Medicare, Modernization and FEHBP
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Summary of Major Points

The Value of Competition and Choice

- Most capitated programs have not generated innovative ways to organize care, but have instead concentrated on enrolling healthy beneficiaries and using crude controls on service use.
- Competition can lead to a number of problems for beneficiaries, including instability in the care they receive.
- Choice of plans will not offer many advantages for beneficiaries, particularly since it is important to limit risk selection through standardized benefits.
- Competition and choice could make it difficult to protect the social insurance nature of the program.

Practical Issues in Moving to an FEHBP-type Approach

- Extra benefits, including prescription drugs, cannot be provided without substantial additional federal resources for Medicare.
- Risk selection is likely to remain a major issue because the state of the art in the area of risk adjustors remains inadequate.
- Rising costs have been a greater problem for FEHBP than Medicare in recent years.
- Withdrawal of plans from participation has plagued both Medicare and FEHBP.
- Costs of administering an FEHBP-type system could be high under Medicare because of the individual-enrollment nature of the program, the need for greater oversight for vulnerable beneficiaries, and the challenge of a much larger enrollee base.

Next Steps in Modernizing Medicare:

- Add a prescription drug benefit as a first step.
- Do more work on risk adjustment.
- Improve fee for service.
- Don't assume that privatization gives beneficiaries what they want.
- Don't assume that regulation and oversight will be simpler with competition.
- Experiment with and improve Medicare+Choice.

Recognize that Medicare will need more resources.

Supporters of using a Federal Employees Health Benefits Program (FEHBP) model for reforming Medicare often tout three major advantages: competition that will bring innovation and take the federal government out of the business of setting prices, choice for beneficiaries selecting plans, and savings to the federal government. Who could be against such a "mom and apple pie" proposal that achieves these outcomes? After all, wouldn't a private sector, capitalist approach be preferred over a public program such as the current traditional Medicare fee for service system? For a number of reasons, I argue that privatization of Medicare can be disadvantageous to beneficiaries of the program, failing to achieve all or most of these advantages and creating additional risks. A go-slow approach to revising the role of private plans in Medicare makes more sense than a rapid move to privatization.

In my testimony I examine the claims regarding advantages from the private sector and put them in the broader context of meeting beneficiaries' needs. In addition to looking at the issues surrounding the economic incentives that are the heart of the argument for privatization, it is also useful to consider experience both with the current Medicare+Choice program and the Federal Employees Health Benefits Program (FEHBP). I conclude my testimony with a set of recommendations aimed at protecting the interests of beneficiaries as Medicare evolves to meet Americans' 21st Century needs.
Medicare evolves to meet Americans' 21st Century needs.

The Elements of an FEHBP Approach

To resemble FEHBP, Medicare would have to change in a number of ways. Under FEHBP, all plans compete for enrollees; they each offer premiums that vary and some differences in deductibles, co-payments and other benefit characteristics. The federal government pays a portion of the premiums according to a formula, where the goal is to require that individuals who choose higher-cost plans pay a greater monthly premium than those choosing lower-cost plans. The idea is to encourage plans to compete on the basis of price and to give those enrolling a stake in choosing less expensive plans. Individuals can change plans once a year during open season; plans can also change their offerings at that time, if approved by the Office of Personnel Management.

While the various characteristics of a Medicare version of this approach could differ, proponents usually cite a number of components as key. Requiring that individuals choose a plan (even those who wish to keep the traditional fee-for-service option) and pay more if its total premiums are higher than an average amount is intended to make Medicare beneficiaries more sensitive to differences in health care costs. Offering multiple plans in a geographic area, including managed care options, is also usually part of such proposals for Medicare. The key is to use economic incentives to spur competition and choice for beneficiaries.

Competition and Choice

Competition and choice are so often cited as desirable, however, that what they mean in the context of health care is rarely even discussed. Thus, it is useful to consider if and why they might be desirable. First, the goal of competition is to raise quality and reduce costs so as to attract customers. In theory, this indirect enforcement mechanism should reduce the need for direct oversight and regulation in a well-functioning market since competitors effectively police each other. Choice is a related “good” because it allows the market to test for what consumers want and presumably, over time, products will change to more closely reflect consumer preferences. Choice also allows for differences in competing products and, hence, avoids the “one size fits all” approach that can result in a single product that no one likes.

Economic incentives can influence behavior in the healthcare market place just as they can for other types of goods and services. But, the health care market does entail unique problems and constraints that need to be taken into account. Further, some traditional incentives may not be appropriate in light of other goals such as societal concerns about access to care and the quality of basic care.

First, consider competition. The real issue facing Medicare's future is not the theoretical attractiveness of competition, but what it means in practice for the delivery of care. How does competition among private plans manifest itself? If we were dealing with a very standardized product, competition should only affect the quality of the product and its price. But when there is little standardization and few norms for quality — as is the case in health care — quality bears little relationship to competition. Furthermore, in neither Medicare+Choice nor FEHBP is competition focused exclusively on price. Offering alternative benefit packages is the major way in which Medicare+Choice plans compete, and this idea underpins FEHBP's structure as well. It is hard to lower costs while allowing a number of options to be proffered.

But when price is an issue, good competitors look around and seek the easiest ways to hold down costs to lower their prices. In insurance plans, such as found in Medicare+Choice, the easiest path to profitability is to attract a healthier mix of patients (unless there is a good payment system that provides incentives to accept sicker patients). This happens not because plans are evil or cruel, but rather because they must make a profit. By seeking healthier enrollees, they can offer their clients a rich mix of services, do well by them and still make a profit. This is good for the company and good for their clients. It is just not good for sicker beneficiaries, for the Medicare program, nor for society as a whole because insurance companies end up getting paid too much for the clients they serve. Can that be altered? Creating a very strong risk adjustor could reduce, but probably not eliminate, the incentives to skim the cream from the market. Further, the existing risk adjustors are weak and progress on improving them has been very slow.

The second way that plans may be able to hold down costs is by obtaining discounts from care providers. Further, supporters of competition often point to the benefits of letting insurers deal with the many prices that need to be set to have health care operate under the traditional Medicare program. Relying on private insurers does not solve that problem, however, but simply moves it to the plan level. Micromanagement would be eliminated at the federal government level, but would be alive and active within the insurance company.

One way or another, the health care market has to contend with administered or negotiated prices. In the case of private plans, health care providers are now striking back with demands for higher fees. If plans enter into long, contentious negotiations, the network of doctors and other care providers participating in a plan may become smaller and less stable, an outcome that hurts consumers.

A competitive environment may also reduce stability for consumers and providers in another way. As plans themselves move in and out of markets, some consumers may lose access to their physicians and other providers and have to learn a new set of rules if they go to another plan. These changes hurt the continuity of care.

Developing innovative and effective tools for reducing unnecessary care is often well down the list of insurers' preferred strategies to reduce the costs of covering Medicare beneficiaries. In practice, such cost-controlling activities are hard to implement, especially for plans that consist of very loose networks of hospitals and doctors. It requires considerable effort and resources to build an infrastructure to coordinate care effectively. Some plans have used cruder methods -- making it hard to get appointments or routinely denying certain
types of care -- but this approach is a far cry from good management and is one that has helped fuel the backlash against managed care plans. Thus, one of the hopes for managed care — that it would use new and innovative strategies to better curtail unnecessary service — has not been achieved.

These limitations on competition mean that private plans can hold down the costs of health care only modestly. Expectations by competition proponents that the savings achieved would be great enough to pay for substantial additional benefits at little or no cost to either the government or beneficiaries has been one of the rationales for supporting such an approach. But even if competition lowers costs somewhat from restricting provider choice and limiting care, savings may be insufficient to pay for expensive benefits like prescription drugs. Given the barriers to competition in this market, the promise of substantial savings has been seriously overstated.

What about choice in health insurance? Is this so important to consumers that it justifies adopting a competitive, private market approach? Here it is important to note that choice issues tend to be thought of in two very different ways. For those enrolled in Medicare, choice is valued when it means the ability to pick one’s own doctor or health care provider. To the health economist, choice usually refers to inviting competition by letting consumers choose among plans. But, the first type of choice is often restricted by plans, which offer limited supplies of providers and no guarantee that providers won’t change over the course of a year. That aspect of choice thus offers a disadvantage to consumers.

Yet, one potential advantage of choice among plans would be to allow individuals to seek policies that cover only the care that they believe they will need -- for example, by excluding certain services (such as home health care) or offering higher deductibles and co-pays. But this flexibility creates a major problem since healthy people can choose a plan with high deductibles or no home health care, most likely putting them into a risk pool that does not attract those in poor health. And if high and low users of health care are not in the same risk pools, then sicker beneficiaries will have to choose among very high premiums costs or limited insurance coverage. And particularly if the risk adjustor that sets payments to plans on behalf of individuals of varying health status is weak, it is essential to limit choice in order to also limit risk selection.

As noted above, another major problem with giving consumers choice of benefits is that it results in a different type of competition than price competition. Beneficiaries would not necessarily choose the lowest cost plan under such a strategy. If true competition were the goal, benefits would also be standardized to assure greater comparability and price comparisons.

What does choice mean when benefits are standardized? Presumably individuals would choose among plans with fixed benefit packages. But on what basis can they make good choices? Plans are likely to advertise why they should be chosen, but they may not provide very helpful information. And the information that people really need, such as what different plans establish as "reasonable payment levels" or define as "medical necessity," is usually considered proprietary. But these seemingly technical issues determine what services are actually covered. Even if this information were made available, it is very hard even for savvy consumers to compare plans. Often, choosing the wrong plan becomes obvious only when the client becomes sick and needs care. Neutral advice and information from government can help consumers choose, but will that be enough to improve health coverage? And will the government invest in the dissemination of the objective data? Numerous studies have documented the problems and discomfort that many beneficiaries experience in trying to make such choices.

For these reasons, I conclude there is little to be gained from expanding competition and choice for the beneficiary at the present. Competition does not offer a panacea. People need to look beyond the buzzwords and weigh the tradeoffs. The risks of dividing Medicare into the sick and the healthy in the name of competition and choice are high. And the potential for undermining the basic goals of Medicare as an entitlement program also argue against relying on private sector initiatives. Assuring universal access to care for those who are eligible is an important precept of Medicare. Splitting up the risk pool and relying on the private sector, which has no stake in social goals, make it difficult to protect the program.

**Experience with Medicare+Choice**

High quality plans seeking to serve patients well certainly exist, but Medicare+Choice is a very troubled program. Medicare has, since the 1980s, formally allowed beneficiaries to choose private plans (paid on a capitated basis) instead of remaining in the traditional fee-for-service part of the program. In 1997, the Balanced Budget Act (BBA) modified the private plan option to allow plans other than health maintenance organizations (HMOs) to participate. The new option was called Medicare+Choice.

The BBA also sought to reform the payment system, which costs Medicare more for each enrollee than if they had remained in the traditional program. Serving a healthier population and lacking an adequate structure for establishing payments, Medicare overpaid its private plans for the cost of Medicare-covered services. But the new payment system has not solved the problems of overpayment; rather, it has created new ones.

Medicare’s rules require that if a plan is paid more than it costs to provide Medicare-covered services (and a normal profit), the plan must either return money to the federal government or offer additional benefits to plan participants. Almost all offer extra benefits; in fact, many plans believe that they must do so to attract enrollees. Thus, even after several years of lower payments from the BBA changes, the General Accounting Office found in 2000 that Medicare+Choice plans used 22 percent of their revenues to provide additional benefits beyond what is required by Medicare. Further, Medicare’s benefit package is recognized as not very comprehensive, making it difficult to manage care without covering other benefits such as prescription drugs. Although Medicare’s payments have been sufficient to pay for Medicare-covered services, plans now have
fewer dollars to offer extra benefits than before. Over the past four years, as Medicare’s contributions to plans have become less generous, extra benefits have been substantially reduced and plans have exited some markets. Withdrawals have left hundreds of thousands of beneficiaries scrambling each year to enroll elsewhere or to get Medigap coverage if they return to traditional Medicare. Further, plans with drug coverage have declined from 84 percent of all plans in 1999 to 71 percent in 2002. And when drug coverage has been retained, stringent caps have been applied or substantial premiums levied on the beneficiary. By 2002, almost two-thirds of enrollees in M+C plans had either no drug coverage or coverage limits of $500 or less.

Both plans and beneficiaries had come to expect the extra benefits that could be offered under the pre-1997 payment levels, and the decline in benefits has disappointed and disillusioned many beneficiaries. In that sense, plans are correct that they are not paid enough to offer an “attractive” benefit package. Should extra federal dollars be used to assure such extra benefits in M+C but not in traditional Medicare? The 86 percent of beneficiaries in traditional Medicare are unlikely to favor such a policy change. But without further federal dollars, enrollment in Medicare+Choice will likely decline further.

Are the problems noted here with Medicare likely to be present under any managed competition arrangement, or are they peculiar to Medicare+Choice? Most likely, many of the issues now facing Medicare+Choice will be present under any system relying on private plans. In particular, adverse risk selection can affect any managed competition arrangement that does not effectively adjust for population differences. It takes only a small amount of risk selection to destabilize the Medicare program, if a large number of beneficiaries have known health problems since their own choices may contribute to risk selection. The lack of reliable information on choices and the absence of good coordinated care are also likely to remain problems.

The size and nature of the benefit package are also likely to plague Medicare in the future unless the basic benefit package is improved. Since Medicare lacks prescription drug coverage, payments to plans will not cover this expensive benefit, even though it is hard to imagine how managed care (or fee for service) can function without such coverage.

At the same time, the administered prices used in Medicare+Choice have created some unique problems, including payments set unnecessarily high or low in response to geographic differences in health care spending under fee for service. But no new payment system has come along that promises to work any better.

Finally, regulatory reform and simplification could help to make a new Medicare approach more attractive to potential participants. This overhaul needs to be carried out in the context of recognizing the special vulnerabilities of some beneficiaries in Medicare, however. There has not been an impartial assessment of the proper balance between beneficiary and provider interests.

**Borrowing from FEHBP**

The Federal Employees Health Benefits Plan has a number of problems of its own that would likely carry over if it became the new template for Medicare. Perhaps most important, the attractiveness of FEHBP in holding down the costs of care has diminished considerably since the mid 1990s, when that approach enjoyed greater success than Medicare. Since then, the rate of growth in spending on FEHBP has been very high. Although results vary with the period examined, traditional fee-for-service Medicare has done considerably better than FEHBP (see Figure 1). Further, in the past several years, deductibles and co-payments required by both managed care and PPO plans have risen substantially. These trends suggest that an FEHBP model for Medicare cannot be expected to lead to improved benefits without substantially higher payments from the federal government.

For this reason, one of the few aspects of FEHBP that Medicare beneficiaries would find appealing -- prescription drug coverage -- would not magically arise without higher federal spending. The estimated cost of such a benefit (based on the average level of FEHBP coverage) would be $750 billion over ten years. Proponents of an FEHBP-type system have argued that it is better not to have fixed benefits, as under Medicare, but rather to let benefit packages evolve over time. But if the money is not there, benefits will not be there either. And Medicare’s benefit package is not generous enough to allow much leeway for benefit package tradeoffs.

The troubling plan withdrawals that have plagued Medicare+Choice have also occurred at nearly the same rate in the federal employee programs. While FEHBP offers more plans than M+C and plan participation in Medicare peaked later, the withdrawal patterns look quite similar (Figure 2). Further, FEHBP has had risk selection problems over the years. A number of the plans that offered more generous benefits and fewer restrictions had to raise premiums so much that doing business became impossible. Those plans pulled out of the market, requiring enrollees to make new arrangements. Now, as a consequence, even though plans can offer varying benefits, all the packages tend to look a lot alike.

Some of the characteristics of FEHBP that would be new features for Medicare may not be in beneficiaries’ interest, even if they work well for federal employees. Many analysts have concluded that any major savings that could be achieved if Medicare were revised using an FEHBP model would come from the differential in the premiums charged, particularly for those who wish to remain in traditional fee-for-service Medicare. If premiums for the fee-for-service option rise dramatically over time and become harder to afford, as some expect, choice for many beneficiaries would be reduced, not increased. Compared to federal employees in FEHBP, a much higher proportion of Medicare beneficiaries are low income. Although special protections for low-income beneficiaries could be added, this would lead to an even more complicated Medicare system, and even then, many needing help would not qualify.

A related factor is the cost of administration. An FEHBP-type model entails administrative costs both at the
federal and plan level. The federal government would need to oversee plan participation, enrollment, payment and quality of care. Insurance offered to individuals includes substantial administrative costs to pay for marketing and management. Unlike FEHBP, Medicare has no employer base to help cover many of these functions. Thus, any savings generated by competition will be at least partially offset by higher administrative costs.

And, in another way, an FEHBP model might not always work well with Medicare and the population it serves. Under the FEHBP payment approach, plans negotiate with the federal government for the premiums that they will charge. FEHBP, as an employer-sponsored insurance program, resembles other insurance plans for workers and gives FEHBP a benchmark for assessing the reasonableness of the premiums. Since there is no full market for health insurance for people 65 and older for the government to use to compare premiums, it will be difficult for negotiators for Medicare to know what is reasonable in a given geographic area. Moreover, Medicare covers 40 million people, at least one-third of whom have substantial health problems. Sheer numbers and geographic variability make negotiation a major challenge.

Geographic variation for Medicare is also much greater than under FEHBP. For one thing, large numbers of beneficiaries reside in rural areas. Accordingly, concerns about how high to set payment levels and whether viable competition can be fostered in rural areas need attention.

Private plans would likely favor the less regulated environment of FEHBP. Any new Medicare private plan option should reduce unnecessary regulation and control, but it will still be important to keep plans accountable to both the government and beneficiaries. Medicare beneficiaries do not have workplace benefit managers to help resolve disputes with plans and vulnerable beneficiaries could be placed at considerable risk unless there is adequate oversight.

Considerable attention is needed to improve Medicare for the future. But switching to an FEHBP model offers neither a magic bullet nor a quick fix. Indeed, it might create more problems than it solves.

**Next Steps in Modernizing Medicare**

Whatever the structure of reform, a number of modernization issues need to be addressed:

- **Add a prescription drug benefit as a first step.** Prescription drugs are essential to the delivery of care, particularly in efforts to effectively manage care and to prevent higher costs over time. Fee for service, competition and managed care approaches cannot work if the benefit package lacks this crucial ingredient.
- **Do more work on risk adjustment.** Without a good mechanism for rewarding insurers for taking sick patients, plans will continue to serve the healthy and won't focus on better ways to provide care to the most vulnerable beneficiaries.
- **Improve fee for service.** For a very long time to come, fee for service Medicare will serve most beneficiaries. New and innovative ways of coordinating this care need to be found. The demonstrations under way are one positive step, but more needs to be done on a small scale to compensate physicians and other current care providers to do basic coordination of care.
- **Don't assume that privatization gives beneficiaries what they want.** The complexity and confusion that arise from choice of plans annoys and frustrates many older Americans. They do not respond well to price competition and they do not want to rethink their insurance coverage every year. The one-third of all beneficiaries in poor health especially need uninterrupted care.
- **Don't assume that regulation and oversight will be simpler under an FEHBP approach.** The more flexibility and variability allowed by private plans, the more important it will be to offer protections for vulnerable beneficiaries. Geographic variation in availability of plans would likely mean different systems in place depending upon the level of competition that emerges. And substantial resources would need to be devoted to improving education and support for beneficiaries who must make choices.
- **Experiment with and improve Medicare+Choice.** The payment system needs to be reformed and adding drugs to the benefit package would add some resources. But do not assume that private plans can do everything, particularly until better risk adjustment is more than a promise.
- **Recognize that Medicare will need more resources.** No reform can succeed if too much pressure is placed on it to generate large savings. As an important program serving one in every seven Americans, Medicare will soon serve one in every five. We need to be willing as a society to provide for this vital program's future.

**Other Publications by the Authors**

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