



1999

# Risky Business: Medicare's Vulnerability to Selection Games of Managed Care Providers

Charles Tiefer

*University of Baltimore School of Law, ctiefer@ubalt.edu*

Heather Akehurst-Krause

*Law Office of Heather L Akehurst-Krause LLC*

Follow this and additional works at: <http://scholarworks.law.ubalt.edu/ublr>



Part of the [Law Commons](#)

## Recommended Citation

Tiefer, Charles and Akehurst-Krause, Heather (1999) "Risky Business: Medicare's Vulnerability to Selection Games of Managed Care Providers," *University of Baltimore Law Review*: Vol. 28: Iss. 2, Article 2.

Available at: <http://scholarworks.law.ubalt.edu/ublr/vol28/iss2/2>

This Article is brought to you for free and open access by ScholarWorks@University of Baltimore School of Law. It has been accepted for inclusion in University of Baltimore Law Review by an authorized administrator of ScholarWorks@University of Baltimore School of Law. For more information, please contact [snolan@ubalt.edu](mailto:snolan@ubalt.edu).

## RISKY BUSINESS: MEDICARE'S VULNERABILITY TO SELECTION GAMES OF MANAGED CARE PROVIDERS

Charles Tiefer†  
Heather Akehurst-Krause††

### I. INTRODUCTION

As Congress accelerates the Medicare population's movement into managed care, Medicare's vulnerability to selection games by managed care providers looms as a serious problem for both the Treasury and the over-sixty-five population. This Article explores the significance and nature of that vulnerability to selection games, before turning to what the government should do to counteract them.

Medicare matters; Medicare managed care matters in particular.<sup>1</sup> Medicare's costs expanded to \$199 billion in fiscal year 1996 to about twelve percent of the federal budget.<sup>2</sup> These costs will grow to \$248 billion in 2001 and to \$347 billion in 2006; only then will the steep phase of the increase begin when the Medicare demands of the "baby boom" generation start in 2010.<sup>3</sup>

Congress began responding to these cost increases in the Balanced Budget Act of 1997 (BBA),<sup>4</sup> using incentives to push the Medicare population toward managed care and other methods of cost control.<sup>5</sup> Currently, Medicare represents the last large population pool still predominantly receiving fee-for-service coverage and

---

† B.A., 1974, Columbia University; J.D., 1977, Harvard Law School. Solicitor and Deputy General Counsel for the House of Representatives, 1984-1995; Professor of Law, University of Baltimore School of Law.

†† B.S. in Nursing, 1995, University of Maryland; Student, University of Baltimore School of Law. The Authors would like to thank Emily R. Greenberg and her skilled staff for their library-computer assistance.

1. See generally Charles Tiefer, "Budgetized" Health Entitlements and the Fiscal Constitution in Congress's 1995-1996 Budget Battle, 33 HARV. J. ON LEGIS. 411 (1996).

2. See Steve Langdon, *With Campaign Dust Settling, Medicare Chances Brighter*, 55 CONG. Q. WKLY. REP. 175, 179 (1997).

3. See *id.*; see also CONGRESSIONAL BUDGET OFF., ECONOMIC AND BUDGET OUTLOOK: FISCAL YEARS 1998-2009 (1999).

4. See Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4701, 111 Stat. 251, 489 (1997) (to be codified at 42 U.S.C. §§ 1396u-2 to 1396u-v).

5. See Charles Tiefer, *Treatment for Medicare's Budget: Quick Operation or Long-Term Care?*, 16 ST. LOUIS U. PUB. L. REV. 27, 34-35 (1996).

moving like a glacier, slowly but on a vast scale, into managed care.<sup>6</sup> Accordingly, legal observers and courts<sup>7</sup> have begun focusing on the problems faced by Medicare and the elderly as a result of this change. These problems include inadequate grievance<sup>8</sup> and appeal procedures,<sup>9</sup> patient dumping,<sup>10</sup> and underutilization,<sup>11</sup> among other things.<sup>12</sup>

Part II of this Article concerns Medicare's vulnerability to managed care provider selection games.<sup>13</sup> Managed care providers have every incentive to enroll healthier, less demanding beneficiaries and leave the program's more problematic beneficiaries unserved. That way lies profit. However, that way also leaves the federal government with increased cost and difficulty in arranging care for residual, problematic recipients.<sup>14</sup> It further leaves those problematic beneficiaries caught between the disincentives that Congress, and rising health costs, will create for Medicare beneficiaries who fail to sign onto managed care and the agility of managed care providers in avoiding their enrollment.<sup>15</sup> As a large part of the population comes

- 
6. See *id.* Traditionally, Medicare beneficiaries received fee-for-service coverage, simply going to the hospital or doctor of their choice, and sending the bill to the government. See Langdon, *supra* note 2, at 179. In 1999, only 15% of Medicare beneficiaries were enrolled in managed care plans. See Mary Agnes Carey, *New Strategy, Old Disputes*, 57 CONG. Q. WKLY. REP. 18, 19 (1999). By contrast, 85% of Americans with employer-based health insurance receive their medical care through managed care, with the plan defining the limits of the care they receive and their choice of hospital and doctor. See *id.*
  7. See *Grijalva v. Shalala*, 152 F.3d 1115, 1121 (9th Cir. 1998). In a recent class action suit, the United States Court of Appeals for the Ninth Circuit held that rulings regarding beneficiary requests for services must be made within a reasonable time, and that such rulings must be written in type large enough for the beneficiaries to read. See *id.*
  8. See Gordon Bonnyman, Jr. & Michele M. Johnson, *Unseen Peril: Inadequate Enrollee Grievance Protections in Public Managed Care Programs*, 65 TENN. L. REV. 359, 362-71 (1998).
  9. See Jess Alderman, *Medicaid & Medicare: HCFA Must Monitor HMOs to Ensure Appeal Rights for Medicare Beneficiaries*, 26 J.L. MED. & ETHICS 253, 254 (1998).
  10. See George P. Smith, II, *Patient Dumping: Implications for the Elderly*, 6 ELDER L.J. 165, 166 (1998).
  11. Mary DuBois Krohn, Comment, *The False Claims Act and Managed Care: Blowing the Whistle on Underutilization*, 28 CUMB. L. REV. 443, 444 (1997-98).
  12. See Karen Visocan, *Recent Changes in Medicare Managed Care: A Step Backwards for Consumers?*, 6 ELDER L.J. 31, 32 (1998) (discussing the consumer protection problems associated with managed care).
  13. See discussion *infra* Part II.
  14. See Smith, *supra* note 10, at 166-74.
  15. See *id.*

to depend on the availability of Medicare-managed care providers for their health care, and sometimes their lives, the potential for burden-evading games by providers could strike justifiable fear in a sizeable percentage of Americans.

Part III of this Article concerns what the government should do. Primarily, the government should institute and improve risk adjustment programs.<sup>16</sup> These programs would adjust the payments to managed care providers so that they would only receive payment commensurate with the risks they take on.<sup>17</sup> The creation of this direct relationship between risk and payment requires addressing the argument that managed care providers function best in a free marketplace with less bureaucratic supervision, rather than with risk adjustment. Others argue the protections of the False Claims Act<sup>18</sup> can be made to apply, thereby permitting the government to pursue wrongful managed care provider efforts to evade the risk adjustment system based in fraud.<sup>19</sup> This proposal involves considering the argument that any such evasion falls short of fraud since it does not involve false billing for nonexistent beneficiaries or for services not rendered.<sup>20</sup>

## II. THE PROBLEM OF MANAGED CARE PROVIDER RISK-SELECTION

### A. Medicare's Evolution

As the largest public program for financing individual health care, Medicare has remained politically popular. Since the inception of Medicare provisions in 1965, as set forth under Title XVIII of the Social Security Act, this non-appropriated<sup>21</sup> entitlement program has steadily increased in cost.<sup>22</sup> The growing elderly population and ever-increasing cost of health care account for this dramatic increase.<sup>23</sup> Preservation of Medicare's financial integrity relies on a

---

16. See discussion *infra* Part III.

17. See Leslie M. Greenwald et al., *Risk Adjustment for the Medicare Program: Lessons Learned from Research and Demonstrations*, 35 INQUIRY 193 (Summer 1998).

18. 31 U.S.C. §§ 3729-33 (1996).

19. See discussion *infra* Part III.C.

20. See *infra* notes 106-22 and accompanying text.

21. See CLARK C. HAVIGHURST ET AL., HEALTH CARE LAW AND POLICY, 226-40 (2d ed. 1998).

22. See *id.* at 226-27. Program costs jumped from \$7.1 million in 1970 to \$70.7 million in 1985 and to \$156.5 billion in 1995, accounting for greater than 10% of the entire federal operating budget. See *id.* at 110.

23. See Judith Feder & Marilyn Moon, *Managed Care for the Elderly: A Threat or a Promise? (Managed Care and Older People: Issues and Experiences.)*, GENERATIONS,

two-fold process: cost reduction and revenue increase.<sup>24</sup> A shift in Medicare administration from a fee-for-service (FFS) model to one of managed care is one viable option for obtaining cost reductions.<sup>25</sup>

In the BBA, the 105th Congress supported a shift to Medicare managed care with the inclusion of provisions for the Health Care Finance Administration's (HCFA)<sup>26</sup> "Medicare Choice."<sup>27</sup> However, with the benefits of managed care comes the participation of Managed Care Organizations (MCOs); their incentives, of course, lie in the direction of profit maximization.<sup>28</sup>

The Medicare program's new Part "C," known as Medicare Choice,<sup>29</sup> offers beneficiaries more options in the allocation of federal financing to their health care entitlement.<sup>30</sup> Part C provides for a variety of private health plan choices for beneficiaries through MCOs categorized as Preferred Provider Organizations (PPOs), Provider-sponsored Organizations (PSOs), and Medical Savings Accounts (MSAs), in addition to the continued traditional FFS option.<sup>31</sup> The new regulations set forth a multitude of provisions

---

June 22, 1998, at 4 available in 1998 WL 16365280.

24. See Tiefer, *supra* note 5, at 29 ("The powerful support in the population for preserving Medicare as much as possible will forge a balance with the political opposition to the painful substantive steps of cost reduction and revenue increase necessary for such preservation.").
25. See *id.*
26. The Health Care Finance Administration oversees the Medicare program administration under the Department of Health and Human Services, which in turn is overseen by Congress. See HAVIGHURST, *supra* note 21, at 111.
27. See *infra* note 28 and accompanying text.
28. See Bradford H. Gray, *Trust and Trustworthy Care in the Managed Care Era*, 16 HEALTH AFF. 34, 35 (Jan/Feb 1997).
29. See 42 C.F.R. § 422 (1998).
30. See HAVIGHURST, *supra* note 21, at 112. For a comprehensive outline of the current Medicare Choice provisions, see Joe Baker, *Medicare HMOs and the Medicare Choice Program*, 85 (Practicing Law Institute New York Practice Handbook series No. F-18, 1998).
31. See Sandra Christensen, *Medicare Choice Provisions in the Balanced Budget Act of 1997*, 17 HEALTH AFF. 224, 224 (1998). PPOs are provider networks that impose lower cost-sharing requirements on an enrollee who uses network providers as opposed to non-network providers. See *id.* PSOs are organizations of "affiliated health care providers that provide a substantial portion of services covered by a plan." *Id.* Generally, the affiliated health care providers "have a majority financial interest in the PSO." *Id.* MSAs offer enrollees a medical savings plan consisting of any excess of Medicare's capitation payment over their plan's annual premium, from which the beneficiary may make non-taxable withdrawals for the purpose of paying out-of-pocket medical expenses. See *id.*

extending from MCO providership to beneficiary participation and the role of the government in each area of the program.<sup>32</sup>

*B. The Risk Selection "Pitfall" in Managed Care*

Studies on the existence and prevalence of risk selection have occurred since the inception of the Health Maintenance Organization (HMO), the preceptor to the growing managed care way of life.<sup>33</sup> Statistics indicate that thirty percent of all health care spending is attributable to one percent of the total population.<sup>34</sup> Though payor-sponsored data suggests that Medicare beneficiaries enrolled in managed care plans are satisfied with their health care coverage,<sup>35</sup> the presence of risk selection, also called "enrollment" or "selection bias," is strongly supported in the medical literature.<sup>36</sup> Advocates for the elderly have also recognized selection bias as a major factor facing the Medicare population in obtaining adequate health care coverage and access to care.<sup>37</sup>

As a result of this research, both the medical and legal communities have acknowledged that selection bias is a significant issue in predicting cost and health care outcomes for managed care recipients, not only in regard to Medicare beneficiaries but also to health care consumers as a whole.<sup>38</sup> The HCFA's inadequate consideration of the possibility that provider plans may manage a disproportionate number of older, more ill beneficiaries is also accountable for poor cost management issues.<sup>39</sup>

---

at 224-25.

32. See 42 C.F.R. § 422 (1998).

33. See generally, Fred J. Hellinger, *Selection Bias in Health Maintenance Organizations: Analysis of Recent Evidence*, 9 HEALTH CARE FIN. REV. 55, 58-60 (1987) (discussing the rise in HMO enrollment and the research on HMOs that demonstrates a high rate of selection bias).

34. See Thomas L. Greaney, *How Many Libertarians Does It Take to Fix the Health Care System?*, 96 MICH. L. REV. 1825, 1832 (1998) (book review).

35. See Steven Brostoff, *Polls Show Public is Satisfied with Managed Care*, NAT'L UNDERWRITER, Sept. 25, 1995, at 16.

36. See Robert O. Morgan et al., *The Medicare-HMO Revolving Door—The Healthy Go In and the Sick Go Out*, 337 NEW ENG. J. MED. 169, 169-75 (1997); see also Jonathan B. Oberlander, *Managed Care and Medicare Reform*, 22 J. HEALTH POL., POL'Y & L. 595, 605-07 (1997); Katherine Swartz, *Risk Selection and Medicare Choice: Beware*, INQUIRY, Summer 1998, at 101, 101-03.

37. See Feder & Moon, *supra* note 23, at 4.

38. See, e.g., Oberlander, *supra* note 36, at 604-07 (explaining how HMO cost controls affect the quality of care received by HMO beneficiaries and that selection bias is one such cost control).

39. See generally 144 CONG. REC. S12, 274-76 (daily ed. Oct. 10, 1998) (statement of

Risk selection occurs in two ways, both of which have a significant effect on the payment scheme of Medicare. The first type of risk selection occurs when beneficiaries "shop around" for the managed care plan that best meets their medical needs.<sup>40</sup> For example, beneficiaries may seek optimal managed care coverage for their health care needs, then disenroll back into the FFS sector seeking more services when their health deteriorates, and re-enroll into managed care once their increased care needs subside.<sup>41</sup> Relatively healthy recipients are more willing to change health care providers or plans than ill individuals who have developed a therapeutic relationship with their providers.<sup>42</sup> Long-term safeguards against this type of selective enrollment, by way of "lock-in" provisions, are discussed later in this Article.<sup>43</sup>

The second type of selection bias—the one of most concern here—occurs due to actions by MCOs.<sup>44</sup> This concept involves targeting the healthy elderly population for enrollment, who are less likely to utilize expensive health care services.<sup>45</sup> Capitated prospective payment<sup>46</sup> to the MCOs for healthy beneficiaries using fewer services logically results in more profit. There are several means by which MCOs have taken advantage of the ability to practice selective enrollment. It is believed that selection bias by beneficiaries encourages these efforts by managed care to enroll low-risk beneficiaries.<sup>47</sup>

---

Senator Frist) (supporting the managed care industry's position that delayed planning of a payment scheme aimed at reducing risk selection, complicated and lengthy regulations, and inappropriate "punishment" legislation bear some responsibility for cost concerns and other issues facing the monumental Medicare transition).

40. See HAVIGHURST, *supra* note 21, at 264; see also Morgan, *supra* note 36, at 170; Swartz, *supra* note 36, at 101.
41. See Morgan, *supra* note 36, at 174 (concluding that ill individuals tend to move out of managed care).
42. See Oberlander, *supra* note 36, at 607 (citing literature concluding that "all 'health plans which restrict an enrollee's choice of provider (i.e., HMOs and exclusive provider organizations) attract relatively healthy individuals'").
43. See *infra* note 55 and accompanying text.
44. See Oberlander, *supra* note 36, at 607.
45. See Swartz, *supra* note 36, at 101. This strategy appears to be working quite well for HMOs. See Oberlander, *supra* note 36, at 607 (noting that beneficiaries who enroll in HMOs tend to be significantly healthier than those in FFS and are therefore less likely to need medical care).
46. See Greenwald et al., *supra* note 17, at 193-209 (describing the evolution of capitated and prospective payment in Medicare).
47. See *id.* at 194.

One major culprit in the area of selective plan enrollment is that of marketing strategies implemented in transitioning Medicare to the managed care arena.<sup>48</sup> Managed care marketing to Medicare recipients is direct, unlike insurer marketing for corporate or business health care contracts for employees.<sup>49</sup> The latter allows insurers to target employers with low-risk employees, while using strategies to seek Medicare enrollees that are in the low-risk category of excessive health care expenditure.<sup>50</sup> While marketing by managed care plans is specifically addressed by the HCFA regulations,<sup>51</sup> there are no minimum marketing requirements that assure dissemination of program information to known high-risk geographic communities, nor are there requirements regarding the advertisement of specific types of programs offered by the managed care plans.<sup>52</sup> It is feasible that plans would only offer programs focusing on well populations, even if the plans were voluntarily presented in high-risk geographic areas. High-risk geographic areas include primarily urban neighborhoods in which there is likely to be a higher per capita rate of recipients with chronic, costly health care needs.<sup>53</sup> The HCFA's provisions in the Medicare Choice rule are currently insufficient for protecting Medicare beneficiaries and the program from the costly effects of selective enrollment.

### III. GOVERNMENT RESPONSE TO RISK SELECTION

#### A. *Selection Bias by Medicare Beneficiaries*

Reverse selection bias—bias practices by the enrollee—will remain an issue under the BBA and the Medicare Choice provisions that allow recipients nearly unlimited disenrollment rights for the first several years after the rule's enactment.<sup>54</sup> This benefit, however,

---

48. See Oberlander, *supra* note 36, at 607 (chronicling the competition among health insurance plans to sign up the best risk enrollees and their marketing strategies to target the best risk population).

49. See *id.* at 608.

50. See *id.* (discussing strategies such as face-to-face meetings and direct telephone marketing practices which enable the provider to investigate a potential enrollee's health status and either encourage or discourage enrollment based on the risk factor analysis).

51. See 42 C.F.R. § 422.80 (1998) (requiring that all marketing materials be approved by HCFA prior to distribution in providership communities and that beneficiaries in the same geographic area each receive the same information regarding plan offerings and benefits).

52. See *id.*

53. See *infra* note 83 and accompanying text.

54. See 42 C.F.R. §§ 422.62, 422.66 (1998) (stating that through 2001, the number

becomes significantly limited when the same provisions mandate a restriction by a "lock-in" period of enrollment that is to begin in the year 2002.<sup>55</sup> Recipients tend to enroll in managed care plans while their health needs are few, but disenroll when they escalate.<sup>56</sup> They disenroll in favor of plans offering additional Medicare coverage, or the FFS sector, and return to lesser-providing MCOs when their acute health issues subside and their needs decline.<sup>57</sup>

The future Medicare Choice limitations prevent enrollees from "plan jumping" in search of better coverage by locking them into one plan for a longer period of time and restricting the opportunity for disenrollment and re-enrollment into other plan options.<sup>58</sup> These long-term limitations allow for better prospective cost analyses and a more effective use of the risk adjustment model in determining a payment scheme for Medicare managed care as a whole.<sup>59</sup>

#### B. Selection Bias by Managed Care Providers

Aside from reverse risk selection, MCO selection bias practices raise significant concerns for the financial welfare of the Medicare program and, more importantly, the medical welfare of the nation's growing elderly population. Just as "lock-in" provisions are anticipated to reduce risk selection by beneficiaries, there will also be a favorable reduction of MCO-biased selection activities.<sup>60</sup> However, Medicare's exposure to these practices will continue due to several other mechanisms employed by MCOs that are not adequately addressed by the current regulations.<sup>61</sup>

For example, as previously noted, selective marketing is a major

---

of elections or changes that a Medicare Choice individual may make is not limited); *see also* Baker, *supra* note 30, at 89; Christensen, *supra* note 31, at 229.

55. *See* 42 C.F.R. §§ 422.62, 422.66 (1998) (explaining that after 2002, individuals may change plans or disenroll, but that either decision may be made only once during the first six months of the year).

56. *See supra* notes 41-42 and accompanying text.

57. *See* Morgan, *supra* note 36, at 174.

58. *See supra* note 55 and accompanying text.

59. *See* Christensen, *supra* note 31, at 229 (discussing the effect that the open enrollment procedures will have in making selective marketing by the MCOs more difficult). *But see id.* (predicting also that selection bias on behalf of enrollees will continue to occur even after lock-in due to plan options, particularly MSAs).

60. *See id.* (noting that the new open-enrollment procedures will tend to reduce favorable selection among new enrollees).

61. *See id.*

method of managed care provider selection.<sup>62</sup> One suggested solution is the inclusion of centralized marketing provisions.<sup>63</sup> Such regulations would restrict providers from directly communicating with prospective enrollees, make favorable risk selection more difficult, standardize program information to all beneficiaries regardless of geographic location, and provide more reasonable protection against abusive and fraudulent marketing practices.<sup>64</sup> Development of standard policies to which benefit information packages must conform<sup>65</sup> and setting standards by which benefits can be measured are other options to ensure the unbiased marketing of the managed care product.<sup>66</sup> The concept of standardized benefits packages is not new nor is it exclusively beneficial to the new Medicare system.<sup>67</sup>

The inability of potential managed care recipients to fully comprehend these confusing options also raises concerns.<sup>68</sup> It is frequently those recipients with the greatest health care needs that are unable to make appropriate health plan choices in light of this confusion.<sup>69</sup> There is an absence of clear provisions offering personal

---

62. See *supra* notes 48-53 and accompanying text.

63. See Oberlander, *supra* note 36, at 620.

64. See *id.* at 620-21. A standardized plan comparison of benefits, premiums, and cost-sharing—similar to that used by the Federal Employees Health Benefit Program—is suggested. See *id.* Professor Oberlander also calls for automatic inclusion of physician and financial plan incentive information in a centralized marketing package as a means of further reducing selection bias that occurs when assertive, educated enrollees make other health plan choices after requesting this additional information from the prospective provider. See *id.* Current regulations require only that this information be distributed upon request. See *id.* at 621.

65. See 42 C.F.R. § 422.80 (1998). HCFA currently requires only that managed care providers provide enrollees with basic benefits information. See *id.* No standardization of plan information is specified. See *id.*

66. See Swartz, *supra* note 36, at 102. Implementing such standards will prevent “tailoring” of benefits packages to healthier individuals, make recipients better able to compare costs of various plans, and prevent false advertising by the insurer. See *id.*

67. See *id.* Medigap policies were required by Congress to conform to 10 uniform benefit packages, as mandated by the Omnibus Budget Reconciliation Act of 1990. See *id.* This legislative change was made to address similar issues of consumer confusion and risk-selection that arise between Medicare beneficiaries and HMOs. See *id.*

68. See Christensen, *supra* note 31, at 228; Swartz, *supra* note 36, at 102.

69. See Christensen, *supra* note 31, at 228 (observing that enrollees will face a “bewildering array” of options and that “[m]aking appropriate health plan choices unassisted may be beyond the ability of some enrollees, especially those who are impaired by disability, age, illness, poverty, or lack of educa-

assistance to needy beneficiaries in making these complicated choices.<sup>70</sup> Implementation of standardized benefits packages is one way to assure dissemination of necessary information.<sup>71</sup> An additional regulation can provide for impartial adjutant services that must remain independent from managed care responsibilities in the enrollment process. This service should allow for one-on-one communication with an appointed assistant whose scope of responsibility would be limited to providing sufficient and timely managed plan information regarding benefits, premiums, and cost sharing requirements, in comparison to those for the FFS sector. Additional provisions for more specific ombudsperson services would also benefit the program as a whole, assisting in establishing trust within the vulnerable elderly population.

Health care provider incentives and influences are a third consideration in the selection bias dilemma.<sup>72</sup> Due to the fact that Medicare beneficiaries depend on their past and present physicians for guidance in decision making, there has always been a danger that managed care providers will use incentives to influence physicians to give advice that is more in the interest of the MCO than the patient. The HCFA already has fairly comprehensive regulations with regard to limitations on how and to what extent managed care administrators can compensate physicians for keeping medical expenditures of enrollees down.<sup>73</sup> The medical community has turned to the managed care industry for a response to the criticisms of poor enrollee care and management, claiming that a lack of fiduciary ethics within the industry is responsible for these concerns.<sup>74</sup>

---

tion").

70. *See id.*; *see also* Swartz, *supra* note 36, at 101. Focus groups participating in HCFA information package testing reported great confusion. *See id.* An anticipated percentage of elderly with memory or mental impairment, and vision or hearing difficulties account for a significant senior population in need of assistance with decision-making. *See id.*
71. *See* Swartz, *supra* note 36, at 102.
72. *See* Gray, *supra* note 28, at 45; *see also* Oberlander, *supra* note 36, at 600, 603.
73. *See* 42 C.F.R. § 422.208 (1998) (defining requirements and limitations of physician incentive plans).
74. Noting the absence of an ethical orientation by organizational health care providers, the American Medical Association (AMA) supports the development of ethical standards within the industry and an increase in physician control within the organizations. *See* Gray, *supra* note 28, at 37-38 (encouraging the establishment of non-profit managed care groups is another suggestion).

Beyond the physician-client and physician-MCO influence question are the concerns of indirect selection bias attributed to managed care affiliate decisions at the corporate level. While Provider Service Organization<sup>75</sup> and MCO provisions exist, the same regulations fail to address the significant influence on selective enrollment that managed care groups have when choosing their affiliating hospitals, physicians, and specialty service contract providers.<sup>76</sup> Undoubtedly, networking of providers and centers occurs, typically oriented to an overall healthy population. For example, community hospitals and centers catering to the healthier middle and upper class are more likely to be sought as network providers over urban teaching facilities that provide a large percentage of indigent care, which is often associated with consumers requiring increased health services at a substantially greater cost per capita.<sup>77</sup> Health care consumers with multiple or chronic requirements tend to be associated with larger, multi-service-providing institutions and will likely opt for FFS care when they experience difficulty in finding an MCO who contracts with their current, multiple-specialty providers.<sup>78</sup>

This system of manipulation has been linked to the need for increased and ongoing quality monitoring.<sup>79</sup> However, hypothesizing a legislative solution is difficult. The Medicare Choice rule addresses monitoring of managed care client data,<sup>80</sup> but determining what measures and data would be most useful in formulating solutions requires more time.<sup>81</sup> One possible solution is to initiate regulations providing for specific minimum service standards that assure availability of any specialty care programs required by health care consumers, either through direct or indirect provider provisions. Examples include mental health services and more traditional medical program needs, such as diabetic care and rehabilitation services. Mandating such services, in addition to existing programs targeted at preventative health care and the well population, standardizes all

---

75. See 42 C.F.R. § 422.350 (1998) (defining Provider Service Organization as a private or public entity that is organized by a group of affiliated providers).

76. See Swartz, *supra* note 36, at 103.

77. Compare Bryan A. Lang, *Understanding and Applying Alternative Dispute Resolution Methods in Modern Medicine Conflicts*, 19 J. LEGAL MED. 406, 406 (1998), with Editorial, *Indigent Care Rigid Law Burdens Urban County Hospitals*, DALLAS MORNING NEWS, Nov. 16, 1998, at 14A.

78. See Oberlander, *supra* note 36, at 607.

79. See Swartz, *supra* note 36, at 103.

80. See 42 C.F.R. § 422.257 (1998).

81. See Swartz, *supra* note 36, at 103.

managed care program benefits. This standardization would result in a reduction not only in MCO selection bias, but also reverse selection bias by high-risk enrollees whose population would be more evenly dispersed among provider groups within a geographic area. Successful implementation of this type of program includes the utilization of the centralized marketing model previously discussed.<sup>82</sup> With these minimum program and marketing provisions in place, the area risk adjustment can be reasonably addressed as the next logical aid in reducing selection bias by managed care providers.

Perhaps most important, Medicare must adjust what it pays managed care providers. Until now, Medicare has paid provider organizations on a basis that ignores the different risks and needs of a diverse pool of beneficiaries. The principle of adjusted average per capita cost (AAPCC),<sup>83</sup> a means by which Medicare costs for fee-for-service recipients were to be reduced by five percent upon their transition into a managed care plan, is included in the BBA as part of a "risk adjustment" plan.<sup>84</sup> Implementation of a new risk adjustment factor<sup>85</sup> should more adequately account for the selection bias by managed care providers that had previously resulted in a six to eight percent increase in cost, instead of the anticipated five percent reduction for recipients enrolled in Medicare managed care plans.<sup>86</sup> Medicare financial examiners have long addressed risk adjustment as a primary solution to risk selection<sup>87</sup> and reliance on it remains unfettered.<sup>88</sup> Risk adjustment counterbalances risks associated with health care provisions in high-risk geographic areas by

---

82. See *supra* notes 63-67 and accompanying text.

83. See Christensen, *supra* note 31, at 225. AAPCC is a method by which Medicare's capitation rates were set at 95% of expected program costs under the FFS management and was figured for similar beneficiaries residing in the same county. See *id.*

84. See *id.*

85. See *id.*; Greenwald et al., *supra* note 17, at 194. The current risk adjusters used in reimbursement rate calculations are age, sex, institutional status, concurrent Medicaid enrollment, and employment status with regard to employment-based insurance. See Christensen, *supra* note 31, at 225. The BBA will implement a "health status" adjustment factor by the year 2000. See *id.*

86. See Christensen, *supra* note 31, at 230 n.3 (citing a Congressional Budget Office memorandum and other sources that demonstrate an increased payment rate for HMOs over the FFS sector); see also Greenwald et al., *supra* note 17, at 194-95 (finding the HMO overpayment range to be anywhere from 5-20%, resulting from selection bias).

87. See Greenwald et al., *supra* note 17, at 193.

88. See *id.* at 202-07 (discussing HCFA's long-term interest in risk adjustment data and implementation).

providing a mechanism for an alternative reimbursement system to corporate care providers who agree to serve such communities, beyond the capitated rates set through the AAPCC formula.<sup>89</sup> Historically, risk adjustment-based payment planning has resulted in variability in reimbursement rates that managed care providers determined too risky in allowing them to predict profits on an annual basis, thereby discouraging plan offerings in these high-risk communities.<sup>90</sup> These decreased offerings in high-risk communities are due in part to the weaknesses of current demographic risk adjusters in explaining individual beneficiary variations in cost.<sup>91</sup>

The BBA lacks specific provisions for the immediate determination and implementation of a health status adjuster.<sup>92</sup> Currently, the addition of a non-specified health status adjuster by the BBA is slated for the year 2000,<sup>93</sup> bringing with it the expectation that reimbursement for enrollee health care in excess of the capitated rates will reduce the avoidance of the medically needy by MCO plans, thereby further minimizing selection bias practices.<sup>94</sup> The benefit sought by legislators of Medicare reform is the reduction of capitation rates in relation to FFS per capita costs.<sup>95</sup>

Minimum regulations, centralization of marketing practices, standardization of benefits, and specialty service provisions are four possible initiatives for tackling the prevalence of selection bias. Constraints on providership incentives and implementation of independent enrollee assistance services are equally important. Moreover, the internal development of fiduciary ethical standards by the managed care industry is a prerequisite to successful management of the selection bias issue.<sup>96</sup>

Only after the appropriate management of these accountable practices is dealt with can implementation of risk adjustments be initiated with hopes at minimizing whatever selection bias remains. Al-

---

89. See Christensen, *supra* note 31, at 225-26 (discussing the AAPCC and the effect of the BBA-proposed blended rates and floors on the provision of care in geographic areas at high risk for variable payment); see also Greenwald et al., *supra* note 17, at 193-95 (discussing the risk adjustment formula).

90. See Christensen, *supra* note 31, at 226; see also Greenwald et al., *supra* note 17, at 194.

91. See *supra* note 85.

92. See Christensen, *supra* note 31, at 229-30.

93. See 42 C.F.R. § 422.256(d) (1998) (providing only that a health adjuster will be added by HCFA, effective January 1, 2000).

94. See Christensen, *supra* note 31, at 228.

95. See *id.* at 227.

96. See generally Gray, *supra* note 28, at 38-41.

though risk adjustment processes have been substantially investigated,<sup>97</sup> closer monitoring of the effects of risk selection strategies on managed care practices and costs is still required. There are measures worth implementing, modeled on the extant scattered provisions, directed toward providing sanctions for violations in care provision and prohibiting specific practices.<sup>98</sup>

Managed care providers may well oppose or criticize the institution of risk adjustment reform by the HCFA. The industry and some members of Congress have consistently criticized efforts by the HCFA at directing managed care as involving too much bureaucratic supervision<sup>99</sup> instead of the preferred solution of trusting the market.<sup>100</sup>

A major concern of the managed care business surrounds the time frame in which health factors are incorporated into the adjustment formula. Managed care providers doubt the HCFA's ability to collect sufficient and timely diagnostic client data to enable them to mandate reasonable risk adjustment.<sup>101</sup> From the beneficiaries' perspective, such data may not be collected in time to prevent their exclusion by specific plans that have met the already reduced minimum enrollment requirements<sup>102</sup> established by the regulations.<sup>103</sup>

The legislative record over the past fifteen years and the HCFA's ensuing regulation support pressing ahead with full-scale risk adjustment. Fifteen years ago, the HCFA engaged in little pricing supervision of providers, and health care cost inflation drove Medicare costs up at incredibly high rates. In a legislative and regulatory revolution, Congress enacted and HCFA regulated a system of prospective pricing, first for hospital care and then for physician

---

97. See generally Greenwald et al., *supra* note 17, at 195-97.

98. See 42 C.F.R. § 422.110 (1998) (stating explicitly that discrimination against beneficiaries is prohibited, but providing no sanctions).

99. See 144 CONG. REC., S12275 (daily ed. Oct. 10, 1998) (statement of Senator Frist).

100. See Mary Agnes Carey, *Managed Care Overhaul Shows New Signs of Life*, 57 CONG. Q. WKLY. REP. 129, 134 (Jan. 16, 1999).

101. See Christensen, *supra* note 31, at 230; see also Greenwald et al., *supra* note 17, at 202-03 (outlining the duties and requirements placed on the Department of Health and Human Services).

102. The BBA effectively eliminates the "fifty-fifty" rule that previously required 50% enrollment of commercially insured recipients (non-Medicaid/Medicare) by managed care plans, and reduces the minimum enrollment requirements for PSOs. See Christensen, *supra* note 31, at 225.

103. See 42 C.F.R. § 422 (1998).

care.<sup>104</sup> The Medicare "market," which is distorted by the government "footing" of the bill and the general lack of protection of ordinary market economics for health care consumers, would not have worked without that regulatory revolution.<sup>105</sup> Initially, risk adjustment, like prospective pricing, will be instituted on a rush basis with less-than-ideal data<sup>106</sup> and with industry complaints of insufficient time to adjust. However, like prospective pricing, time will polish its rough edges and make it seem, in retrospect, an inevitable necessity.

C. *Applying the False Claims Act to Managed Care Risk Selection*

The previous suggestions may be insufficient because of powerful incentives for managed care providers to improve their profit position by selecting lower-risk Medicare beneficiaries. Even a risk adjustment system depends on a degree of good faith cooperation from providers.<sup>107</sup> Managed care providers could furnish inaccurate information to the HCFA, reporting that they are assuming more risk than they actually are, just as health service providers have submitted false information that they provide more valuable services than they actually do—what is commonly known as "upcoding." On the other hand, providers may furnish truthful information, yet seek preferred risks, in ways not caught by the relatively simple risk adjustment data sets.<sup>108</sup> Given the prevalence of fraud in federally-reimbursed health care,<sup>109</sup> not to expect such abuses is somewhat optimistic, if not naive.

In federal health care programs, the emerging legal check on such problems has become the False Claims Act,<sup>110</sup> among other fraud and abuse statutes.<sup>111</sup> The False Claims Act allows the Depart-

---

104. See Tiefer, *supra* note 1, at 450.

105. See *id.*

106. See Greenwald et al., *supra* note 17, at 207.

107. See generally PAMELA H. BUCY, HEALTH CARE FRAUD: CRIMINAL, CIVIL, AND ADMINISTRATIVE LAW (1996).

108. See generally MALCOLM K. SPARROW, LICENSE TO STEAL: WHY FRAUD PLAGUES AMERICA'S HEALTH CARE SYSTEM (1996).

109. See *id.*

110. See generally David J. Ryan, *The False Claims Act: An Old Weapon with New Firepower is Aimed at Health Care Fraud*, 4 ANNALS HEALTH L. 127 (1995).

111. For discussions of the anti-kickback laws, see generally James F. Blumstein, *The Fraud and Abuse Statute in an Evolving Health Care Marketplace: Life in the Health Care Speakeasy*, 22 AM. J.L. & MED. 205 (1996); see also Francis H. Hearn, Jr., *Curing the Health Care Industry: Government Response to Medicare Fraud and Abuse*, 5 J. CONTEMP. HEALTH L. & POL'Y 175 (1989).

ment of Justice to sue those who make false claims, including Medicare care providers,<sup>112</sup> for such abuses as fraudulent billing, misstatements of utilization,<sup>113</sup> and false claims about the quality of health care rendered.<sup>114</sup> Moreover, under the Act's qui tam provisions, private individuals—"whistleblowers"—can file suit on behalf of the Treasury for recovery, collecting a portion of the proceeds of the judgment or settlement as a reward.<sup>115</sup>

To assure that the False Claims Act applies to the risk adjustment context, HCFA should require managed care providers to forward certifications in order to receive payment. The certifications can simply concern the accuracy of the risk adjustment data, or could more broadly oblige the MCO to certify that it has disclosed any pattern or practice which would operate to distort the statistical validity of the risk adjustment system. In effect, such certifications shift the burden from the government to the managed care provider of surfacing provider game-playing in the risk adjustment process.

Managed care providers could raise several objections to such a policing mechanism. First, they could complain that it adds to the burdens of bureaucratic supervision, reporting, and red tape, the excessive penalties and intrusiveness of certification requirements and the False Claims Act remedy. This argument comes down to weighing the dangers in the risk adjustment process against the burdens on the managed care providers.

Second, the managed care providers could argue that, absent gross and crude fraud, the government suffers no concrete harm. Obviously, fraud cheats the Medicare program, but managed care providers can point out that they may face investigation, litigation, and liability for risk selection approaches far from gross and crude.

---

112. See Gregory T. Jaeger & Jonathan L. Dieneshaus, *Fractionous Fraud Fights*, LEGAL TIMES, Oct. 21, 1996, at S32; see also Christopher A. Myers & Michael L. Martinez, *Looking Closely at Doctors' Bills*, Legal Times, Mar. 4, 1996, at S26-27.

113. See Carolyn J. Paschke, *The Qui Tam Provision of the Federal False Claims Act: The Statute in Current Form, Its History and Its Unique Position to Influence the Health Care Industry*, 9 J.L. & HEALTH 163, 169-70, 177-78, 180 (1994-95).

114. See David C. Hsia, *Application of Qui Tam to the Quality of Health Care*, 14 J. LEGAL MED. 301, 302 (1993); see also Michael M. Mustokoff et al., *The Government's Use of the Civil False Claims Act to Enforce Standards of Quality of Care: Ingenuity or the Heavy Hand of the 800-Pound Gorilla*, 6 ANNALS HEALTH L. 137, 141 (1997).

115. See Gretchen L. Forney, Note, *Qui Tam Suits: Defining the Rights and Roles of the Government and the Relator Under the False Claims Act*, 82 MINN. L. REV. 1357, 1383 n.159 (1998).

Suppose, for example, the marketing methods of managed care providers "inadvertently" have some "subtle" selection effect, not consciously intended, and not showing up on HCFA's risk adjustment factor set. This would not involve any out-and-out intentional falsification of data provided to the government, but moreover, the provider could argue that the government suffers no real harm. After all, the managed care provider furnishes the services it claims to provide and the government pays the fee for such services.

Similar arguments have occurred elsewhere regarding the application of the False Claims Act, and Congress has not imposed any higher state-of-mind requirements or proof burdens.<sup>116</sup> The issue is whether the statute should apply in what managed care providers term the absence of "actual harm," where the provider actually provides the services it claims, and without actually engaging in false billing, finds ways to get around Medicare's inevitably simplified and limited risk adjustment system.

The courts have begun addressing situations where the provider does render the services billed for, but evades some aspect of the government's regulatory requirements. Notably, in *United States ex rel. Thompson v. Columbia/HCA Healthcare Corp.*,<sup>117</sup> Columbia Healthcare had billed for Medicare services actually provided.<sup>118</sup> It merely violated Stark laws regarding improper incentives to physicians who referred its patients.<sup>119</sup> Columbia argued that the violation of such regulations did not amount to a false claim where it actually furnished the services.<sup>120</sup> The district court agreed with Columbia, but the Fifth Circuit reversed.<sup>121</sup> The United States Court of Appeals for the Fifth Circuit held that if the government would not pay for Stark non-compliant services, then falsely certifying compliance with the Stark requirements, was a false claim.<sup>122</sup>

More generally, there are several ways to conceptualize the appropriateness of imposing certification requirements and False Claims Act penalties to back up the risk adjustment system. The purpose of the Medicare program, including the risk adjustment system, is not merely to buy a set amount of services. Rather, the

---

116. See *United States ex rel. Thompson v. Columbia/HCA Healthcare Corp.*, 125 F.3d 899, 902 (5th Cir. 1997).

117. 125 F.3d 899 (1997).

118. See *id.* at 901.

119. See *id.* at 900 n.1.

120. See *id.* at 900, 902.

121. See *id.* at 902.

122. See *id.*

program aims to provide for the health care needs of the Medicare beneficiary population, which requires effective statistical distribution of the coverage risks. A provider who gives actual services, but plays games with the distribution of coverage risks, deprives the government of what it seeks to buy.<sup>123</sup> The nation will increasingly pay out a sizeable portion of its federal government funds to purchase Medicare managed care coverage for its aged. This country cannot accept not getting what it is paying for.

#### IV. CONCLUSION

The enormous scale of Medicare costs in coming years makes the movement of the Medicare beneficiary population into managed care one of the largest public law developments of our time.<sup>124</sup> The authority enacted by Congress for the Health Care Finance Administration falls short in significant ways that allow participating managed care providers the means for manipulating the system for financial gain, without providing the necessary protections for program recipients.<sup>125</sup> Implementation of risk adjustment principles, though necessary, does not suffice. No single adjustment factor can treat the infirmities of the health care system.<sup>126</sup> Whether shoring it up by vigorous implementation of fraud sanctions might help enough as to the risk selection problem is an open question.

Medicare has evolved rapidly. Given the public reluctance to radically change Medicare's economics by cutting benefits or by raising dedicated taxes, Medicare can use every sensible reform that will make its funds go as far as possible. The reform discussed in this article would be a start.

---

123. For a fuller treatment of these issues, see Charles Tiefer & Michael Blumentfeld, *Qui Tam Recovery Without "Actual Damages,"* 6 FALSE CLAIMS ACT & QUI TAM Q. REV., July 1996, at 23.

124. See *supra* notes 1-12 and accompanying text.

125. See *supra* Part II.

126. See *supra* notes 83-102 and accompanying text.