Proposed Changes in the Structure of Medicare Under the Balanced Budget Act of 1995
Testimony before the House-Senate Democratic Caucus Joint Informational Hearing on Medicare and Medicaid
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Most of the attention over the proposed changes in Medicare has focused either on the overall size of the spending reductions or on what will happen to the Part B premium. These issues can be translated into dollar differences among various proposals for Medicare, leading to the suggestion that all that is needed for compromise is to "split the difference" in the numbers. But the proposals of the Congress and the Administration differ on much more than the dollar magnitude of the changes. Key structural differences between the proposals need to be understood as well. Dollar changes can be readily modified over time, but structural changes may be much more difficult to undo. More attention is needed to understand the implications of these proposed structural changes.

How does the Congressional proposal for Medicare found in the Balanced Budget Act seek to achieve savings? On the traditional fee-for-service side of the equation, proposed changes continue to rely upon restricting payments to the providers of services and less directly imposing limits on the use of services (for example, by combining payments for services such as home health care into episode-based payments rather than payments per service used). Altogether, these changes would generate about two thirds of all the savings in the legislation. And a new "failsafe mechanism" would penalize providers further if growth rates exceed the targets—thus placing additional pressures on providers to limit the use of services. In fact, because the initial estimates of savings are insufficient to meet the desired totals, the CBO numbers suggest that nearly $12 billion in additional savings would need to be generated using this mechanism in the first seven years.

Limits on payments to health maintenance organizations and other private plans that enter this new market will be constrained with specific growth targets—to growing an average of about 5.1 percent per year per capita through 2002 and a steady 5 percent per year after that. This implicitly means the plans, and not the government, will decide how to allocate resources, likely relying strongly on limiting use of services. In addition, plans will have considerable discretion over any extra benefits to offer and on whether to pass some additional costs onto beneficiaries in the form of premiums.

STRUCTURAL ISSUES RAISED IN THE BALANCED BUDGET ACT

The Balanced Budget Act would make a number of important structural changes that differ from current law and signal a new direction for policy for Medicare. Overall, the Congressional approach to reform would stress moving Medicare beneficiaries into private plans of various types. And while there has long been an option under Medicare to allow beneficiaries to enroll in health maintenance organizations (HMOs), the proposed legislation developed by the Congress would seek to expand the opportunities for the private sector to offer new types of plans and to change the way in which these plans would interact with the traditional part of the Medicare program.

An important overarching theme of the Congressional Balanced Budget Act proposal can be found in its approach to oversight and control over the Medicare program. Across a broad array of elements of the program, the Congressional approach would relax limitations and restrictions on offerings of comprehensive private plans, allowing beneficiaries more choice and more exposure to both the benefits and vagaries of the private market. For example, the Balanced Budget Act would provide little coordination between offerings of private supplemental policies that are used in combination with traditional Medicare and open season for its MedicarePlus comprehensive private plans—an important activity if beneficiaries are truly going to be able to shift between the traditional fee-for-service side and MedicarePlus. By failing to change the Medigap market, those who leave traditional Medicare to try new comprehensive plans may find it difficult to return. There will be no guarantee of access to Medigap coverage for such individuals. Further, the Congressional approach would de-emphasize federal oversight of MedicarePlus plans with regard to loss ratios and other criteria to
control the market. The degree of oversight represents an important philosophical position that ought to be carefully debated and assessed. Experience with Medigap plans in the past suggests that unscrupulous insurers may take advantage of many beneficiaries faced with a confusing array of new choices.

In addition, four key issues are important for determining how these new incentives would operate under the Balanced Budget Act. The first of these reflects a problem common both to the current system and to any proposal for retaining or expanding private options—the issue of risk selection. The remaining three arise because of specific structural changes built into the legislative proposals. The failsafe mechanism would exacerbate the problem of risk selection and place traditional fee-for-service Medicare at risk. Further, the caps placed on payments to private plans would affect the basic guarantee in the Medicare program of access to a set of benefits. Finally, geographic differences arising under Medicare would be altered by changes in the way in which payments are made.

Risk Selection as a Continuing Problem

Most research conducted on the operation of the current health maintenance organization (HMO) option for Medicare suggests that those attracted to this alternative tend to be healthier than the average beneficiary in the same age, sex and other categories used to adjust the payments provided by Medicare. In practice, such patients have been estimated to cost the plans only about 89 percent as much as the average beneficiary although Medicare pays at a 95 percent rate. As a result, Medicare overpays HMOs while sicker (and hence more expensive) beneficiaries remain in the traditional program. As yet no one knows how to satisfactorily resolve this issue.

Moreover, expansion in the types of private plans allowed under the Balanced Budget Act—including medical savings account/catastrophic plans that may naturally attract healthier beneficiaries and association plans that would help to fragment the risk pool—are likely to exacerbate the existing problem with risk selection. For example, medical savings accounts are likely to attract a disproportionate share of healthier beneficiaries, particularly when beneficiaries are allowed to shift plans on a year to year basis. Fragmenting the risk pool under Medicare in this way will not save the program money until better ways are found to adjust for differences in risks. Allowing too much choice in Medicare can also generate problems, for example, by allowing plans to carefully package extra services or provide cash rebates to appeal only to certain beneficiary groups.

Choice is critically important when choosing among managed care plans since that allows better access to doctors, hospitals and other providers. Allowing alternative fee-for-service plans makes much less sense, however. Thus, although a longer term strategy of promoting private plans and more choice may make sense, in the near term, expansions that worsen the risk selection problem could be harmful to the stability of the Medicare program, particularly in concert with the application of the failsafe mechanism described below.

Inequity and the Failsafe Mechanism

A new element of Medicare would be added by the Balanced Budget Act—a failsafe mechanism to enforce overall spending limits on Medicare. If all of the changes enacted fail to hold aggregate Medicare spending to the level sought, this mechanism would be triggered to ratchet down levels of payment under the traditional fee-for-service side of the program. Within the confines of the fee-for-service program, this approach could appropriately penalize the fee-for-service program if, for example, use of services rose more rapidly than was projected, thus encouraging providers to limit excess use of services.

A severe problem would arise, however, when penalties are imposed on the fee-for-service sector for excess spending that represents a failure not in fee-for-service, but rather elsewhere. If there is significant risk selection in Medicare's private plans, costs of fee-for-service will naturally rise. This would then inappropriately trigger lower payments to providers through the failsafe mechanism.

A failsafe mechanism that punishes one part of the system for problems caused elsewhere is inequitable and likely to be unsustainable as public policy over time. Its end result could be to drive payments so low under the fee-for-service portion of the program that providers become increasingly unwilling to participate, especially if they can still treat Medicare beneficiaries through private plans. This piece thus could further weaken the fee-for-service side of Medicare by driving people unwillingly into private plans.

Moving from a Defined Benefit to a Defined Contribution Approach

A crucial element of the Congressional reforms for Medicare would be to establish a fixed rate of growth in payments made to private plans on beneficiaries' behalf. Year to year changes in these payments would be set by law and not by changes in the cost of a particular benefit package. Thus, each year a specified rate of increase would be used to adjust payments that could be higher or lower than the actual costs of maintaining a particular level of services. Beneficiaries would thus be entitled to a level of payment (hence a "defined contribution") rather than a set benefit package. This is a major departure from the current guarantees in the Medicare program.

This approach does not represent a full move to a voucher program since beneficiaries would retain the option of remaining in the traditional Medicare program where the benefit would still be guaranteed. But if the failsafe mechanism puts increasing pressure on traditional Medicare, discouraging providers of service from participating, then many beneficiaries may find it increasingly difficult to remain in traditional Medicare. And if there are other barriers making it difficult to move back to the traditional Medicare program, those who initially choose MedicarePlus plans may effectively be locked in.

Further, whether the structure of Medicare would devolve to a defined contribution plan also depends upon
the level of payments from Medicare to private plans. If the level of payments to MedicarePlus plans closely track variations in the costs of providing services, then there would be little impact from moving to a defined contribution approach. But since the goal of the Balanced Budget Act is to lower the rate of growth of health care spending, tight limits on payment growth should be expected. Indeed, the Balanced Budget Act would result in an average per capita rate of growth over seven years of 5.1 percent per year, and after 2002, the amount would be permanently affixed at 5 percent. This amount is above the projected growth in the rate of general inflation (of about 3 percent per year over the period), but considerably less than the historical differences in health spending growth. After controlling for inflation, this would imply a rate of growth of less than two-thirds of that expected in the private insurance sector over the next seven years and about half what was spent under Medicare over the last seven years.

Since MedicarePlus plans would be relatively well paid in the beginning (because of the selection issue described above), problems with funding would not arise immediately. However, if rates of payment growth are kept low over time, any surpluses in the payment levels would be absorbed. Plans that cannot stay within these limits through improved efficiency or lower payments to providers do have recourse, however. MedicarePlus plans have considerable flexibility to either scale back any supplemental benefits offered (assuming additional services were initially part of the package) and/or to raise premiums on beneficiaries over time. The Congressional legislation would allow premiums up to a limit and unlimited premiums for supplemental benefits. Although plans can now also charge premiums or limit supplemental benefits, the major change in this legislation is that by imposing strict limits on the rate of growth of Medicare's payment, the risk of any higher costs over time is shifted directly to plans and/or beneficiaries. There would no longer be any mechanism to recognize extraordinary growth in the costs of health care. A better strategy would be to seek ways to tie the payment levels to what is happening in the broader health care market.

By 2002, premiums on private plans over and above Medicare-covered services would be allowed to be as high as about $100 per month, offering considerable opportunities for shifting additional costs onto beneficiaries. Indeed, for a plan that begins in 1996 as a zero premium plan, the ability to raise premiums would allow a plan receiving the average growth rate of 5.1 percent over seven years, to recoup enough of a premium to enable a 7.9 percent overall rate of growth over the period—an amount even higher than the expected growth in the costs of plans in the private insurance sector, for example. Thus, it would be possible for private plans to shift all of the increased risk that Medicare does not cover onto beneficiaries. The amount of such premium growth will depend on the degree to which plans are able to hold down cost growth and on the competition they face in local markets, but shifting at least part of the costs seems to be a likely strategy for private plans over time.

Geographic Variations

All of the discussion thus far has assumed that private plans would be treated the same throughout the United States. In practice, there would be considerable variations in how private plans would be treated, and, in the balance between the fee-for-service sector and private plans within geographic regions. The Balanced Budget Act would seek to reduce the variation in payments provided to private plans that now exists across the country. For example, at present the highest paid counties receive payments nearly four times as high as those in the lowest paid counties. Some of this differential reflects differences in the costs of providing care, but some also reflects differences in the patterns of service use that we may not wish to maintain.

Recalibrating the payments for private plans and then disassociating them with the actual experience of traditional Medicare raises the possibility that in some areas of the country, private plans will be given substantial advantages over the traditional Medicare program, while in other areas private plans may end up at a considerable disadvantage. For example, the new minimum payments under the Balanced Budget Act would boost payments to about one-third of all the counties in the U.S., some of them by well over 50 percent in just two years. Over the seven year period, we estimate that the areas with the highest growth rates would average 15.7 percent per year as compared to the 5.8 percent expected for Medicare's fee-for-service program. Other areas where payment levels are high would experience growth averaging as low as 2.7 percent per year over the seven year period. This may affect substantially the range of choices available to beneficiaries—limiting private options in some areas and placing traditional fee-for-service at risk in others. Careful study needs to be undertaken to determine the possible impacts of these adjustments and whether they will hinder or help the expansion of alternative opportunities under Medicare.

THE IMPLICATIONS OF THESE STRUCTURAL ISSUES

One major effect of these various pieces of the Balanced Budget Act would be a substantial weakening of the fee-for-service alternative under the traditional Medicare program. Physicians and other providers of health care may opt out of traditional Medicare. Low payment levels and restrictions on balance billing and other activities may discourage participation by physicians, particularly when they can join private plans and serve Medicare patients elsewhere. The uncertainties of the failsafe mechanism may also drive providers out of traditional Medicare.

In addition, after choosing alternative MedicarePlus plans, beneficiaries would likely find it increasingly difficult to return to traditional Medicare even if they wished to do so. Medigap plans might not accept them, fearing that those who leave MedicarePlus plans would be the less healthy and more in need of care; lack of coordination in terms of enrollment guarantees and other protections mean that some beneficiaries would have few options. Further, if beneficiaries' doctors work exclusively for one or several private plans but not for traditional Medicare, even dissatisfied patients may find that they have limited options and are locked in. Thus, if premiums begin to rise under these plans once the growth limits begin to take hold, beneficiaries...
may have little choice except to stay with their MedicarePlus plan. Beneficiaries may also face higher costs if premiums for these plans rise rapidly and if they join arrangements where physicians are allowed to balance bill, charging patients additional amounts for services provided. All of these problems could ultimately conspire to result in less, not more choice, by beneficiaries.

The structure of the program matters. Movement into private plans does not have to carry all of these negatives. But without careful attention to the details, it may be difficult to undo a new environment once the genie is out of the bottle. Fragmenting Medicare's risk pool and placing more of the risk and burdens on beneficiaries while government remains on the sidelines as a disinterested source of partial funding is likely not what most beneficiaries envision when they hear talk of saving Medicare.

About the Researcher:

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Notes

1. A major problem with this approach has been characterized in the economics literature as the "free rider" issue. The penalty on any single provider from misbehaving is very small and since the penalty is applied equally to all providers, there is little real check on anyone's behavior. In fact, the losers are those who play by the rules while others violate them since everyone is penalized equally.

2. The Administration plan errs in the other direction. By retaining the current approach that links payment to local Medicare fee-for-service experience, rates of growth may be too high.

3. This is the monthly actuarial value of Medicare cost sharing projected to 2002 using the 5.7 percent per capita spending growth allowed for fee-for-service in the Balanced Budget Act (as shown in Table 3).

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