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Measuring adverse selection in managed health care

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Abstract

Health plans paid by capitation have an incentive to distort the quality of services they offer to attract profitable and to deter unprofitable enrollees. We characterize plans' rationing as a "shadow price" on access to various areas of care and show how the profit maximizing shadow price depends on the dispersion in health costs, individuals' forecasts of their health costs, the correlation between use in different illness categories, and the risk adjustment system used for payment. These factors are combined in an empirically implementable index that can be used to identify the services that will be most distorted by selection incentives. © 2000 Elsevier Science B.V. All rights reserved.

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1. Introduction

Many countries are turning to competition among managed care plans to make the tradeoff between cost and quality in health care. In the U.S., major public programs and many private health insurance plans offer enrollees a choice of managed care plans paid by capitation.[1] Recent estimates are that 40% of the poor and disabled in Medicaid and 14% of the elderly are enrolled in managed care plans paid by capitation (Medicare Payment Advisory Commission, 1998). Medicaid figures are increasing rapidly. In private health insurance, about three-quarters of the covered population is already in some form of managed care, though in many cases, employers continue to bear some or all of the health care cost risk (Jensen et al., 1997). Health policy in the Netherlands, England, and other countries shares similar essential features. Israel, for example, recently reformed its health care system so that residents may choose among several managed care plans which all must offer a comprehensive basket of health care services set by regulation. A common feature of such reforms is for plans to receive a capitation payment from the government or private payers for each enrollee.[2]

The capitation/managed care strategy relies on the idea that costs are controlled by the capitation payment and the "quality" of services is enforced by the market. The basic rationale for this health policy is the following: the capitation payment plans receive gives them an incentive to reduce cost (and quality), while the opportunity to attract enrollees gives plans an incentive to increase quality (and cost). Ideally, these countervailing incentives lead plans to make efficient choices about service quality.

Competition in the health insurance market has well known drawbacks, the most troubling one being adverse selection. As competition among managed care plans becomes the predominant form of market interaction in health care, adverse selection takes a new form which is much harder for policy to address than in conventional health insurance. With old-fashioned fee-for-service insurance arrangements, a health plan might provide good coverage for, say, child-care, to attract young healthy families, and provide poor coverage for hospital care for mental illness. If it appeared that refusing to cover hospital care for mental illness was motivated by selection concerns, public policy could force private insurers to offer the coverage through mandated benefit legislation. As health insurance

[1] For representative discussions in the U.S. context, see Cutler (1995), Newhouse (1994), Enthoven and Singer (1995). See also Netanyahu Commission (1990) for Israel, and van Vliet and van de Ven (1992) for the Netherlands. For a discussion of state-level reforms in the United States, see Holohan et al. (1995). Van de Ven and Ellis (2000) contain a recent and comprehensive review.

[2] For a recent survey of how health plans are paid in the U.S. by all major payer groups, see Keenan et al. (2000).

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