Selection Bias Between 2 Medicare Capitated Benefit Programs

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Objectives: To assess enrollment selection bias between a standard Medicare health maintenance organization (HMO) and a higher-priced social health maintenance organization (SHMO) offering full prescription drug and unique home-based and community-based benefits and to assess how adverse selection was handled through SHMO finances.

Study Design: Kaiser Permanente Northwest offered the dual-choice option in the greater Portland region from 1985 to 2002. Analysis focused on 3 "choice points" when options were clear and highlighted for beneficiaries. Data collected included age and sex, utilization 1 year before and after the choice points, health status data at enrollment (1999-2002 only), mortality, and cost and revenues. Data were extracted from health plan databases.

Methods: Hospital, pharmacy, and nursing facility utilization for 1 year before and after the choice points are compared for HMO and SHMO choosers. Health and functional status data are compared from 1999 to 2002. Utilization and mortality data are controlled by age and sex.

Results: SHMO joiners evidenced adverse selection, while healthier members tended to stay in the HMO, with leaner benefits. Despite adverse selection, the health plan maintained margins in the SHMO, assisted by frailty-adjusted Medicare payments and member premiums.

Conclusion: This high-low option strategy sought to offer the "right care at the right time" and may be a model for managed care organizations to serve aging and disabled beneficiaries under Medicare's new special needs plan option.

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The Medicare Prescription Drug, Improvement and Modernization Act of 2003 allows Medicare to contract with a new type of managed care organization called a special needs plan (SNP). The SNPs exclusively or disproportionately serve 1 of the following 3 categories of special needs beneficiaries: institutional residents, Medicaid eligibles, and those with severe or disabling conditions.[1] Besides this targeting provision, the legislation and regulations to date do not require SNPs to do much that is "special" for special needs beneficiaries. Nor is there much experience in the Medicare health maintenance organization (HMO) market about what types of benefits to offer these beneficiaries or how beneficiaries will choose SNPs versus other options, particularly in the third category focused on beneficiaries with chronic illnesses and disabilities.

This article details the experience of Kaiser Permanente Northwest (KPNW) from 1985 to 2002, during which time it offered Medicare-aged beneficiaries a choice between a standard HMO and a social health maintenance organization (SHMO).[2,3] Operating under Medicare demonstration waivers, SHMOs can be seen as a precursor to SNPs for beneficiaries with chronic illnesses and disabilities. They offer complete prescription coverage plus benefits for "community care" (eg, personal care, homemaking, adult day services, personal emergency response systems, and short institutional respite care), as well as service coordinators to manage these latter benefits and to coordinate with medical care.

The KPNW strategy for marketing the SHMO was similar to its approach to its earlier HMO demonstration,[4] including mailings, newspaper advertisements, and internal marketing to aged KPNW HMO members and to members turning age 65 years ("age-ins"). The SHMO members were also allowed to switch to the HMO. Marketing representatives explained how to compute personal out-of-pocket drug copayments under both plans, because this was often the deciding factor.

Our hypothesis is that the 2 KPNW Medicare programs attracted different memberships: persons joining the SHMO would be sicker, while healthier HMO members would stay with the HMO's leaner benefits and lower monthly premiums. If Medicare capitations were sensitive to risk characteristics and if member premiums covered additional costs, the programs could operate in a cost-effective manner.

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METHODS

Analytic Approach

We gathered and analyzed data on benefits, prices, marketing, enrollment levels, enrollee characteristics, and utilization. After discussing the historical record with KPNW staff, we decided to illustrate choice patterns by focusing analysis on specific "choice points" when options were clear and highlighted for beneficiaries. We call these beneficiaries the decision makers.

The first choice points are geographic expansions when the SHMO expanded from Multnomah and Washington counties (greater Portland) to Clackamas County (Oregon) in 1990, and to Clark County (Washington) in 1995. The KPNW Medicare HMO members in the new counties, as well as age-ins, were offered the SHMO option. The second choice point is 1991, when the differential in member premiums between the HMO and the SHMO jumped from $26 to $59 because of the repeal of the Medicare Catastrophic Coverage Act. During this period, we analyze those who chose to convert from the SHMO to the HMO and those who converted to the SHMO despite premium differences. The third choice point is 1999 to 2002, when switching was allowed at any point during the year. Self-report health status data on new members to the 2 programs were available to compare selection bias. Table 1 summarizes the benefit and price differences between the HMO and the SHMO during the study period.

Data

We linked the SHMO membership files with the KPNW membership files to form a consolidated file that merges small eligibility gaps (<90 days) when subscribers changed pro-

Table 1. Evolution of Member Premiums and Benefits

	Premium, $		Prescription Benefit		Office Visit, $		
Year	HMO	SHMO	HMO	SHMO	HMO	SHMO	Other SHMO Extras
1990	49	75	30% of 30-d prescription or 100 doses, $50 maximum on formulary	$5/30-d prescription	5	5	CC 10% copayment, maximum $12 000/y, 30 custodial nursing home days, glasses 100% every 2 y (HMO $50), hearing aid 50% every 2 y
1991	66	125	No change	No change	5	5	No change
1995	81	156	No change	No change	5	5	14 custodial nursing home days, CC copayment up to 20%
1999	75*	170	No change	No change	5	5	HMO adds travel and health/fitness clubs in 1997, SHMO none
2000	81	176	No change	$10 for 30-d supply, 50% for nonformulary	10	10	Dentures added to CC, SHMO adds fitness and travel
2001	89†	190‡	No change	No change	10	10	Hearing excludes digital and some brands, glasses only for standard frames and lenses
2002	81	180	No change	$10 for 30-d generic supply, $20 for 30-d brand supply	10	10	—

*Eighty-one dollars in Clark County, Washington.
†Became $81 with revenue from 2000 Medicare law changes.
‡Became $176 with revenue from 2000 Medicare law changes.
HMO indicates health maintenance organization; SHMO, social health maintenance organization; CC, community care benefit (covering personal care, homemaking, adult day services, etc).

grams. These data include only Medicare-aged beneficiaries who were individual members of the HMO or the SHMO, as the SHMO option was not offered to groups because it was not available throughout the service area. We used the ZIP code for residential address at year end to determine the county. We selected persons continuously enrolled during the calendar year before the decision point and created a variable for the number of months enrolled in the year after the decision point. Date of birth and enrollment year were used to determine age. The membership system holds a termination date and a reason code for the end of every enrollment episode.

Utilization data are from KPNW systems. Hospital and nursing facility days beyond the cutoffs were truncated to year end. The following 2 pharmacy utilization measures were developed: total days supplied and total number of prescriptions. Health status data for beneficiaries joining from 1999 to 2002 were collected using the KP standard mailed questionnaire (response rate, 80%-90%).[5] The following 2 probability risk indexes have been developed using these data: the risk of frailty (being dependent on another person for daily care) and the risk of advanced illness care (likelihood of surviving the next 36 months). Definitions are available in the online Appendix A (available at **www.ajmc.com**).

Statistical Analysis

Analysis files were created from multiple annual administrative files using SAS statistical software (SAS Institute, Cary, NC) to form longitudinal person-based files. SPSS version 13.0 (SPSS Inc, Chicago, Ill) was used for *t* tests, analysis of variance, and logistic regression analysis to test for group differences. Unadjusted means of the outcome variables are reported, and the odds for joining the SHMO are adjusted by age and by months of eligibility.

RESULTS

Enrollment and Demographics

At the end of 1985, the SHMO had 3087 members, and the HMO had almost 10 000 nongroup members. The HMO peaked at about 18 000 individual members in 1987 and fell to 16 000 in 2002. The SHMO membership peaked at 6081 in 1990 and then fell (after premiums jumped) to around 4000 for the rest of the study period. The proportion of SHMO members 85 years or older rose from 7.7% in 1985 to 23.6% in 2002. The percentage of HMO members 85 years or older held steady at 10% during the study period.

Selection Bias

Choice Point 1: 1990 and 1995 Expansions. In late 1989, HMO nongroup members and age-ins were informed that the SHMO would be offered in Clackamas County. Clackamas is a large, mostly rural county whose northwest corner reaches the Portland area. The analysis is based on 2094 persons who were offered the choice and had a full year of health plan data before and after the decision point. Of these decision makers, 354 (16.9%) joined the SHMO. Switchers did not differ in age from nonswitchers, but switchers had higher hospital and prescription use before and after switching (Table 2). A multiple regression analysis controlling for age (the statistics are available online in Appendix B at **www.ajmc.com**) found that, for every additional 10 days of hospital use in the prior year, decision makers were 1.26 times more likely to choose the SHMO. Also, those who selected the SHMO were 1.57 times more likely to have died by 2002, after controlling for age. Expansion to Clark County in 1995 resulted in 11.5% of decision makers switching to the SHMO, with similar differentials in preutilization and postutilization after controlling for age (data not shown).

Choice Point 2: 1991 Heightened Dual Choice. In 1991, the SHMO premium rose from $75 to $125, while the HMO premium rose only from $49 to $66. The KPNW marketing

Table 2. Clackamas County 1990 Selection Bias Unadjusted Means Tests

Variable	Selected SHMO (n = 354)	Remained in HMO (n = 1740)	*P*
Age, mean, y	74.16	74.45	.46
Hospital days			
Pre	1.83	1.14	.01
Post	1.82	1.15	.004
Skilled nursing facility days			
Pre	0.75	1.01	.72
Post	0.75	0.85	.86
Rx days' supply			
Pre	946	574	<.001
Post	1027	583	<.001
Rx dispensed			
Pre	21	12	<.001
Post	23	13	<.001

HMO indicates health maintenance organization; SHMO, social health maintenance organization.

brochure presented options in a manner that was unique during the study period. Not only were HMO members in covered counties mailed information about how to switch to the SHMO, but members in the SHMO were also explicitly offered the option to switch to the cheaper and less comprehensive HMO.

Almost 1000 family units asked for information to join or leave the SHMO. Having peaked at 6081 members in December 1990, SHMO membership fell to 5170 a year later. The proportion of age-ins choosing the SHMO decreased from 40% in 1985 to 17% in 1991. After this increase in the premium differential, SHMO membership dropped steadily for 10 years to a low of 3913 at the end of 2000.

We compared preutilization and postutilization for the 3 decision groups (selected SHMO, dropped SHMO, and remained in SHMO), controlling for age. Results show that members leaving the SHMO in 1991 had fewer total hospital days, prescriptions filled, and prescription days supplied in 1990 than those who selected the SHMO or chose to remain in the SHMO (Table 3). Those leaving the SHMO continued to have lower hospital and drug utilization than the other 2 groups in 1991 (Table 4). For the group selecting the SHMO, the 2 prescription measures increased from the preperiod to the postperiod from a mean days' supply of 765 to 924. This could indicate declining health status or a constrained demand relieved by a richer prescription benefit.

Choice Point 3: Internal Consolidation From 1999 to 2002. This analysis used 4612 individuals joining the HMO or the SHMO in this 4-year period for whom we had self-report health data. The mean age for 1623 SHMO joiners from KP was 72.3 years, which was significantly younger than the mean age for 276 SHMO joiners from the community (74.8 years). The mean age for the HMO joiners was 73.2 years. There were 2 other significant differences between the SHMO joiner subgroups: The community group was more impaired than the KP joiners in instrumental activities of daily living movement tasks (meals, shopping, chores, and getting places) and in instrumental activities of daily living cognitive tasks (money management, taking medications, and using the telephone). The former difference disappeared after controlling for age, while the latter did not. Because only 1 difference remained after age adjustment, the 2 subgroups of SHMO joiners were merged for the selection bias analysis.

The goal of the selection bias analysis was to take a snapshot of utilization and health status differences between those who joined the SHMO (n = 1899) and those who joined the HMO (n = 2713). Consistent with prior analytic findings, KPNW records show that the SHMO joiners in the year after joining used 100% more total hospital days, 91% more skilled nursing facility days, 64% more total days of prescription drug supply, and 57% more total drug records than the HMO joiners, adjusting for eligibility months and age (data not shown). The health status survey data show the SHMO joiners reporting double the rates of hospitalization, almost 5 times the rates of emergency department use, and triple the rates of daily use of 5 or more prescriptions (Table 5). Odds ratios for frailty measures and for use of community care services and devices also show wide differentials. These utilization and functional status differences reflect underlying differences in major chronic disease: 51% of the SHMO joiners reported diabetes mellitus, heart trouble, or lung problems, compared with 32% of the HMO joiners (unadjusted for age). Moreover, logistic regression analysis,

Table 3. Analysis of Prior Year 1990 Mean Utilization (Adjusted for Age) Among Decision Makers in 1991

Variable	Selected SHMO in 1991 (n = 441)	Dropped SHMO in 1991 (n = 986)	Remained in SHMO (n = 4954)	*P*
Hospital days	2.08	0.95	1.86	<.001 (dropped vs selected and dropped vs remained)
Skilled nursing facility days	1.53	1.18	1.24	Not significant
Rx days' supply	764.81	607.02	958.39	.001 (dropped vs selected), <.001 (dropped vs remained)
Rx dispensed	17.35	13.26	21.88	<.001 (dropped vs selected and dropped vs remained)

SHMO indicates social health maintenance organization.

adjusting for age, demonstrated that the SHMO joiners were more than twice as likely to be at risk of frailty and advanced illness.

Selection Bias and the Bottom Line

How did the SHMO survive adverse selection? The key factor was a Medicare waiver for a frailty-adjusted capitation formula, which paid about double the standard Medicare HMO underwriting factors for members who resided in the community but who met nursing facility preadmission screening criteria. To maintain budget neutrality, the formula also paid a little less than the standard factors for members who did not meet these criteria.[6] This formula was phased out from 2004 to 2007 in favor of a frailty adjustment to Medicare's new diagnosis-adjusted payment.[7] Another payment difference is that the SHMO was paid 100% of the estimated county-based fee-for-service equivalents, while the HMO was paid 95%.

Table 4. 1991 Mean Postdecision Utilization (Adjusted for Age and Eligibility Months)

Variable	Selected SHMO in 1991 (n = 441)	Dropped SHMO but Stayed in KPNW (n = 625)	Remained in SHMO (n = 4954)	*P*
Hospital days	2.43	1.48	2.15	.007 (dropped vs selected), .005 (dropped vs remained)
Skilled nursing facility days	1.48	1.03	1.17	Not significant
Rx days' supply	923.97	602.15	980.26	<.001 (dropped vs selected and dropped vs remained)
Rx dispensed	21.14	13.18	22.68	<.001 (dropped vs selected and dropped vs remained)

SHMO indicates social health maintenance organization; KPNW, Kaiser Permanente Northwest.

As SHMO members' frailty rose beyond community averages, revenues rose above what the program would have received using the standard formula. For example, in 1992 the SHMO accounted for 13% of KPNW Medicare members and 14% of Medicare revenues. By 2002, the SHMO represented only 9% of membership but still accounted for 13% of Medicare revenues. The ratio of the SHMO to HMO Medicare payments per member per month (PMPM) went from 1.13 in 1992 to 1.48 in 2002.

The higher Medicare payments were justified by higher acute care utilization. The ratio of SHMO to HMO hospital days per 1000 rose from 1.03 in 1986 to 1.40 in 1992 and to 1.66 in 2002. The ratios of skilled nursing facility days per 1000 and outpatient visits per 1000 were much steadier, rising from 1.28 in 1986 to 1.64 in 1992 and to 1.51 in 2002 for skilled nursing facilities and from 1.30 in 1986 to 1.24 in 1992 and to 1.23 in 2002 for outpatient visits. In addition, costs for community care and resource coordination grew from $21 PMPM in 1986 to a high of $98 PMPM in 2001, amounting to about 15% of Medicare revenues in all study years. During the later years, more than 30% of the members lived at home but met nursing facility preadmission screening criteria, and about 25% received community care.[8]

The rising costs in both programs, relative to Medicare revenues, led to increases in beneficiary premiums, which have been much higher in the SHMO than in the HMO. The differential has been more than 2:1 since 1997, with the absolute differential about $100 per month since 2000 (Table 1). In addition, community care benefit copayment revenue rose from about $5 PMPM in the early 1990s to more than $10 PMPM by 2001.

Finally, the effect of the high-low choice on overall Medicare revenues should be considered. Although the standard diagnosis-based Medicare payment system and the frailty-adjusted version were actuarially sound standing alone, this is threatened by our finding that frailer elders tended to pick the high-option side of a high-low choice and that healthier elders tended to choose the HMO. Clearly, the 2 payment formulas produced a more favorable revenue situation for KPNW than would have occurred with only 1 formula, aside from the "extra" 5% in the SHMO payment.

DISCUSSION

Since the inception of Medicare managed care, policy makers and providers have struggled to find the combination

Table 5. Likelihood of Self-reported Characteristic Respondents Selecting SHMO Compared With HMO (Age Adjusted) Among 4612 Subjects From 1999 to 2002

Variable	Odds Ratio (95% Confidence Interval)
Poor health	2.68 (2.05-3.50)
≥5 Medications/d	3.22 (2.84-3.67)
Impaired mobility	1.90 (1.62-2.24)
≥2 Hospital admissions in past 12 mo	2.22 (1.79-2.75)
≥4 Emergency department visits in past 6 mo	4.66 (2.20-9.87)
≥4 Medical office visits in past 6 mo	1.65 (1.44-1.90)
Diabetes mellitus, lung problems, or heart trouble	2.20 (1.95-2.48)
Osteoporosis, arthritis, or hip fracture	1.29 (1.14-1.45)
≥1 Activities of daily living assisted*	1.82 (1.48-2.25)
Instrumental activities of daily living assisted	
Movement tasks†	2.05 (1.76-2.38)
Cognitive tasks‡	1.64 (1.35-1.99)
Limited community mobility	1.52 (1.34-1.72)
Safety: bars, handrails, ramps	2.31 (1.98-2.69)
Equipment: walkers, oxygen, lift bed	2.43 (1.97-2.98)
Community service received	2.83 (2.26-3.53)
Transportation assistance	1.49 (1.17-1.90)
Tried to lose weight	1.24 (1.10-1.40)
Had flu and pneumonia vaccines	0.622 (0.546-0.708)
Frailty index§	2.19 (1.78-2.70)
Advanced illness index‖	2.76 (2.29-3.32)

*Bathing, dressing, toileting, transferring, and eating.
†Preparing meals, shopping, chores, and getting places.
‡Money management, taking medications, and using the telephone.
§Measure of the likelihood of being dependent on others for daily care (see **Appendix A** available at **www.ajmc.com**).
‖Measure of the likelihood of surviving the next 36 months (see **Appendix B** available at **www.ajmc.com**).
SHMO indicated social health maintenance organization; HMO, health maintenance organization.

Take-away Points

For 25 years, social health maintenance organizations (SHMOs) have operated prototypes for Medicare special needs plans serving disproportionate shares of beneficiaries with severe or disabling conditions. This study looks at how one health plan used a SHMO to control costs.

- Kaiser Permanente offered its SHMO alongside its standard health maintenance organization (HMO), and sicker and more disabled beneficiaries chose the high-benefit, high-cost social HMO.
- The SHMO stayed solvent by using a frailty-adjusted Medicare payment formula and by charging much higher member premiums.
- Health plans are ill advised to offer special needs plans with benefits for frail beneficiaries (eg, personal care, homemakers, and adult day services) unless Medicare offers a frailty adjuster and allows these benefits to be paid for with savings.

of appropriate payment systems and care models to serve increasingly frail beneficiaries. Kaiser Permanente Northwest used subtle, but potentially important, changes in financing, marketing, care delivery, and organization to create a new choice of benefits for Medicare elders—a standard HMO supplement alongside a more expensive SHMO with full prescription drug and community care benefits. Despite adverse selection into the SHMO, KPNW successfully adjusted the member premiums and copayments to maintain margins, assisted by frailty-adjusted Medicare payments. Rising cost and benefit differentials further drove adverse selection, but the SHMO remained viable and compelling, attracting persons with poorer health seeking more services. This high-low strategy sought to offer the "right care at the right time" to beneficiaries, and many were ready to pay when the time came.

Because the SHMO waivers end in December 2007, it is not clear which elements of this approach will be available to KPNW or other health plans in the future. One option is for the SHMOs at KPNW, Elderplan, and SCAN Health Plan (the initial sites) to become "disproportionate share" SNPs, because 25% of members in each of the plans meet nursing facility level-of-care requirements.[9] Elderplan took this option in 2006. However, the new regulations make no provision for frailty-adjusted payment for SNPs not operating under demonstration waivers. Given KPNW's experience with adverse selection, Medicare Advantage plans would be ill advised to offer such a choice to beneficiaries without similar payment protections. The Centers for Medicare &

Medicaid Services is phasing out the current SHMOs' frailty adjuster from 2008 to 2010.

One policy option for Medicare would be to give the frailty adjuster only to SNPs that offer benefits designed for special needs beneficiaries (eg, community care, comprehensive prescription coverage, and more). Kaiser Permanente Northwest met these criteria in 2006, offering comprehensive drug coverage through the "doughnut hole" in the SHMO and an increase in the value of its community care benefit from $12 000 to $14 400 per year. The beneficiary premium jumped to $215 a month versus $76 for the HMO, but the SHMO continued its modest growth. The fact that significant numbers of beneficiaries continue to pay this high monthly premium shows the value they place on the benefits.

Unfortunately, even if the Centers for Medicare & Medicaid Services were to extend the frailty adjuster to protect against adverse selection, their policy for 2006 further discouraged the option of offering community care benefits by prohibiting Medicare Advantage plans from using savings to pay for services that are not "health care related," including "homemaker services...to assist people to meet personal, family, or domestic needs."[10] Under this policy, it will be difficult if not impossible for SNPs to follow the SHMO model and offer benefits to meet nonmedical special needs.

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