San Bernardino	All	15	226	7
Calif. San Diego	All	17	179	9
Calif. San Francisco	All	4	106	4
Calif. San Jose	All	10	99	10
Fla. Miami	AFDC & SSI	4	143	3
Ill. Chicago	AFDC	91	502	18
Md. Baltimore	All	21	164	13
Mich. Detroit	AFDC & SSI	87	390	22
Ohio Cincinnati	AFDC	3	62	4
Ohio Cleveland	AFDC	6	158	4
Ohio Columbus	AFDC	16	61	27

Source: State Medicaid agencies and Health Care Financing Administration. Data is county level.

zero Medicaid HMO enrollments and nonmetropolitan areas in order to ensure that our estimates would not underestimate market share.

Our findings are shown in table 1, recording the shares of the Medicaid market held by HMOs in states where HMO enrollment for Medicaid beneficiaries is voluntary. In one-half of the metropolitan areas included, HMO penetration did not exceed 10 percent. In only 2 of the 14 metropolitan areas included (namely Detroit and Columbus) did HMO penetration exceed 20 percent. In Detroit beneficiaries must enroll in some case-management program, either an HMO or some institution with a gatekeeper physician. Only partially implemented, this program is at least one reason for the high market share in Detroit.

Under mandatory enrollment of beneficiaries, the HMO market share of the Medicaid market is, by definition, close to 100 percent. If Medicaid saves a fixed amount per beneficiary regardless of the proportion of beneficiaries that enroll, then even the most successful

voluntary enrollment programs now yield savings which are one-quarter of what would be saved if the programs were mandatory. In reality, at low levels of HMO penetration the savings are likely to be less than proportional due to higher administrative costs and possible adverse selection from enrollment by people with reason to believe they will need more than average amounts of health care.

Given the low penetration rates under voluntary enrollment and, consequently, the small savings that the Medicaid program is likely to achieve if HMO enrollment is voluntary for Medicaid beneficiaries, mandatory enrollment in HMOs is likely to be increasingly considered by states in efforts to impose cost control. The issue of freedom of choice for Medicaid beneficiaries under mandatory HMO enrollment, therefore, can be expected to become more salient.

We now proceed to a discussion of the available data and what we can learn about freedom of choice of physicians and site of care for Medicaid beneficiaries under mandatory HMO enrollment versus fee for service.

Measurement Issues and Data Limitations

It is important to note at the outset that the data are not available to do a rigorous econometric comparison of physician availability to Medicaid beneficiaries under mandatory HMO enrollment versus Medicaid fee for service. The data do permit, however, a preliminary comparison which, although not quantitatively sophisticated, is certainly capable of giving the correct order of magnitude. Given the immediate policy importance of the issue in the face of the rapid growth in HMO enrollment in the general population, it is crucial, in our judgment, to find out as much as we can at this juncture.

Our measure of physician choice for HMOs under Medicaid is the percentage of physicians who are willing to include Medicaid patients in their practices, as measured by those who are certified to participate in the Medicaid program. In many cases, they are willing to accept some financial risk. (In Santa Barbara, the only available data were administrative records of physicians actually seeing patients.)

A weakness of this measure is that it does not necessarily reflect at least one medicaid beneficiary seen during the observation period. It also fails to differentiate between physicians who rarely see a Med-

icaid patient and those who see many (see for further discussion Hadley 1979; Held, Holahan, and Carlson 1983). Nor does it take into account the fact that physicians may accept some of the Medicaid patients who come to them but refuse to see others (see Perloff, Kletke, and Neckerman 1987). Still, it is adequate as a first approximation because it does measure the supply of physicians who have shown willingness to take Medicaid patients. In the Arizona program, for example, 90 percent of the physicians on their list are estimated to see Medicaid patients (personal communication Dorothy Lloyd, Arizona Health Care Cost Containment System).

We restrict our focus to the participation of primary care physicians, because most initial contacts are with such physicians, and they are typically responsible, within the HMO system, for utilization decisions and for continuity of care. It should be noted that in most programs Medicaid beneficiaries can switch primary physicians within an HMO every month and they can switch HMOs every year (more frequently for cause). Thus, a measure of participating physicians in the mandatory HMO sector does reflect ability to choose within that group.

Our methodology is to compare physician participation in areas with mandatory HMO enrollment for Medicaid beneficiaries with participation in traditional fee-for-service Medicaid in other parts of the same state where possible, and for the United States as a whole where state-specific fee-for-service Medicaid data are unavailable. Note that a conceptually preferable comparison would have been with fee-for-service Medicaid in the same area before the introduction of mandatory enrollment. The data were not available to do this. In particular, the largest mandatory HMO program is in Arizona, which had no Medicaid program before the introduction of mandatory enrollment.

Data on Mandatory HMOs

We restrict our analysis to Medicaid HMO programs in which enrollment is mandatory and providers are placed at some financial risk. As argued above, without mandatory enrollment HMOs' market share is much smaller than otherwise, making an HMO policy much less attractive for Medicaid. Without being placed at risk, providers will

TABLE 2
Major Medicaid Programs with Mandatory HMO Enrollment

Site	Year started	Number of counties	Enrollment (000s)	Eligible population
Arizona	1982	16	163	All
Santa Barbara, Calif.	1983	1	21	All
Wisconsin	1984	3	120	AFDC
Kansas City, Mo.	1984	1	27	AFDC
Monroe County, N.Y.[1]	1985	1	40	AFDC
Minnesota	1986	3	34	AFDC & SSI
Philadelphia, Pa.	1986	part of 1	108	All
Total			513	

[1] Ended in December 1987.

not control costs. Of those programs that enroll at least 10,000 beneficiaries, we analyze the universe.

Seven programs meet these criteria (see Freund and Neuschler 1986), the basic characteristics of which are presented in table 2. Arizona, by virtue of being statewide, is the largest. The programs in Wisconsin and Philadelphia also have in excess of 100,000 beneficiaries. Three other programs are limited to one county. The Minnesota program includes a rural county, a suburban one, and a random sample of one-third of the beneficiaries in an urban county.

Three of the programs are limited to AFDC beneficiaries. Four programs involve all categorically Medicaid-eligible beneficiaries (that is, AFDC, aged, disabled, and blind beneficiaries). Of these, Arizona, Santa Barbara, and Philadelphia also include the medically needy. Medically needy are less often included because these people become eligible only upon "spending down" to a specified level of after-health-care income. Thus, it is difficult to include them in HMOs because the financial risk of the HMO typically starts when the patient is already in the hospital.

Participation is calculated as a percentage of physicians in the service area. The Health Resource and Service Administration, an agency of the U.S. Department of Health and Human Services, maintains estimates of physicians by county as part of the "Area Resource File." Hospital-based physicians (excluding residents) are included where some HMOs are hospital based, that is, in Arizona, Kansas City, and

Monroe County. For Philadelphia, which has the only service area that is a section of a county, a list of physicians in the area was obtained from the state Medicaid agency.

The numbers of physicians participating in mandatory Medicaid HMOs were supplied by the state Medicaid agency in the case of Arizona, Santa Barbara, Kansas City, and Monroe County. In the case of Philadelphia, the Medicaid agency supplied a list of physicians participating in the HMO program, and we calculated the percentage of physicians participating. In the case of Wisconsin and Minnesota, where the state Medicaid agencies could not supply the data, we obtained them from the individual HMOs. Because there were different plans in different counties in Wisconsin, and because the vast majority of beneficiaries were in Milwaukee, we used data only for the Milwaukee HMOs. For the same reasons, in Minnesota we used data only for HMOs in the two counties in the Minneapolis-St. Paul area. In each state, we made a composite list of physicians to avoid double counting due to physicians having contracts with several IPAs.

Although lack of comparability due to border crossing is, in principle, a problem with raw physician counts, it is at most a minor problem for our data. When disaggregated data were available, as was the case for Philadelphia, Minnesota, and Milwaukee, only physicians with clinics in the service area were counted as participating. For Santa Barbara, Kansas City, Monroe County, and Arizona, the state Medicaid agency supplied total figures. In Santa Barbara, Monroe County, and Arizona, however, the urbanized area, which includes most of the suburbs of metropolitan areas, is a subcomponent of the county (or the state) (U.S. Bureau of the Census 1982). This makes it unlikely that physicians from outside the county (or the state) would participate in the HMO program. In Kansas City, the urbanized area spills over into the adjacent county, but participating physicians were required to have an office in the county.

Physician participation in fee for service is usually measured as physicians who *claim* to have any Medicaid patients in their practice, and several analyses have used the National Opinion Research Center (NORC) Survey (e.g., Mitchell and Schurman 1984). The use of survey data has the measurement problem that physician respondents overstate the proportion of the Medicaid patients actually in their practices. (Kletke et al. [1985] indicate that, for pediatricians, the true figure is 40 percent below the reported one.) NORC data are

TABLE 3
Physician Participation under Fee-for-Service

	Physician participation rate in 1983	Sample size
U.S.	81%	1,277
California	82	157
New York	67	100
Pennsylvania	70	69
Minnesota plus Wisconsin	90	51

Source: National Opinion Research Center.
Office-based primary care physicians only.

comparable across location, and—like our measure for the HMOs—reflect physicians who are willing to accept Medicaid HMO enrollees, even if not all of them actually have Medicaid beneficiaries at any given time. (Participation may be overstated in both sectors, in the fee-for-service sector because physicians claim to see more patients than they actually do and in the HMO sector because physicians may be certified to participate but not see any patients. The relative size of these overstatements is unclear.) NORC data also have the advantage that state-specific participation rates can be calculated, at least for the larger states.

Physician Participation in Medicaid: Mandatory HMO Enrollment versus Fee for Service

Table 3 records the physician participation rates for fee-for-service Medicaid for areas as comparable as possible to our mandatory HMO areas. (Deborah Williams of HCFA kindly supplied us with these figures. Missouri and Arizona were excluded because of low sample size.) Participation rates are high in Minnesota and Wisconsin, where Medicaid fees are similar to Medicare fees, and low in New York, where Medicaid fees are less than one-half of Medicare fees (Holahan 1984). This reflects the fact that higher reimbursement rates increase fee-for-service participation (e.g., Perloff, Kletke, and Neckerman

1986). (Given that decreases in Medicaid fees decrease physician participation, one might infer that Medicaid beneficiary's access to physicians would suffer. However, Long, Settle, and Stuart [1986] demonstrated that lower fees merely shift care from physician offices to outpatient hospital departments, emergency rooms, and clinics.)

We will compare HMO physician participation rates to state-specific rates for California, New York, and Pennsylvania. The rates for Minnesota and Wisconsin are combined because of the states' proximity to each other and their similar Medicaid physician fee schedules. For Missouri and Arizona the United States rate will be the baseline. The only HMO programs large enough to affect statewide rates are in Arizona, Wisconsin, and Pennsylvania. Arizona will be compared to the national rate. The potential effect of the other two programs on statewide rates does not concern us here, because the HMO programs began after the NORC survey was conducted.

Physician participation rates under mandatory HMO enrollment are presented in table 4. The programs with the lowest participation rates are Santa Barbara and Philadelphia. Both have rates of about 40 percent, in contrast to 82 percent for fee for service in California and 70 percent in Pennsylvania. Both programs are HIOs rather than traditional HMOs (that is, the programs sign insurance contracts with individual physicians, who accept some financial risk). And neither has sought to maximize the number of physicians participating. The Santa Barbara HIO originally planned to require that each participating physician have at least 125 patients, so that each physician's risk would be spread over a sizable number of patients. (Given that Americans average one visit per quarter [Wilensky and Bernstein 1983], 125 patients would translate into 125 visits per quarter, a magnitude larger than the 10 visits proposed by Hadley as the lower bound for a physician to be counted as "participating" in Medicaid.) Pressure from physicians with smaller Medicaid patient loads forced the HIO to drop this limitation, however. This attempt to exclude nominal participation (or even moderate levels of participation) demonstrates that the agency did not consider a simple measure of participation to be important for access. The Philadelphia HIO did not attempt to exclude nominal participants but does not push for higher physician participation in the recognition that fewer physicians make it easier to maintain quality assurance because physicians can be audited more carefully (personal communication, Eileen Schoen, Office

TABLE 4
Medicaid Physician Participation:
Mandatory HMO Enrollment vs. Fee for Service

Site	Physicians participating in HMOs	Physicians in area	% in HMO	Fee-for-service baseline	HMO market share
Santa Barbara, Calif.	120	288	42%	82%	NA[a]
Philadelphia, Pa.	363	926	39	70	NA
Arizona	1,300	2,438	53	81	14%
Kansas City, Mo.[b]	378	725	52	81	12
Monroe County, N.Y.	400	629	64	67	30
Minnesota (Hennepin and Dakota Co.)	1,069	1,102	97	90	45
Wisconsin (Milwaukee Co.)	745	775	97	90	31

Sources: State Medicaid agencies, Health Resources and Services Administration, U.S. Department of Health and Services, NORC, Milwaukee and Minneapolis-St. Paul HMOs, and Interstudy (1986).
Only primary care physicians (MDs and DOs) are included. Data pertain to 1986 except for the fee-for-service rate, which pertain to 1985. Market share is the percentage of the general population of the MSA enrolled in HMOs, except in Arizona, where the state is the unit.
[a] HMO market share is not applicable to HIO programs that do not contract with HMOs as separate organizations.
[b] Under physician pressure, the Kansas City program allowed beneficiaries to enroll with fee-for-service physicians. Only 21 percent of beneficiaries did so; these 55 physicians are excluded from the calculations.

of Medical Assistance, Pennsylvania). The participation rates of 40 percent must be viewed in this light.

It is useful to distinguish between HMO programs in areas with high HMO penetration in the general population and areas with low participation (see the last column). Figures for HMO market shares pertain to metropolitan statistical areas (MSAs), except in the case of Arizona. Arizona and Kansas City have physician participation of about 50 percent, which is substantially below the average fee-for-service rate for the nation. This lower participation reflects the fact that those mandatory HMO programs exist in areas where the HMO market share in the general population is still small. HMO market share in Arizona in 1986 was 14 percent, but was only 6 percent in 1982 when the Medicaid HMO program was started. In Kansas City HMO market share in 1986 was 12 percent.

Three HMO programs are in areas with high HMO market share in the general population. In Monroe County, 64 percent of the physicians participated in the mandatory HMO program. This participation rate is only slightly less than the rate in the comparable fee-for-service sector. These relatively low rates in the fee-for-service sector compared to those in other states reflects the relatively low fees that New York Medicaid pays physicians. The HMO market share in the Rochester MSA, of which Monroe is the principal county, is 30 percent.

In the two Minnesota counties and Milwaukee County in Wisconsin, virtually all of the primary care physicians participate in the mandatory HMO program—a somewhat higher proportion than participate in fee-for-service Medicaid in the two states.

On the basis of this, admittedly limited, experience it appears that physician participation in existing mandatory HMO programs is less than in fee-for-service Medicaid in areas where HMO market share in the general population is small, but it rises dramatically in high areas of HMO penetration. It is important to note, however, that even in the low penetration areas physician participation rates in mandatory HMO programs are far above those in the traditional type of HMOs, such as Kaiser. If these were the only type of HMO, physician participation in mandatory HMO programs would be in the neighborhood of 10 percent. The substantially higher rates shown even for the low penetration areas in table 4 reflects the prevalence of the IPA form of organization.

Site of Care

An alternative way to measure choice of physician and access involves the site of care. The underlying idea is that quality of care for the poor is ensured if the poor receive their care at the same sites as the middle class. The only data we were able to obtain on site of care under mandatory Medicaid HMO enrollment is for Arizona. Even so, it is worth exploring the experience of one state to get some indication of how one measure of freedom of choice compares with another. Table 5 presents the proportion of ambulatory visits for three sites of care in Arizona Medicaid. The National Medical Care and Expenditure Survey, collected by the National Center for Health Services

TABLE 5
Site of Ambulatory Visits

	Physician's office	Emergency room	Outpatient or clinic[a]
Medicaid, Arizona	84%	6%	10%
Private insurance, mountain West	90	5	6
Medicaid, mountain West	80	4	16

Sources: National Medical Care Expenditure Survey (NMCES) for 1977 and Arizona Health Care Cost Containment System for 1986.
Rows may not sum to 100% due to rounding. The nonpoor with private insurance throughout the year are compared to people with Medicaid throughout the year.
[a] Outpatient and clinic visits are grouped together because the NMCES data did not satisfactorily distinguish between the two.

Research in 1977, provides a very rough comparison in terms of fee-for-service Medicaid and private insurance. The residents of the mountain West are the nearest comparison group available in the NMCES data.

It should be noted that the 1977–1986 comparison may overestimate the proportion of cases in physicians' offices under traditional Medicaid versus Arizona's mandatory HMO Medicaid, because participation in Medicaid has dropped off since 1977 (Perloff, Kletke, and Neckerman 1987). In any case, the site of care distribution under mandatory HMO enrollment for Medicaid beneficiaries is closer to the visit distribution under private insurance than is traditional fee-for-service Medicaid. By this measure, Arizona's mandatory HMO program has been somewhat more successful in mainstreaming its Medicaid population than other Medicaid programs.

Conclusion

This article has used available evidence to pursue the issue of freedom of choice under mandatory HMO enrollment for Medicaid beneficiaries, using physician participation in Medicaid as our primary measure. The available data are inadequate to undertake rigorous econometric analysis; thus, the evidence allows for only very approximate

estimates. For example, there are only seven programs of mandatory HMO enrollment for Medicaid beneficiaries. The data we used to measure HMO physician participation in Medicaid is not strictly comparable to the data we used to measure physician participation under Medicaid. Given these uncertainties, the degree of freedom of choice under mandatory HMO enrollment seems to be related to general HMO penetration in the market area. In areas of low HMO penetration, the physician participation rate under mandatory HMO enrollment is lower than under comparable fee for service Medicaid. As HMO enrollment rises, participation rates under mandatory enrollment rise. And, at HMO market shares above 25 percent, the physician participation rates under mandatory Medicaid enrollment and under fee for service are indistinguishable.

The reason for this seems to be the increasing prevalence of the IPA form of HMO organization. Physicians affiliated with an IPA essentially have two doors to their office: one labeled fee for service and one labeled HMO. When IPAs predominate, as they do in Wisconsin and Minnesota, mandatory HMO enrollment does not restrict Medicaid beneficiaries from entering that office; it only requires them to enter it through the HMO door.

Although we cannot incorporate it formally in our analysis, physician participation in Medicaid is influenced by policies other than mandatory HMO enrollment or fee for service. The generosity of payment has been consistently found to affect participation under fee for service (see Long, Settle, and Stuart 1986, for a review of this literature). It would be surprising if payment level were not a determinant of whether HMOs are willing to participate in Medicaid. Thus, states face a tradeoff between containing costs and encouraging provider participation regardless of whether reimbursement is fee-for-service or capitation.

Physician participation is also affected by how Medicaid is administered. Under fee for service Medicaid, much paperwork and slow payment rates sometimes discourage participation. Under mandatory HMO enrollment, a number of administrative devices can facilitate participation. For instance, a period of guaranteed eligibility helps to stabilize enrollment in HMOs (Hurley 1986). Also, states can inform providers in a timely fashion of beneficiaries who are enrolling or disenrolling. Finally, states, who must develop policies to assign beneficiaries who do not actively select a provider, can ensure that

high-risk patients are evenly distributed across providers (Anderson and Fox 1987). That payment levels and administrative procedures have influenced the participation rates presented above must be kept in mind.

The analysis of this article might be boiled down to the following (oversimplified) conclusion: In areas where general HMO market share is large, mandatory HMO enrollment for Medicaid beneficiaries does not restrict freedom of choice of provider. Stating a conclusion baldly facilitates discussion of its limitations. In this case, there are at least two categories of caveats. As stated immediately above, HMOs' willingness to participate in Medicaid is determined, in part, by state policies such as Medicaid's payment rate. Thus, decisions regarding mandatory HMO enrollment and payment level should not be made separately. The second general caveat is that a physician's willingness to see a Medicaid beneficiary or whether at least one beneficiary was seen are minimal measures of participation. Physicians may see some beneficiaries but refuse to see others; they may encourage all Medicaid beneficiaries or discourage them. They may even be physically located away from most beneficiaries, such that their willingness to see beneficiaries is largely irrelevant. And those that see beneficiaries may be of above or below average quality.

For the purposes of discussion, one could go a step further and state the following proposition: In areas where general HMO market share is large, mandatory HMO enrollment is a good policy. Although a complete discussion of this proposition would require another article, one issue must be noted, namely quality of care. Although PGPs such as Kaiser give their physicians little incentive to over- or underprovide health care because they are on salary, many IPAs give their physicians incentives to underprovide care in order to contain costs. Even though fee for service gives physicians the incentive to overprovide care (which may be harmful), many people are more concerned with quality in HMOs than in fee for service. Adding to this concern, Ware et al. (1986) found that Medicaid beneficiaries who were randomly assigned to an HMO (not an IPA) had more medical problems after a period of enrollment than those assigned to fee for service. The fee-for-service system used for the comparison in that study was more similar to private insurance than to Medicaid, but this result cannot be ignored.

Given these concerns, any mandatory HMO program should include

a grievance procedure, the opportunity to disenroll for cause, and a strong quality-assurance program. Quality-assurance programs, which should include medical record audits, are operational in Arizona and Wisconsin (Schaller, Bostrom, and Rafferty 1986; Schramm et al. 1986). With such quality assurance, mandatory HMO enrollment programs could plausibly have greater quality than fee for service. The development of quality-assurance programs should be a high priority for Medicaid HMO programs, and the analysis of quality-assurance programs should be a major focus of future research.

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Acknowledgments: The opinions expressed here are those of the authors and do not necessarily represent the views of the Office of Management and Budget, the Urban Institute, or its sponsors. The authors wish to thank state Medicaid agencies, HMOs in Milwaukee and Minneapolis-St. Paul, HCFA, HRSA, and NCHSR for supplying data. We also wish to thank Jack Hadley and Felicity Skidmore for helpful comments.

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