ABOUT THIS REPORT

THE RETIREMENT PROJECT IS A MULTIYEAR RESEARCH effort that addresses the challenges and opportunities facing private and public retirement policies in the twenty-first century. As the number of elderly Americans grows more rapidly, Urban Institute researchers are examining this population’s needs. The project assesses how current retirement policies, demographic trends, and private-sector practice influence the well-being of older individuals, the economy, and government budgets. Analysis focuses on both the public and private sectors and integrates income and health needs. Researchers are also evaluating the advantages and disadvantages of proposed policy options. Drawing on the Urban Institute’s expertise in health and retirement policy, the project provides objective, nonpartisan information for policymakers and the public as they face the challenges of an aging population. All Retirement Project publications can be found on the Urban Institute’s Web site, at http://www.urban.org/retirement. The project is made possible by a generous grant from the Andrew W. Mellon Foundation.

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Projected increases in Medicare’s spending because of the high costs of health care and growing numbers of persons eligible for the program will create substantial challenges for taking Medicare into the twenty-first century. As a consequence, a number of proposals have been offered to reform Medicare with the goal of achieving substantial reductions in spending growth. Much of this debate over Medicare’s future thus far has centered on whether or not to substantially restructure the program or to seek more limited reforms.

The National Bipartisan Commission on the Future of Medicare (hereafter referred to as the “Commission”) was created as part of the Balanced Budget Act of 1997 to address issues of long-term reforms for Medicare and to come up with a bipartisan approach. The Commission held numerous hearings and meetings, and although a proposal emerged that obtained support from a majority of Commission members, it did not achieve support from the “super majority” required to make a formal recommendation.

Nonetheless, the proposal presented by the cochairs, Senator John Breaux (D-La.) and Representative Bill Thomas (R-Calif.), offered a vision of a comprehensive overhaul to the Medicare program that has become the major framework for discussing structural reform. Termed “premium support,” this approach uses as a model the Federal Employees Health Benefits Program (FEHBP). Like FEHBP, Medicare beneficiaries would choose from a range of insurance plans—in this case, both private plans and traditional Medicare. The government would pay part of the premium, with the contribution established as a share of the national average premium price. Individuals who choose more expensive plans would pay a substantially higher premium than those choosing less expensive plans. The goal would be to give beneficiaries a financial incentive to opt for less expensive plans while offering them a choice among a variety of...
options. (See the Appendix at the end of this volume for a more complete description.)

The intellectual origins for premium support can be found in the work of Alain Enthoven (1993) and more recently of Henry Aaron and Robert Reischauer (1995). Some of the practical issues surrounding such a restructuring have been analyzed by the National Academy of Social Insurance (1998). But neither this study nor the staff work of the Commission explored the full range of practical issues that arise in contemplating implementation of such a major restructuring of Medicare.

Filling in some of the gaps in thinking about how such a competition approach to Medicare would work in practice was the goal of a conference held at the Urban Institute in the spring of 1999. The goal was not to pass judgment on the “worthiness” of the approach, but rather to tackle the practical issues that would need to be addressed to determine the feasibility of such a reform. Attendance was limited to a small number of policy analysts, Clinton administration and Hill staff, and others knowledgeable about the issues.

To set the stage, we commissioned a paper from Beth Fuchs and Lisa Potetz to raise issues about premium support and to contrast these issues with concerns arising over more incremental reforms. A draft of the paper was shared with the participants before the meeting. The final version of the paper appears here as part I of this volume. The goal of this paper was to provide a balanced and comprehensive look at the practical considerations.

In addition, we asked several researchers to consider in more detail some of the important issues facing premium support and to lead the discussion on those issues at the conference. Those papers constitute the five essays in part II. They are intended to be a bit more provocative concerning the feasibility of premium support than the Fuchs/Potetz paper, capturing the views of the specific authors. This portion of the volume begins with an analysis of the administrative issues key to making premium support work. Mark Merlis examines a range of these issues, including the question of whether a separate administrative body is needed to manage the program rather than the Health Care Financing Administration, how much flexibility is desirable, and what protections are needed for beneficiaries. The goal of relying on an independent board is usually to keep politics out of the administration of the program, but skeptics question both
the feasibility of such a goal and how to establish alternative means for ensuring accountability of a program that would cover nearly 40 million people.

The second essay, by Peter Fox, examines what private plans would require before they would be willing to participate in such a restructured Medicare program. Competition will only work if there are health plans willing to serve Medicare beneficiaries. In addition to the important question of whether plans could make profits under such a structure, what other arrangements would they likely demand? Fox suggests that stability and a perception of a level playing field with the traditional Medicare program are also key factors that private plans would assess before participating.

Two key issues that will affect the success of the program from the perspective of both government and beneficiaries are whether a viable framework for establishing premiums in each area can be developed and whether a mechanism for adjusting for differing health status of enrollees is possible. Without these two technical factors, competition is unlikely to be effective. Len Nichols, who has served as a member of the committee trying to mount a Medicare demonstration on competitive bidding, took on the task of discussing how premiums should be established. While he stresses that some form of competitive bidding is essential, there are many important lessons to be gleaned from the difficulties that have faced efforts to mount a demonstration project in this area.

Stuart Guterman examines the issue of how risk adjustment would work in practice and whether the methodology has reached a stage in which it can protect against adverse selection of enrollees. Without effective risk adjustment, plans have a strong incentive to discourage enrollment of persons known to be more expensive to insure. The technical means to implement such a system exist, but there is considerably less certainty about whether the adjustment mechanisms are adequate to the task.

Another key question for any competitive approach to health insurance is whether the consumers will behave as expected. Will they respond to price differences? Tom Buchmueller, who has examined this issue for the University of California system, examined what evidence exists to suggest how willing older Americans are to make choices on the basis of price. Competition will only be effective in holding down costs if enough consumers respond by choosing lower-cost plans. The evidence is mixed, suggesting that younger workers are much more responsive than older
retirees to these incentives. Older persons have a tendency to stay with what they know and trust, and they will often pay substantially higher prices to do so. However, not all consumers have to respond; rather, the issue is whether there will be a large enough reaction to discipline the market.

Although not raised explicitly in this volume, a final key issue for judging reforms is the extent to which the desire is to treat Medicare like a straightforward insurance program, or to protect its additional role as social insurance as well. As described in the summary to this conference (Moon 1999), Medicare has also been important in protecting the most vulnerable beneficiaries through entitlement to universal coverage and a pooling of risks. Will a largely private system offer the same level of protections? Will traditional Medicare be there as a “default” plan that protects beneficiaries? Can requirements on private plans fill this role? These broader questions along with the practical concerns raised in this volume need to be addressed before moving forward with substantive reforms of Medicare.

Where is Medicare headed? The controversy surrounding structural reforms suggests that it will be some time before we know the answer to this question. Since its earliest days, the Medicare program has been a touchstone for criticism. Many critics argue that it is too big, too expensive, too cumbersome; their solutions usually call for a larger private-sector role. At the same time, there are also critics who focus on the inadequacy of the benefit package and the need to update benefits to reflect the current state of health care delivery. And while few observers of Medicare argue that no changes are needed, there is also a deep conviction among many supporters concerning the important role that this program has played and should continue to play in the well-being of older Americans and persons with disabilities.
PART I

A Framework for Comparing Incremental and Premium Support Approaches
A Framework for Comparing Incremental and Premium Support Approaches
Beth C. Fuchs and Lisa Potetz

OVERVIEW

Work of the National Bipartisan Commission on the Future of Medicare highlights two views about the future of Medicare that reflect fundamental differences in philosophy. One view is that only a premium support approach will sustain the Medicare program through the baby boom retirement. That view is based on a belief that the existing social insurance program will become too burdensome on the government and taxpayers whereas a premium support system will encourage market forces to control costs and limit government and taxpayer obligations.

The other view is that incremental changes can be made within the social insurance structure of Medicare to sustain the program. Those holding that view believe either that a premium support approach will be unnecessarily harmful to beneficiaries or, at best, that the outcome of a change to premium support is too uncertain to risk such a shift without trying other steps first.

The differences between the two approaches are significant, yet a number of common policy areas exist that need to be addressed under either approach. In fact, in some ways both paths converge on a future Medicare program that—absent a political decision to devote more financing to the program—has increasingly constrained resources, a greater role for private health plans and managed care delivery systems, and a potentially higher share of program costs paid by beneficiaries.

Financial Viability

The expected shortfall in the Hospital Insurance Trust Fund and the historically high rates of growth in per-beneficiary spending have led to a consensus that the program cannot continue on its present path indefinitely without changes of some sort. There is perhaps less consensus about
how much more we can afford to invest in Medicare—how much new revenue should be allocated to address the baby boom problem, and where it should come from. That question will need to be faced eventually regardless of the approach taken to reform. Political forces can be expected to delay discussion of the issue as long as possible, and the uncertainty of long-term forecasts makes it difficult for analysts to discuss options with much precision.

If policies to raise revenues or to reallocate funds from other national priorities are not acceptable, then the long-term survival of Medicare is likely to require measures to (1) curb government expenditures on Medicare, (2) increase the amount of program costs paid by beneficiaries, or (3) some combination of both. The incremental approaches described in the following pages adopt all three strategies. The premium support alternative assumes that the competitive market has the potential to hold down health care-costs. If cost-saving fails to occur, and depending on the design of the premium support system, beneficiaries and the government may be at risk for added costs. Most at risk may be beneficiaries who remain with traditional Medicare.

**Changes in Traditional Medicare**

Even the premium support approach advanced by Senator John Breaux (D–La.) and Representative Bill Thomas (R–Calif.) envisions an important continuing role for the traditional fee-for-service Medicare program (hereafter referred to as “traditional Medicare”). Therefore, issues about how to control Medicare costs and improve benefits will be addressed whether or not the premium support approach is adopted. And as also discussed, what happens to traditional Medicare is central to both the incremental and premium support approaches.

If adopted, the range of program modifications included under the umbrella of “modernizing” Medicare could blur the distinctions between the traditional program and private plan options. Traditional Medicare could evolve into something akin to a large preferred provider organization (PPO). Selective contracting, package pricing for episodes of illness, intensified utilization review and prior authorization requirements, and similar techniques designed to obtain discounted prices from providers and manage beneficiaries’ use of the services could replace the current unrestricted, fee-for-service delivery system. Still, traditional Medicare would
continue to offer beneficiaries the advantages of a publicly financed and
publicly administered program.

Under a fully implemented premium support system, the future of tra-
ditional Medicare may largely depend on its ability to compete on a level
playing field with private health plans. Without the tools to manage use
and constrain payments to providers, that may not be possible. Nor may it
be possible if the benefit package offered under traditional Medicare is less
generous than the benefits offered by the private plan options. That is one
of the reasons for the heated debate among Commission members over the
inclusion of a prescription drug benefit under traditional Medicare.
Complicating the issue further is the future of Medigap and other policies
that supplement Medicare. To the extent that they become increasingly
expensive, private plan options gain a competitive advantage. In that light,
if traditional Medicare does not modernize, it could become the insurer of
last resort, enrolling only those beneficiaries for whom no other health
plan alternative is available or appropriate. That might be the case for peo-
ple living in rural areas lacking private health plans. It might also be the
case for chronically ill beneficiaries requiring continuing care from
providers not participating in any of the available private plan options.
The critical variable in preventing such an outcome is risk adjustment.
Will there be an adequate method for adjusting the government’s contrib-
ution for the relative risk of enrollees in traditional Medicare versus those
who elect the private plans to ensure that the latter do not profit from
favorable selection?

An alternative perspective is that traditional Medicare is already posi-
tioned to compete favorably against private plans and should not be given
more advantages in the market. Its provider payments are below private-
sector rates, its administrative costs are far below those of private insurers,
it has a huge share of the existing market with more than 80 percent of ben-
eficiaries currently enrolled, and it commands substantial “brand loyalty”
(beneficiaries like and trust traditional Medicare). Moreover, Medicare is
the dominant payer in the health care marketplace and wields enormous
power through its reimbursement, coverage, and other policies.
“Modernization” changes that would make it even more powerful would
tilt the competition against the private plans and should, therefore, be
rejected.
Role of Private Plans

Private health plan options for Medicare beneficiaries may continue to grow in importance under the current program and are central to a premium support approach. Therefore, issues about beneficiary education, plan oversight, payment methodologies, and risk adjustment of payments to plans need to be addressed under either scenario. In fact, if enrollment in private plans under the Medicare+Choice program grows large enough, the Medicare program of the future may look a great deal like the market model envisioned by advocates of premium support, with the key differences perhaps being a matter of how the government contribution is determined, how competition between private plans and traditional Medicare is structured and administered, and the incentives for beneficiaries to choose less-costly plans. The many issues related to the role of private plans are explored in the section of this paper on program operations.

Treatment of Vulnerable Populations

Without any changes in law, Medicare beneficiaries will be bearing a growing share of the program’s cost, raising issues about how low-income beneficiaries are protected. Any program reform scenario is likely to require increased beneficiary contributions, with the issue arising most directly under a premium support approach of how much support for whom? Would there be adequate protections to assure that premiums are affordable and that covered services are accessible and adequate? How would those beneficiaries now covered by Medicaid as well as Medicare be affected? Even under more incremental reforms, improved protection of vulnerable populations may be warranted. Significant improvements could be made, for example, in the coordination of managed care services for beneficiaries who are eligible for both Medicare and Medicaid.

A premium support system raises additional questions. To what extent would the government’s premium contribution support the purchase of adequate coverage by lower-income beneficiaries? Would the package of benefits purchased by the government’s contribution be adequate and appropriate for the disabled and chronically ill? Under current payment methodologies, private health plans have not had an incentive to seek out such individuals; once enrolled, however, chronically sick and disabled beneficiaries may find it difficult to obtain the specialized care they need in a timely manner. In the view of some experts, the willingness and abil-
ity of health plans to care for the disabled and chronically ill may improve once a health status risk adjustment system is implemented that ensures that plans are more adequately compensated for the higher costs associated with that population.

Beneficiaries living in medically underserved areas present another challenge in considering different reform options. For many rural and urban core communities, access to health services is hampered by the compound problems of disproportionately high-risk populations, a shortage of providers, and various resource constraints. To date, private plans have been slow to enter these areas. Over 11 million or about 29 percent of beneficiaries currently live in areas in which there are no Medicare managed care plans today. Another 3.9 million live in areas in which there is only one such plan (Medicare Payment Advisory Commission [MedPAC] 1998a, 1999). The design of a premium support system in these areas of limited competition offers particular challenges, including the viability of traditional Medicare as an alternative.

**Medicare’s Other Missions**

Today’s Medicare program helps to support various policy goals, such as the training of interns and residents, and the provision of care for low-income and rural populations. These are missions that reach beyond Medicare’s pure insurance function and help finance goals that benefit the public at large. They have come under especially close examination as policymakers look for ways to extend the life of Medicare’s Part A Trust Fund. The most fundamental issue is whether the Medicare program or the federal government more generally should play a role in financing these goods. That debate will continue regardless of whether incremental or premium support approaches are pursued.

Removing Medicare support for the missions is likely to be a serious option under either approach. Under the Breaux-Thomas proposal, for example, Medicare’s payments to support direct costs of teaching (such as the salaries of supervising physicians) would be removed from Medicare and funded through the appropriations process. Although Medicare’s method of supporting graduate medical education, rural hospitals, and disproportionate share hospitals could continue in its current form under a premium support system, the level of support would decline as beneficiaries shifted out of the traditional program to the private plan options.
Should consensus exist that Medicare continue to finance those activities, consideration may have to be given to doing so outside the premium support system, such as through direct payments to hospitals out of a separate pool of funds.

**Accountability and Oversight**

As the role of private plans increases, control of how Medicare dollars are spent is shifted from the government and its agents to private health plans. Under the existing program, the government raises the money through taxes and premiums to finance the program and controls how the money is paid through reimbursement and coverage policies. Policymakers seeking to contain spending growth under the traditional fee-for-service program must make explicit and public decisions about the level of payment rates, coverage criteria, and, to some extent, medical necessity determinations.

Under Medicare+Choice and a more expansive premium support system, the government continues to raise the money to finance the program but no longer directly controls how the money is spent on services. Decisions about provider payments, medical necessity, and other methods to manage costs and care are left, for the most part, to the discretion of private health plans, albeit under federal plan standards.

Such a transfer of decisionmaking to private plans has significant implications for health care providers and beneficiaries. Market accountability could largely replace the public accountability that is now achieved through administrative and judicial review as well as congressional oversight. If beneficiaries and providers are unsatisfied with a plan’s policies, they can switch plans. However, the strong public support for government oversight of managed care plans and “patient’s rights” legislation raises questions about the extent to which policymakers can successfully transfer accountability to private plans. An alternative approach would retain a strong role for government for requiring accountability even while transferring financial risk for providing health care services to private plans.

**Coordination with Other Sources of Insurance Coverage**

A significant portion of Medicare beneficiaries’ health care costs is financed through other sources of coverage, including employer-sponsored health plans and individually purchased Medigap policies. These supplemental sources of coverage are themselves evolving. A
declining portion of beneficiaries are being insured by employer plans, and those that are may be receiving less-generous coverage than in the past. As premiums continue to escalate, Medigap coverage is becoming a less-viable option for many beneficiaries. Another source of coverage for some Medicare beneficiaries is Medicaid. State Medicaid programs are wary of absorbing new costs that may be shifted from Medicare under various reform options.

Any significant reform of Medicare is likely to interact with the supplemental sources of coverage in ways that may be hard to predict. What would be the effects on such coverage if, for example, the Medicare benefit package was modernized to include prescription drugs and different beneficiary cost-sharing requirements? Would state Medicaid programs experience new costs or savings under a premium support approach? If Medicare benefits are expanded, is there any practical way of ensuring the continuation of current levels of financial support by employers and the states?

**Can the Reform Option Work?**

One of the major challenges faced by comprehensive reform proposals is their technical complexity and political volatility. Even some incremental changes such as the various cost containment options envisioned under modernized Medicare proposals could involve significant changes to the program. Efforts to introduce more competition into the program already have experienced substantial setbacks when attempted as demonstration programs.²

A comprehensive reform such as envisioned under premium support could rearrange billions of dollars and affect millions of beneficiaries, thousands of health care providers, and numerous others who have a stake in the Medicare program, such as suppliers and financial investors. Its success would depend on the way all the interests respond to changing incentives. One small turn of a policy knob (e.g., the nature of the benefit package or the percentage of premium paid by the government) could have a dramatic effect on the option’s potential to save or cost money. Predicting the magnitude or even direction of that effect can be hazardous because of the inherent uncertainties of beneficiary, provider, and plan responses. Indeed, the same could hold true for various of the Medicare “modernization” measures.
Another key to the success of any major reform effort is the way it is received by Medicare beneficiaries. Despite its flaws, Medicare is a popular program. Ambitious reform in any realm presents challenges, but the hurdles faced by policymakers seeking major changes in Medicare may be high given the age, disability, and health care needs of the Medicare population. Coming generations of beneficiaries are likely to be more experienced with managed care and competitive markets than the current beneficiary population, but even they will want their health care coverage to be comprehensive, affordable, and easy to understand.

**Evaluating Reform Options**

Any evaluation of Medicare reform proposals depends on an assessment of the way they measure up to various criteria, which are likely to vary depending on who is doing the evaluation. Sometimes the criteria are made explicit. For example, Commission documents emphasized the need for any long-term reforms to improve Medicare program efficiency, responsiveness to the needs of beneficiaries, and solvency.

The importance to Medicare reform options of efficiency, solvency, and responsiveness to beneficiary needs seems self-evident. The view that Medicare’s benefit package should be adequate to cover the services needed by beneficiaries is one that few would dispute. However, adequacy of benefits may come in conflict with other criteria, such as program solvency. Efficiency—often understood as getting the most value for the least dollar—is a widely held virtue. But maximizing efficiency often means trading off other objectives, such as equity or responsiveness to beneficiary needs.

The framework for analysis presented here assumes that any proposal to reform Medicare should take into consideration certain criteria, such as adequacy and universality of coverage, affordability for beneficiaries, and effectiveness in extending the life of the program. They are presented more explicitly in figure 1. Although not all criteria are relevant to all aspects of the Medicare reform proposals, they can be helpful in evaluating the strengths and weaknesses of the options as a whole. And as already observed, important criteria often are in conflict, requiring tradeoffs to be of such competing values presents a major challenge and is likely to be central to the debates over Medicare’s future.
One approach to Medicare reform is to make a series of incremental changes (Biles et al. 1998). That approach does not attempt to set out all the changes that may be needed over the next generation of Medicare but only to start the process. It does not preclude major reforms in the future. Even the Breaux-Thomas premium support model includes numerous incremental changes to “modernize” traditional Medicare.

Incremental approaches, including some discussed by the Commission, encompass a variety of program changes (Etheredge 1996). They include cost containment efforts, changes to the program’s benefit structure, continued development of alternative health plan choices for

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**FIGURE 1. Selected Criteria for Evaluating Medicare Reform Options**

- **Adequacy and universality of coverage**  
  Is there a benefit package that provides sufficient coverage to all beneficiaries to ensure that beneficiaries are adequately insured and are not exposed to unreasonable out-of-pocket costs?

- **Access**  
  Would the proposed option ensure access to covered services?

- **Affordability**  
  Would the government’s contribution to the purchase of coverage be sufficient to ensure that the insurance is affordable for beneficiaries?

- **Freedom of choice**  
  To what extent would the proposed option affect the ability of beneficiaries to choose their own providers?

- **Equity**  
  Would the proposed option provide for equity among beneficiaries with respect to costs, coverage, access, and quality of care? Would it spread the burden of financing equitably between taxpayers and beneficiaries?

- **Quality**  
  Would the proposed option improve the quality of health care available to Medicare beneficiaries?

- **Accountability to taxpayers and beneficiaries**  
  Would the proposed option provide for public accountability?

- **Feasibility**  
  Would the proposed option result in an administratively workable program?

- **Fiscal viability**  
  Would the proposed option produce the balance of revenues and savings to ensure the long-term viability of Medicare?

*Source: Author’s analysis.*
beneficiaries, and introduction of additional revenue. Key features are that the defined benefit structure of traditional Medicare would be maintained and beneficiaries would remain free to choose their health care providers, while also having the option to enroll in a private Medicare+Choice health plan.

Cost containment efforts could involve both continuation of current approaches that limit Medicare provider payments and new strategies such as those recommended by the National Academy of Social Insurance (NASI) Study Panel on Fee-for-Service Medicare (1998). Current approaches such as those included in the Medicare portion of the Balanced Budget Act of 1997 (BBA) are generally targeted at reducing growth in provider payments. Under the NASI recommendations, strategies used by private health plans would be adopted to control growth in Medicare outlays, and the secretary of health and human services would be given authority to waive requirements of the Medicare law to experiment with new cost containment strategies in local areas. Although cost containment and improved program efficiencies are a major goal of those efforts, some strategies also are promoted as ways to improve the quality of health care provided to Medicare beneficiaries.

Medicare’s basic benefit structure is another target for incremental reform. The addition of an outpatient prescription drug benefit and changes to the structure of deductibles and cost-sharing would make the defined package of Medicare benefits look more like typical plans currently available in the private group health insurance market. In addition, financial support for low-income beneficiaries could be improved. Of course, Congress could consider cutting back on benefits or increasing cost-sharing as a means of addressing Medicare’s financial problems. Not surprisingly, such options are not being widely discussed.

Reducing program outlays and adding revenue are additional possible features of an incremental approach to Medicare reform. President Clinton’s budget proposals for fiscal year 2000 would reduce Medicare payments for hospital stays and other items and services by $7.8 billion over the next five years, institute a variety of user fees for Medicare plans and providers, and credit $670 billion to Medicare of expected federal budget surpluses over the next 15 years, with the intention of postponing exhaustion of the Hospital Insurance Trust Fund to the year 2025. In addition, the administration has indicated its intent to seek compensation for
the federal government’s share of costs of smoking-related illnesses from
the tobacco industry on behalf of Medicare among other federal programs.

**Premium Support**

While proposals vary on the specifics, the basic notion of a premium support
approach is that private plans meeting certain standards would com-
pete for the enrollment of beneficiaries. Traditional fee-for-service
Medicare (“traditional Medicare”) would compete as if it were a private
plan. Both the private plans and traditional Medicare would have to cover
a common set of services. In this way, the approach is similar to the exist-
ing program, in which beneficiaries are able to elect either traditional
Medicare or a Medicare+Choice plan, if one is offered in their area.

Unlike Medicare+Choice, however, the federal government’s share of
the cost for both traditional Medicare and the private plan options would
be determined and paid for in the same way. The government’s share of
the premium would be fixed in advance. For example, the government
contribution might be set to equal the average premium of all plans com-
peting in the Medicare market.

Also, unlike Medicare+Choice, beneficiaries might have to pay an
additional premium amount for basic Medicare benefits. If a beneficiary
elected a plan costing more than the average premium, he or she would
have to pay the difference out-of-pocket. A beneficiary electing a plan
costing less than the average would pay a lower premium. This amount
might be lower than the Part B premium that is paid today as the base pre-
mium for either traditional Medicare or a Medicare+Choice plan. It is thus
a change from today’s system where the beneficiary gets extra benefits if
a plan’s costs are lower than traditional Medicare. The premium for tradi-
tional Medicare would be computed based on its expected costs per ben-
eficiary, either locally or nationally. Most proposals call for private plan
premiums to be derived through a process of competitive bidding.

The rationale for this approach is that exposing beneficiaries to the
possibility of paying additional premiums would give them a financial
incentive to elect the plan offering the best value. That, in turn, would
encourage plans to offer the most attractive coverage at the lowest possi-
ble premium. Depending on the approach used to set the government’s
level of premium support (see “Setting the Government Contribution”),
beneficiaries would have more or less financial risk associated with select-
ing higher-cost health plans. Whatever the growth trend permitted, each Medicare beneficiary would be entitled to a level of federal support toward the purchase of health insurance. Medicare would no longer guarantee an open-ended entitlement to today’s benefits delivered without restriction on provider choice.

But how would such a premium support approach actually work? What services would plans have to cover? How would premiums be determined? How would plans become qualified to participate in the new program? How would the government’s contribution be determined? How would vulnerable populations such as low-income beneficiaries pay for their share of the premium? How would the newly restructured Medicare be administered? No proposal currently being discussed provides sufficient specificity to answer all of these questions. Nonetheless, only through addressing such questions can the implications of the proposals be anticipated.

The remaining sections of this paper address these and related issues as they arise in the context of incremental and premium support approaches. (A “road map” for the presentation of issues is included in table 1. A summary and analysis of the Breaux-Thomas proposal are provided in the appendix to this volume.)

ANALYZING THE OPTIONS: PLAN BENEFITS

Influenced by pension program terminology, it is commonplace now to distinguish health insurance programs as being either defined benefit or defined contribution in design. A defined benefit program is one in which the participant is promised coverage of specified health services regardless of how much the cost to the plan sponsor of providing these services may vary over time. A defined contribution program is one in which the participant is promised that the plan sponsor will contribute a fixed amount toward benefits. Inflation and other factors will determine whether that amount is sufficient to maintain a given level of benefits over time. By design, therefore, the defined contribution approach limits the sponsor’s financial liability. Enrollees, on the other hand, may experience increasing out-of-pocket costs. In contrast, the defined benefit approach guarantees a certain level of coverage for enrollees but leaves the sponsor exposed to rising costs.3
## TABLE 1. Road Map. A Conceptual Framework for Comparing Incremental and Premium Support Approaches to Reforming Medicare: Summary Table

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<tr>
<td></td>
<td>• Establish an annual cap on beneficiary cost sharing</td>
<td>• Actuarial equivalence</td>
</tr>
<tr>
<td></td>
<td>• Add prescription drugs</td>
<td>• Core services / “FEHBP approach”</td>
</tr>
<tr>
<td>Supplemental coverage</td>
<td>• Current law for Medicare+Choice</td>
<td>• Multiple standardized packages</td>
</tr>
<tr>
<td></td>
<td>• Medigap reforms</td>
<td>• Uniform standardized benefit package</td>
</tr>
<tr>
<td><strong>What Is the Structure of the Program?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administration of the program/managing the competition</td>
<td>HCFA remains administering agency with reforms to improve efficiency</td>
<td>HCFA or Board with authority to approve service areas, negotiate premiums, approve benefit changes, and so forth.</td>
</tr>
<tr>
<td>Cost containment</td>
<td>• Continuation of BBA types of cost-containment measures.</td>
<td>Not applicable, although measures could be applied to original Medicare (“government-run FFS”) to enable it to compete better with private plans.</td>
</tr>
<tr>
<td></td>
<td>• Innovative cost-containment approaches from private-sector models.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Modifications to increase enrollment in Medicare+Choice plans.</td>
<td></td>
</tr>
<tr>
<td>Standards/conditions for plan participation</td>
<td>Reduce “regulatory burden” on participating plans.</td>
<td>• Federal versus state regulation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Plan standards</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Plan participation</td>
</tr>
<tr>
<td><strong>Structuring the Competition</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Setting the government contribution</td>
<td>Modify rates for Medicare+Choice plans to increase plans offered.</td>
<td>• Approach to setting the level of contribution</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Updates over time</td>
</tr>
<tr>
<td>Determining the beneficiary contribution</td>
<td>Current law.</td>
<td>• What percentage of premium does beneficiary pay?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• How should “savings” be treated if beneficiary elects plan with premiums below government contribution?</td>
</tr>
<tr>
<td>Accounting for geographic variations</td>
<td>Current law.</td>
<td>Different effects of locally or nationally based bids.</td>
</tr>
<tr>
<td>Issues in setting the contribution</td>
<td>Current law.</td>
<td>• Establishing plan premiums</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Capacity and availability of lower-cost plans</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Affordability of traditional Medicare</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Risk adjustment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Benefit packages</td>
</tr>
</tbody>
</table>
| Quality of Care                        | Current law for original Medicare and Medicare+Choice. | • Plans competing partly on basis of quality-consumers choose with their feet. 
  |                                               | • Quality assurance mechanisms. 
  |                                               | • Report cards. |
| Treatment of Vulnerable Populations and Areas of Limited Competition | Shift of low-income support from Medicaid to Medicare to improve coverage. 
  | Vulnerable populations—low income | • Better coordination of Medicaid with Medicare. 
  |                                               | • Improved benefit package. 
  | Areas of limited competition | Current law. | Are there adequate protections to assure affordability of premiums and program benefits for this population? 
  |                                               | How are dual eligibles addressed? 
  |                                               | If low-income receive help, how is that help determined and structured? 
  |                                               | What is the structure of plans and benefits in historically underserved rural and inner-city areas? 
  |                                               | What happens if no or only one private plan serves the area with respect to beneficiary access and cost? |
| Medicare’s Other Missions | Take out of trust fund and make it a discretionary program. | “Carve out” of government contribution and pay directly to hospitals. Could combine with change to discretionary program. |
| Graduate medical education | • Take out of trust fund and make it a discretionary program. 
  | Disproportionate share hospital and rural provider subsidies | • Carve out of Medicare+Choice payments and pay directly to hospitals in same way as GME was carved out in Balanced Budget Act of 1997. |
| Transition Issues | Phase in changes where necessary to minimize beneficiary confusion and disruption. | • Apply program changes to all beneficiaries or just new ones? 
  | Transition | • Phase in changes or implement all at once? 
  |                                               | • Are the effects of changes monitored to enable mid-course corrections? 
  |                                               | • Is there any mechanism other than legislation for slowing or freezing transition if events so warrant? |
| Financing and Fiscal Viability | Income-relate beneficiary premium. 
  | Financing | Increase payroll tax. 
  |                                               | Use other revenues (e.g., excise taxes). 
  |                                               | Use tobacco settlement money for Medicare. 
  |                                               | Allocate budget surplus to Medicare. 
  | Fiscal viability—will the proposal extend the long-term life of Medicare? | Depends on specifics of proposal. | Same as for fee-for-service program. |
|                                               | Uncertainty of estimates. |
At present, Medicare clearly meets the definition of a “defined benefit” program. Both the traditional fee-for-service and new Medicare+Choice programs guarantee a level of benefits that is specified in statute and regulation regardless of how high the government’s costs may rise. Under traditional Medicare, beneficiaries are also promised a fee-for-service delivery system with an unrestricted set of providers. Beneficiary premiums are uniform.

Because the defined benefit nature of Medicare exposes the federal government to an open-ended liability, some have proposed that Medicare be transformed into something that is closer to a defined contribution program. Under that approach, there would no longer be a statutorily defined set of benefits. Benefit packages would be allowed to vary to meet market conditions. Beneficiary preferences would shape the nature of the benefits offered. Moreover, private plans could adjust benefit packages in response to changes in medical technology and health services delivery. The government’s financial liability would be more readily controlled. (Alternatively, the benefit package could be fixed but the government’s liability limited by restricting the level of government support for plan premiums. Using this “knob” to control Medicare spending is discussed under “Setting the Government Contribution” below.)

In the context of Medicare reform in 1999, it thus appears that two major options are on the table. One is to maintain traditional Medicare as a defined benefit program, but to modernize its benefit package. The other is to alter the benefit design of the plan options offered under a premium support system. While some proponents of premium support favor benefit flexibility, others call for at least a basic, standardized benefit package.

**Incremental Reforms**

Medicare’s complex cost-sharing requirements are often described as an artifact of the program’s 1965 benefit structure that make little sense in light of current health care financing and delivery practices (Moon 1996a). For example, inpatient hospital benefits are subject to a large deductible ($768 in 1999) and cost-sharing for long hospital stays ($192 for days 61–90, $384 for days 91–150, with no benefits beyond 150 days). In addition, Medicare does not provide an annual limit on cost-sharing borne by beneficiaries, unlike the typical employer-based coverage (Smith 1996).
As discussed by the Commission and others, updating Medicare’s cost-sharing structure is generally described to involve instituting a single deductible and uniform copayments across services. It would replace the current mix: an inpatient hospital deductible and its derivative copayments for hospital and skilled nursing facility stays, a separate Part B deductible and coinsurance on most Part B services. An annual cap on per-beneficiary cost-sharing would be added as a new feature to the benefit structure. The addition of an outpatient prescription drug benefit is considered by some to be an important requirement of updating the basic Medicare benefit package. (See table 2.)

Reforming Medicare’s basic benefit package has several possible advantages aside from simply making it more up-to-date: improving the comprehensiveness of coverage, keeping the traditional program competitive with private plans, and changing beneficiary incentives.

**Improving the Comprehensiveness of Coverage**

Medicare lags behind private insurance in overall comprehensiveness of coverage, providing benefits that are estimated to be only 84 percent as valuable as the typical private-sector fee-for-service plan offered by medium and large employers (Smith 1996). One major difference is outpatient prescription drug coverage, which is not part of the Medicare package yet typically is offered in group private-sector plans. The average Medicare beneficiary paid half the cost of prescription drugs in 1995, compared with only 34 percent for the U.S. population in general (Davis et al. 1999).

Extensive cost-sharing requirements and lack of outpatient prescription drug coverage mean that Medicare beneficiaries pay a significant share of their health care costs. In 1998, Medicare premiums and cost-sharing paid by beneficiaries covered about 21 percent of Medicare spending. Out-of-pocket costs for Medicare and other acute health expenses absorbed about 19 percent of the average beneficiary’s income in 1998, a figure expected to rise to 29 percent by 2025 (Moon 1999a). In 1996, 2.3 percent of Medicare beneficiaries incurred cost-sharing liability of $5,000 or more. That small number of beneficiaries bore about 23 percent of total cost-sharing amounts paid by Medicare beneficiaries that year (Health Care Financing Administration [HCFA] 1998a).

A further argument for restructuring benefits is that dollars spent on individual Medigap coverage—averaging $1,300 in 1997 for a typical
### TABLE 2. Benefits and Cost-Sharing under Current Medicare and Approaches for “Modernizing” Medicare Benefits

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Current Medicare</th>
<th>Possible Changes to “Modernize” Medicare Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital stays</td>
<td>Beneficiary pays deductible of $768 in 1999; cost-sharing of 1/4 the deductible for days 61–90 of a hospital stay ($192 a day in 1999). For longer stays beneficiaries may use up to 60 “lifetime reserve” days, with cost-sharing of 1/2 the deductible ($384 a day in 1999). No coverage available for stays of more than 150 days.</td>
<td>No day limits on inpatient hospital coverage. No separate hospital deductible. A single annual Medicare deductible would apply to all services.</td>
</tr>
<tr>
<td>SNF care</td>
<td>Beneficiary pays no deductible and no cost-sharing for the first 20 days of a skilled nursing facility (SNF) stay. Cost-sharing of 1/8 the hospital deductible for days 21–100 ($96 in 1999). No coverage for stays of more than 100 days.</td>
<td>No change in 100 day limit, but the single Medicare deductible and 20 percent cost-sharing would apply.</td>
</tr>
<tr>
<td>Home health care</td>
<td>No cost-sharing for this benefit, which covers unlimited medically necessary intermittent skilled nursing care, physical therapy, speech language pathology services, home health aide services, durable medical equipment and supplies, and other services.</td>
<td>Options include continuing no cost-sharing, adding cost-sharing (generally discussed as a 10 percent rate), adding a nominal copayment amount, or placing a limit on the number of visits.</td>
</tr>
<tr>
<td>Physician services; durable medical equipment; other medical supplies</td>
<td>An annual $100 annual deductible applies to these services; beneficiary pays 20 percent of the approved amount after the deductible has been met; except mental health services cost-sharing is 50 percent. Limits on amount physicians may charge in excess of Medicare payment.</td>
<td>Single Medicare deductible would apply, cost-sharing retained.</td>
</tr>
<tr>
<td>Outpatient physical therapy</td>
<td>Beneficiary pays 20 percent of the first $1,500 of physical therapy services or occupational therapy. No benefits after the cap has been reached, although outpatient hospital therapy services do not count towards the limit.</td>
<td>Limits would continue; single Medicare deductible and 20 percent cost-sharing would apply.</td>
</tr>
<tr>
<td>Clinical lab services</td>
<td>No beneficiary cost-sharing.</td>
<td>Cost-sharing could be applied to clinical laboratory services.</td>
</tr>
<tr>
<td>Outpatient hospital visits</td>
<td>Beneficiary generally pays 20 percent of charges after the Part B deductible has been met. Coinsurance is gradually being reduced to 20 percent of the Medicare payment amount.</td>
<td>Single Medicare deductible would apply to all services with 20 percent cost-sharing.</td>
</tr>
<tr>
<td>Prevention: screening mammogram, pap smear, colorectal screening</td>
<td>Beneficiary pays 20 percent of approved amount without application of deductible. No coinsurance on lab tests.</td>
<td>No changes generally discussed.</td>
</tr>
<tr>
<td>Cap on out-of-pocket spending</td>
<td>None.</td>
<td>Add annual cap on out-of-pocket payments for deductibles and coinsurance for all services.</td>
</tr>
<tr>
<td>Outpatient prescription drug coverage</td>
<td>No coverage, except certain drugs provided in an outpatient setting that cannot be self-administered.</td>
<td>Various options for adding a drug benefit, including features such as a separate deductible, copayments, and an overall cap on benefit.</td>
</tr>
</tbody>
</table>

**Source:** See notes below.

**Notes:**

- a. Options for a “modernized” benefit package reflect Commission discussions and other sources such as O’Sullivan 1998 and Moon 1996a. Details on the current program can be found in U.S. House of Representatives (1998).
- b. The cost-sharing amounts are not annual, but apply to a benefit period. The benefit period begins on the day of an admission to a hospital or skilled nursing facility and ends when the beneficiary has not been in a hospital or skilled nursing facility for 60 consecutive days. A beneficiary who is readmitted to a hospital within 60 days of a discharge from a hospital or SNF would not have to pay a second deductible. A beneficiary can pay multiple deductibles in a year if they have hospital stays in different benefit periods.
community-rated plan—could be more efficiently applied to a restructured basic benefit package (Physician Payment Review Commission [PPRC] 1997).

On the other hand, restructuring Medicare benefits would shift costs from these payers to the program at the same time one goal of reform is to improve the program’s long-term financial health. Moreover, in the late 1980s, Congress enacted and then repealed the Medicare Catastrophic Coverage Act, which included the addition of prescription drug coverage, an out-of-pocket cap, and other changes in the Medicare cost-sharing structure. A factor in the ultimate rejection of the program improvements was the perception by many beneficiaries that the restructuring added little to their total benefit package, including supplemental coverage (Moon 1996b). Indeed, nearly two-thirds of Medicare beneficiaries have some level of drug coverage (Davis et al. 1999).

**Keeping the Traditional Program Competitive**

Some argue that the basic benefit package should be improved to keep the traditional program competitive with plans offered under Medicare+Choice. The concern is that without improvements, a beneficiary’s decision about whether to choose between the traditional program and various Medicare+Choice options will be skewed by deficiencies in the basic benefit package. That argument is made specifically regarding the addition of a prescription drug benefit. Currently, most beneficiaries in Medicare+Choice plans have prescription drug coverage available to them, many at no additional costs (Davis et al. 1999). Others pay additional premiums for such coverage to managed care or private Medigap plans, and many go without any prescription drug coverage.

An alternative view is held by those who believe the long-term survival of Medicare depends on managed care plans and other private Medicare+Choice options. Under that point of view, if private plans are efficient enough to provide a drug benefit in addition to the basic Medicare package, it is appropriate to use this as an incentive for beneficiaries to choose these plans.

**Improving Beneficiary Incentives**

Cost-sharing is viewed both as a way to help finance the cost of care and as a means of encouraging beneficiaries to limit their use of services.
Changes in Medicare’s cost-sharing structure therefore could affect total costs of care used by beneficiaries as well as the allocation of costs between the government and beneficiaries. Such issues should be explored when considering the possible impact of restructuring benefits as part of an incremental approach to Medicare reform.

The role of supplemental coverage complicates the analysis of changes to Medicare’s basic benefit structure. Some 87 percent of beneficiaries enrolled in the traditional fee-for-service program have some sort of supplemental coverage, including employer-sponsored retiree health benefits, individual Medigap policies, and Medicaid coverage for low-income beneficiaries (Eppig and Chulis 1997).

Analysis of one cost-sharing restructuring approach considered by the Commission illustrates the possibility of unintended results. According to the Medicare actuaries, most beneficiaries would experience an increase in cost-sharing. Of those experiencing a reduction, low-income beneficiaries (dual eligibles) would have the largest gains. Thus the Medicaid program would benefit more than individual beneficiaries from the restructuring. Sensitivity of the distributional effects to the details of the revised cost-sharing structure should be explored. For example, results could be different if cost-sharing did not include a 20 percent coinsurance on inpatient hospital stays that was assumed in the plan analyzed by the actuaries.

How would such changes affect aggregate Medicare spending? Some analysts have long argued that because most Medicare beneficiaries have supplemental coverage, they are insulated from incentives to keep down their individual health care use. Studies have shown that beneficiaries with supplemental coverage have rates of service use that are one-fourth to one-third greater than those without supplemental coverage (PPRC 1996). A policy change to prohibit such coverage would therefore be expected to reduce service use. Short of a prohibition, a policy to restructure basic Medicare benefits, particularly the addition of a cap on total out-of-pocket costs, might restore individual incentives to limit use of services if fewer beneficiaries choose to purchase individual supplemental coverage. On the other hand, after extensive analysis, the Physician Payment Review Commission found mitigating factors and concluded that “beneficiaries with supplemental insurance report fewer barriers to care than those without it, suggesting that some of the additional care they use may be medically necessary or appropriate” (PPRC 1997).
Premium Support

Transforming Medicare into a premium support system could provide an opportunity to undertake a full-scale redesign of Medicare benefits. The basic question is whether, in a competitive bidding framework, all plans should bid on the same benefit package or whether variations would be allowed. If a standardized package is required, a second question is whether it matches today’s package. A third issue (and one that largely goes beyond the scope of this paper) is whether the government contribution should subsidize all allowed benefit variations.

Benefit package options range along a continuum from least to most specified in terms of the plan’s ability to vary them. Each option has different implications for flexibility, adequacy of coverage, ease of comparison, risk selection, and the process for modifying and overseeing benefit packages. (See table 3.) The options include (1) a flexible benefit package allowing unlimited variation; (2) actuarial equivalence to a benchmark plan; (3) a set of core service categories with flexibility to define their scope, limits, and cost-sharing requirements; (4) standardized core benefits with actuarially equivalent cost-sharing; (5) multiple standardized benefit packages; and (6) a standardized and uniform benefit package with no variations allowed, even for cost-sharing.

Two caveats are in order in evaluating these alternatives. Adequacy of coverage in this discussion refers to the extent to which the benefits cover medically necessary health care. Together with the government’s premium contribution, it provides a measure of the insurance guarantee to beneficiaries. Plans could be required to provide a comprehensive benefit package, but that package may not afford much protection if the government is contributing, for example, only 50 percent of its cost. The second caveat is that differences in plan standards for medical necessity determination are likely to lead to different interpretations of benefits, regardless of how standardized a benefit package may be.

Benefit Design Options

Flexible Benefit Package. Under this approach, the federal government would not place any requirements or constraints related to the content of the benefit packages offered by health plans to consumers. Instead, the benefits would be determined by the plans. Plans best able to match consumers’ preferences at the right price would attract the most enrollment.
Health plans probably would find that the most popular benefit packages were relatively comprehensive, providing coverage for those services most important to consumers. This option would also enable plans to readily update benefit packages to reflect changing technology and medical practice.

Giving health plans free rein to determine the content of their benefit packages has drawbacks. One concern is that plans might use benefit design to influence risk selection. Coverage of mental health services, for example, is known to attract persons who are above-average users of medical care. So, too, would coverage of transplants or coverage of certain high-cost drugs. On the other hand, routine dental coverage and health club memberships are benefits known to attract younger, healthier individuals. Also, plans might exclude or limit benefits most needed by the

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**TABLE 3. Defining a Medicare Benefit Package: A Comparison of Alternative Approaches**

<table>
<thead>
<tr>
<th>Benefit Design Option</th>
<th>Plan Flexibility</th>
<th>Nature of Benchmark to Determine Adequacy</th>
<th>Ease of Comparison of Plan Benefits</th>
<th>Potential for Selection Bias</th>
<th>Role of External Entity to Review or Modify Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flexible benefit package</td>
<td>Maximum flexibility. Plans determine benefit content.</td>
<td>Would have to be specified.</td>
<td>Little comparability.</td>
<td>Maximum.</td>
<td>None.</td>
</tr>
<tr>
<td>Actuarial equivalence</td>
<td>Substantial flexibility to vary benefits so long as they achieve value of benchmark plan.</td>
<td>Could be a defined benefit package or a specified dollar value.</td>
<td>Little comparability.</td>
<td>High potential for selection bias.</td>
<td>Reviews for equivalence. No authority to modify benefits.</td>
</tr>
<tr>
<td>Core service categories (similar to FEHBP)</td>
<td>Substantial flexibility to vary scope, limits, cost-sharing.</td>
<td>Specified core service categories.</td>
<td>Little comparability.</td>
<td>High potential.</td>
<td>Reviews for adequacy, selection bias, cost. Has authority to modify benefits.</td>
</tr>
<tr>
<td>Standardized core benefits with actuarially equivalent cost-sharing</td>
<td>Flexible other than for required core benefits.</td>
<td>Specified core benefits.</td>
<td>Some comparability, but still significant variation.</td>
<td>Depends on extent to which external entity regulates benefit content.</td>
<td>Reviews for adequacy, selection bias, equivalence. No authority to modify benefits.</td>
</tr>
<tr>
<td>Multiple standardized packages (similar to Medigap model)</td>
<td>Plan can choose 1 or more packages to offer; cannot vary content of selected packages.</td>
<td>Linked to one of the model plans.</td>
<td>Depends on number of options. Fewer means easier comparison.</td>
<td>Depends on extent of variation of standardized benefits.</td>
<td>Checks consistency with model packages. No authority to modify benefits.</td>
</tr>
<tr>
<td>Uniform standardized benefit package</td>
<td>Little flexibility (may allow variation for supplemental benefits).</td>
<td>Specified benefit package.</td>
<td>Basic benefits fully comparable; supplemental benefits (if any) could vary.</td>
<td>Not on basic package; possible to affect selection with supplemental benefits.</td>
<td>Approves annual filings and checks additional benefits. No authority to modify benefits.</td>
</tr>
</tbody>
</table>

Source: Author’s analysis.

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One concern is that plans might use benefit design to influence risk selection.
chronically ill, such as home health care. Another concern is that beneficiaries might find it difficult to make informed choices of health plans. Plan offerings might vary widely, not only with regard to the types of services covered but also with regard to the scope and limits of the benefits and the enrollee cost-sharing requirements. Comparing plans would, therefore, be challenging. Finally, while the option offers plans the greatest flexibility to meet beneficiary preferences, it also means that there would no longer be one standard benefit package to judge the Medicare program’s adequacy.

**Actuarial Equivalence Model.** This approach envisions the use of a benchmark benefit package but would allow private plans the flexibility to offer a set of benefits different from but actuarially equivalent to the benchmark. For example, a plan could be required to offer benefits equal to the actuarial value of traditional Medicare or to the Blue Cross Blue Shield standard option under the Federal Employees Health Benefits Program (FEHBP). Alternatively, plan benefits might be required to match a specified dollar value, such as $5,000 per year for the average beneficiary. Agreement on the methodology for computing actuarial equivalency would be necessary and could be difficult to achieve. One issue, for example, would be whether to value benefits as if provided on a national basis to an average beneficiary rather than allowing local variations. That might be necessary to prevent geographic and other variations in price from affecting the generosity of the package.

Whether or not the model provided for adequate coverage would depend on the benchmark selected. It would give plans substantial flexibility to tailor benefits to beneficiary preferences, but would also raise the chances that benefit packages would be designed to select risks. For beneficiaries, plan comparisons also would be more difficult. Insurance proposals incorporating such a model typically require an external entity (such as an insurance commission) to ensure that each plan’s benefit proposal meets the actuarial equivalence standard. In the Medicare context, that role could be given to HCFA or to a new entity.

**Core Services Model.** Under this approach, similar to FEHBP’s, health plans would be required to offer at least a core set of services, such as coverage for hospital, physician, and clinical laboratory services. Cost-sharing and copayments could vary at the plan’s discretion, as could a benefit’s scope and limits. In that way, all Medicare beneficiaries would be guaranteed a minimum level of coverage and plans would retain flexibility to tai-
lor the benefits. If the approach closely approximated that of FEHBP, the flexibility would be somewhat constrained. The Office of Personnel Management (OPM), which administers FEHBP, uses its authority to “jawbone” plans to offer certain benefits and to ensure that benefit changes that it has not required do not add to the cost of the premium. In its oversight role, OPM also tries to guard against the use of benefits by a plan to influence risk selection.

By guaranteeing a minimum level of benefits, the approach would better enable beneficiaries to evaluate the adequacy of coverage than the previous options. Variable cost-sharing and coinsurance, however, would make such an evaluation more complicated. As with plan choices under FEHBP, making comparisons between plan benefit packages poses a significant challenge. Providing help to beneficiaries with benefit comparisons, such as those OPM and others provide to federal employees each year, no doubt would emerge as a growth industry. Even then, many Medicare beneficiaries, especially the most frail and elderly, could face a bewildering range of choices. Informed selection might improve with time as they became more experienced with the process and more familiar with insurance terminology.

Taking the FEHBP analogy one step further, an OPM-like entity could be given the authority to regulate the benefit content of the participating private plans. Plans could be required to submit their proposed benefit changes for the coming years. The changes could be reviewed to determine their effects on premium cost and risk selection. Benefit variation between plans could be constrained. That would reduce the consequences of choices for beneficiaries. Would the OPM-like entity have the last word or could its decisions be appealed? Would the entity have the capacity to do an adequate review of potentially thousands of different plan policies? What criteria would be used in placing limits on benefit variations? Those are just a few of the design issues that would have to be resolved.

**No Variation in Core Benefits with Actuarially Equivalent Cost Sharing.** Under this approach, plans would have to offer the same set of benefits, defined with specificity regarding each benefit’s scope and limits. The option is somewhat similar to the benefit specifications for the Medicare+Choice coordinated care plans. It differs in that Medicare+Choice plans can add benefits, such as outpatient prescription drug coverage, to their core package without a premium. The approach is
less flexible than the previous ones but would still allow variations in cost-sharing requirements. Comparison of the various options would be somewhat easier, thus simplifying the selection process for beneficiaries. The opportunity to use benefit design to influence risk selection would be less since the only variations would be on cost-sharing amounts. Adequacy of coverage could be readily assessed.

**Multiple Standardized Packages.** Congress or an external entity such as a Medicare board or oversight body would establish some number of model benefit packages that could be offered by a health plan and selected by a beneficiary. Like the 10 standardized Medigap benefit packages, they could range from offering basic to comprehensive coverage. The model increases choice while preserving some comparability. The fewer the standardized packages, the easier the comparisons. Risk selection still would be an issue depending on the extent of variation of the standardized benefits. For example, the existing Medigap policies that offer prescription drug coverage attract higher users of health care than those without such coverage.

**Uniform Standardized Benefit Package.** Under this approach, all health plans would have to offer the same benefit package to all beneficiaries. This would ensure a uniform and predictable level of basic benefits. Beneficiaries could compare plan options on the basis of price and quality of services and would not have to worry about differences in benefits. The adequacy of coverage could be clearly measured, and plans could not use benefit design to attract the best risks. On the other hand, requiring all plans to offer the same benefit package would limit the choices available to beneficiaries, especially those with special circumstances or special health care needs. It would not allow the kinds of cost-sharing differences that typically help to differentiate different types of plans (e.g., health maintenance organizations [HMOs] and PPOs). Finally, the approach also would limit the ability of plans to compete by offering extra benefits and, depending on the procedure for modifying benefits, could impede their modernization to meet changing medical practice. (An external entity such as a Medicare board could be given this power rather than leaving it to a change in law as is the case currently.)

**Treatment of Traditional Medicare.** Regardless of design, there remains the issue of how traditional Medicare would be treated under a premium support system. Would traditional Medicare and the private plan options...
be required to offer the same benefits, be given flexibility in determining benefits, or operate under different rules? By its very nature, flexible benefit packages may not be compatible with traditional Medicare because of the general need for uniformity. On the other hand, applying different rules to traditional Medicare could encourage selection bias. For example, if traditional Medicare’s benefit package were more generous than private plans, traditional medicine would experience adverse selection. The degree of adverse selection would depend, in part, on the relative premiums of traditional Medicare and its private plan competitors. This is an especially tricky design issue because traditional Medicare could experience adverse selection even if benefits are less generous. Sicker beneficiaries are more likely to have a relationship with a set of providers and would thus want the freedom of choice of providers offered by the traditional program’s fee-for-service delivery system. Inertia also could lead to selection bias. Beneficiaries who were frail and sick would be unlikely to migrate to other plans even if confronted with higher premiums.9 The extent to which risk adjustment could address the problem is a critical issue. (See “Determining the Government Contribution” in the following pages.)

**Additional Considerations**

Other benefit-related issues that may need to be addressed under a premium support system include the following:

**Cost-Sharing.** What, if any, limits, would apply to beneficiary cost-sharing? Would plans be required to cover coinsurance amounts in excess of some threshold amount, so that beneficiary out-of-pocket expenses were limited? (This is known as a “catastrophic limit.”) Could plans impose limits on their per patient liability (i.e., lifetime limits), as they often do for younger populations? Would providers be allowed to balance bill?

**Flexible Benefit Options.** Would plans be required to make all benefit options available to all beneficiaries in a market area or could they vary benefits within a market area? (This was a significant issue in the transition from the Medicare risk contract program, where such variation was permitted, to Medicare+Choice, in which the statute does not allow benefits to vary within a market area.)10

**Additional/Supplemental Benefits.** Would plans be required or allowed to provide benefits other than those specified in the basic benefit package?
Would these benefits be included as part of the base premium or would an additional premium be assessed? Would such additional benefits have to be included in all of the plan’s options or a subset of them? Would supplemental benefits be used to encourage risk selection?

**Delivery System Options.** A related set of issues concerns the delivery system for providing covered benefits. For example, would network-based plans be required to offer point-of-service options? Would limits be applied on the use of “gatekeepers” that restrict access to specialists? Would private fee-for-service arrangements be permitted (as they are under Medicare+Choice)? Would expanded choice of delivery system options, such as private, fee-for-service arrangements, affect risk selection?

**Other Sources of Coverage.** As noted earlier, many beneficiaries in traditional fee-for-service Medicare have private, supplemental health coverage through Medigap or employer-sponsored health plans. A significant portion of beneficiaries (about 15 percent in 1995) are covered by Medicaid (House 1998). To what extent would such coverage be replaced under a premium support system? What would be the effects on federal and state government, employer, and beneficiary spending (CBO 1999)? Much would depend on the relative generosity of the benefit package offered by the private plans.

**ANALYZING THE OPTIONS: STRUCTURE OF THE PROGRAM**

This section deals with the changes in the way in which the Medicare program would operate under both incremental and premium support approaches. Because the premium support approach envisions a more fundamental restructuring of the program, it commands more of the discussion in this and subsequent sections.

**Incremental Reform**

In general, an incremental approach to Medicare reform would retain the current operational structure of the program but make changes to permit innovative approaches to cost containment.
**Continuation of Past Cost-Containment Approaches**

Since the 1980s, the general approach to Medicare cost containment has used so-called “prospective payment” or administered pricing approaches, which establish fee schedules for specific services and limit growth in payments (i.e., reduced update factors). This has been a successful approach to reduce growth in spending for most inpatient hospital services and physician fees. Prospective payment has recently been implemented for skilled nursing facility services and is scheduled to be put in place for outpatient hospital, home health, and other services.

Growth limits on fees under those systems have been set as part of multiyear federal budget legislation that has a permanent effect on Medicare spending. Additional future savings could be achieved by continuing restrained growth in payments, as the default payment updates that are used to project long-term program expenditures are generally indexed to inflation factors.

In addition to limits on growth in fees, other adjustments and refinements could continue to be made to payments for Medicare services. For example, President Clinton’s budget for fiscal year 2000 includes provisions to reduce payments for certain outpatient drugs, medical equipment and supplies, and partial hospitalization mental health benefits. A variety of user fees would be required for providers and plans that participate in the program.

These cost-containment approaches could generate significant savings. For example, the Medicare actuaries estimated that a package of reductions in update factors included as part of the preliminary Breaux-Thomas proposal would generate $57.1 billion in 10-year savings, or 1.7 percent of program expenditures (Commission 1999a).

**Modifying Medicare+Choice**

The Medicare+Choice program is expected to grow in importance over time. The March 1999 Congressional Budget Office baseline projections estimate that the proportion of beneficiaries enrolled in Medicare+Choice plans will more than double in the next 10 years—from 16 percent in 1999 to 31 percent in 2009.

Just as on the fee-for-service side, cost-containment efforts could include constraining the growth in payments to these plans, which are
indexed to growth in Medicare per capita expenditures (less 0.5 percentage points for fiscal years 1999–2002).

Concerns about the effect of a cost-containment policy on plan participation in Medicare+Choice will be a factor in the consideration of tightening plan payments, however. In fact, some members of Congress have called for increasing plan payments—easing up on cost-containment efforts under way—to encourage more plans to participate in the program and increase beneficiary enrollment in Medicare+Choice plans. Under the BBA, geographic differentials in plan payment are being reduced; those differentials have also contributed to the tradeoff between savings from capitation payments to plans and savings from increased plan enrollment.

Greater plan participation also may be encouraged by easing administrative requirements on plans. Such changes are already under consideration by the Clinton administration. As the Medicare+Choice portion of the program continues to grow and more experience is gained with issues such as beneficiary education, adjusting payments to reflect health status of enrollees, and handling of plan withdrawals, further adjustments and improvements can be expected.

Competitive bidding is often discussed as a means of using local markets to determine payments to Medicare+Choice plans. Demonstration projects are in development that would test that alternative to government-established payment rates. Under a competitive bidding approach, savings to the government would depend upon local market conditions and would be difficult to predict or guarantee.

**Possible “Modernized” Cost-Containment Approaches**

Administration of the traditional Medicare program requires ongoing adjustments to provider payments in reaction to changes in health care delivery and provider practices. Data lags, procedural requirements, and limited regulatory authority can make it cumbersome for payment adjustments to be made quickly. Some analysts argue that such constraints unnecessarily expose the program to creative attempts by providers to maximize their payments.

Other cost-containment approaches that would be new to Medicare are based on adapting strategies used by managed care plans. Many of the approaches were recommended by the NASI committee and included in the Breaux-Thomas proposal to modernize the traditional Medicare pro-
gram. NASI also recommended an aggressive approach to ongoing program innovation including broad waiver authority to allow Medicare to test new policies first in local areas. The approaches include the following:

- Creation of a Medicare preferred provider system (PPO). Providers would accept lower fees in exchange for greater volume of patients. The PPO could be accomplished by limiting the participation of providers in Medicare, by giving beneficiaries financial incentives to see certain providers or “centers of excellence,” or both. Quality factors and price could be used to select preferred providers.

- Competitive procurement of items and services. Rather than determining prices administratively, Medicare would negotiate market-based prices with providers. Beneficiaries would have to receive services from designated providers.

- Package pricing or mini-capitation. Payments for all items and services used during an episode of illness would be bundled into a single payment amount.

- Disease and case management for beneficiaries with chronic conditions. This could involve coordination to reduce unnecessary services and improve quality through patient education and self-management, improved provider profiling and education, and package pricing.

- Requirement of prior authorization and tightening of definitions of medical necessity to address overuse or misuse of services.

The Medicare actuaries estimate that implementing such modernization provisions could generate about $22 billion in program savings over fiscal years 2000–2009 (Commission 1999a).

Although they would potentially generate program savings, the tools described would affect the Medicare program and its beneficiaries in other ways that bear consideration.

*Isn’t Medicare Already a PPO?* For the most part, Medicare prices are already discounted, and mechanisms are in place to continue or deepen these discounts into the future. How much more saving could be generated by a preferred provider or centers of excellence approach to managing Medicare? Would the savings be offset by the additional administrative expenses required to establish and maintain a preferred provider system?
What changes would need to be made in supplemental coverage to encourage beneficiaries to choose preferred providers, and how would they affect beneficiaries’ out-of-pocket costs? What would be the effect on beneficiary access and continuity of care if fewer providers were participating in the program? What quality measures could be used to select participating providers? What would be the effect on providers who were not selected to participate in Medicare? Could they survive?

**How Would Package Prices Work?** Under the traditional Medicare fee-for-service approach, constraining fees for particular services gives providers an incentive to unbundle or redefine services and shift care to sites with more favorable payment levels. A package pricing approach would address this problem and improve program efficiency. A Medicare demonstration program that bundled hospital and physician payments for heart bypass surgery found that having joint incentives with physicians helped some hospitals reduce their treatment costs (HCFA 1995). Yet package pricing requires examination of other issues: What services should be included in the package? What entity receives the payment? What oversight is required to ensure that beneficiaries receive all the services they need for the fixed price? How would the packaged price reflect variation in patient case-mix?

**How Would Disease and Case Management Work?** These approaches are promising because they focus on individuals who are high users of care, but they are in the early stages of use even among private managed care plans. What special requirements are posed in pursuing patient education and other disease management approaches with an elderly and disabled population? To what extent would savings be offset by case management costs?

**Who Should Make Individual Care Determinations?** Private plans often require prior authorization for hospital stays and other services. They also use definitions of medical necessity that allow them to limit or deny payment for services that might otherwise have been prescribed by the patient’s physician. In many cases, the basis for the decisions is not disclosed to enrollees or providers. Part of the current debate over managed care regulation centers around public discomfort with health plans making those decisions. Under Medicare+Choice or the premium support approach, the government distances itself from such individual determinations and leaves plans to operate within an oversight structure. Although
Medicare itself already makes coverage decisions that affect individual patients, use of prior authorization and other private-sector approaches would put the government in a more visible oversight role with respect to individual care. What are the tradeoffs associated with giving the government an expanded role in determining the availability of services to individual beneficiaries?

**Will Medicare Shift Costs to Private Payers?** Discussions of cost-shifting have come full circle at least once. When Medicare began its cost-containment strategies, analysts believed that hospitals and other providers were able to make up Medicare losses by increasing charges to other payers, who at the time were exposed by their own lack of cost-containment activity. Now, concern appears to be the opposite—some providers apparently identify Medicare as their most generous payer, suggesting that aggressive price discounting in the private sector has exposed Medicare to cost-shifting. What, if any, effect would more aggressive cost containment by Medicare have on the private sector? Would providers succeed in causing private payers to ease up on their own efforts?

**At What Point Does Paying Less Buy You Less?** The tradeoff between constrained provider and plan payments and quality of care has been a perennial question ever since Medicare began its emphasis on cost containment. Can providers find ways of improving efficiency over the long term if payments do not keep pace with inflation? Will Medicare beneficiaries lose access to certain providers and services because payments are inadequate? Will fewer plans choose to participate in Medicare+Choice if capitation payments are constrained? Moreover, because traditional Medicare is the single largest payer in the health care system, paying significantly less over time has the potential to affect the overall health care system. Some of the “modernized” cost-containment approaches recommended by NASI and others attempt to address this issue by incorporating quality aspects into purchasing decisions rather than focusing only on prices. But the basic tradeoff remains an issue—and an issue for the premium support approach as well.

**Will Beneficiaries Recognize a “Modernized” Medicare?** Some approaches to modernizing Medicare operations would involve limiting beneficiary access—either by restricting which providers can participate in the program or by giving beneficiaries a strong financial incentive to choose certain providers. Beneficiaries might be required to seek prior approval for

Because traditional Medicare is the single largest payer in the health care system, paying significantly less over time has the potential to affect the overall health care system.
services or have their plan of care determined by a case management approach. Depending on their nature and extent, these approaches could change the traditional program so much that from the beneficiary perspective, it is hard to distinguish traditional Medicare from a private Medicare+Choice preferred provider plan. While making Medicare look and act like a private plan might be the goal of some advocates of modernization, it raises the question, Why keep the traditional program? Is there a point at which the program must undergo so much change that it is not worth the effort required from a program administration and beneficiary education point of view? Is there value added by having the government directly run an insurance program?

**Merging Parts A and B.** The Part A/Part B split in Medicare financing, benefits, and administrative structure is another possible dimension of modernizing the traditional program, and it may be necessitated by other program changes (Caplan and Gross 1999). For example, the unified cost-sharing structure described earlier might require that beneficiaries participate in the full program, thus eliminating the optional nature of Part B coverage. Most beneficiaries participate in Part B; less than 2 million are Part A-only enrollees.

Distinctions between Part A intermediaries and Part B carriers could be an obstacle to broader implementation of bundled payments and preferred provider arrangements. This happens because the approaches would require an administrative structure that takes into account the broad range of services across what are now Parts A and B. In fact, some analysts have argued that the artificial distinction between inpatient and outpatient services caused by the separation of Parts A and B has led to a program management approach in which payment structures and oversight of services are handled in “silos” rather than as part of an integrated system of benefits. From a beneficiary perspective, a single administrative entity could be an improvement. Under the current system, beneficiaries receiving both inpatient and outpatient services have two contacts for inquiries and appeals.

Despite these benefits, a major overhaul of Medicare’s administrative structure would have costs. Redesigning the role of contractors, designating contractors, and providing oversight of a newly structured administrative system would require resources at a time when HCFA faces limited resources and competing priorities.
Often, consideration of how to finance Medicare into the next century focuses solely on the solvency of the payroll-tax-funded Part A Trust Fund. Part B is viewed as fully funded without considering the general revenue transfers that would be assumed without any program changes. A combined program would make the financing choices clearer.

Under a combined program, financing would have to be restructured. Payroll taxes are based on income and could flow into a unified trust fund without any difficulty. Beneficiary premiums would have to be redefined, since they are currently pegged to cover 25 percent of the costs of Part B only. In addition, the general revenue subsidy would have to be reviewed. Of course, because the program faces financing difficulties, these issues would have to be examined even if the two parts of the program were left as is.

Finally, a larger question looms regarding merging the two parts of the program. Since Part A is an entitlement and Part B is a voluntary program, the nature of the combined program would have to be defined. This raises many of the same issues posed by the premium support option. To what Medicare benefits are the elderly and disabled entitled? How much are they expected to contribute toward their Medicare coverage?

What Process Would Be Used to Implement the Changes? Are there limits to letting Medicare act as a private health plan? Rule-making and other procedures exist to assure that the government’s decisions are not arbitrary. The tradeoff is often slower decisionmaking. Giving the program’s managers more flexibility has been cited as a key component to letting Medicare maneuver in the health care marketplace more like a private health plan. But if typical government administrative procedures are waived, what process will replace them? For a program as large as Medicare, the stakes are very high for participating providers and plans as well as program beneficiaries. Increased flexibility and perhaps less openness in the decisionmaking process could be perceived as unfair by the public and Congress. How much flexibility or arbitrary decisionmaking will Congress and the courts permit?

Premium Support

The premium support approach envisions a restructuring of the way in which the Medicare program operates, from its administration to the method by which covered services are reimbursed. Just as with benefits,
the design issues related to program operations are numerous, with varying implications depending on the choices made. This section highlights two of the issues that would have to be addressed: managing the competition (who runs the program?) and specifying standards for plan participation.

**Managing the Competition**

One of the fundamental ways in which a premium support approach differs from a voucher or pure competitive approach is the role of government in managing the competition. Under a voucher program, the government would merely provide the money to beneficiaries, who, in turn, would choose a health plan in the private marketplace. Plans might be subject to some government rules and standards, but mostly the market would be allowed to operate as unfettered as possible consistent with the health and safety of beneficiaries. Under a premium support program, the government would structure or manage the competition. It would not only provide for standards for participating health plans but also work to ensure that plans competed fairly on the basis of cost and quality and not on risk selection. Accordingly, the government or its agent would play an active role in establishing and reviewing plan standards, qualifying plans, and then overseeing benefit packages, premiums, marketing, and other aspects of plan operations.

An issue in the debate over premium support is location of the functions. Should it be the existing Medicare agency, HCFA; elsewhere in the Department of Health and Human Services (DHHS); in a new agency placed within DHHS; in a new independent board or commission; or in a nongovernmental entity? While the issue may seem academic, the decision could significantly influence a premium support program’s legitimacy and success. Much depends on the values judged to be important. Some place the greatest importance on administrative efficiency and flexibility, others on due process and uniformity.

While both are arguably rough approximations of premium support programs, Medicare+Choice and FEHBP illustrate somewhat distinct approaches to managing market competition. More detailed comparisons between the two programs are provided elsewhere (Merlis 1999; Fuchs and Merck 1998; GAO 1998), but a few general points merit mention.
The Medicare+Choice program operates on the basis of relatively detailed legal and regulatory requirements relating to solvency, adequacy of the provider network, marketing, claims processing, quality assurance, internal and external grievance procedures, and more. Plan compliance is assessed at the time of initial contracting and then at three-year intervals, with more frequent reviews if there is an indication of problems (such as a high level of complaints or disenrollments). Those functions are performed by a large number of HCFA personnel located in the central Baltimore office and regional offices around the country. Most aspects of the Medicare+Choice program are subject to public disclosure, and once it has been fully implemented, substantial data will be available on the participating plans and on the program as a whole. Any action by HCFA to suspend or terminate a plan for noncompliance is subject to specific administrative and legal procedures.

In contrast, the statute and regulations governing FEHBP are less specific. Instead, OPM provides much of the instruction to existing and potential plan contractors through annual “call letters” and contracting requirements. Either through design, accident, or necessity, OPM clearly has more discretion to negotiate with health plans about benefits and premiums than does the Health Care Financing Administration. Also, unlike HCFA, the Office of Personnel Management functions entirely out of a central office. There are no local or regional OPM offices, although enrollment, premium collection, and certain other responsibilities are handled by the federal agencies and departments for whom the FEHBP plan enrollees work. Finally, although OPM is making an increasing amount of information available to enrollees about the participating plans and the program as a whole, those activities are less bound by statute.

Many have argued in favor of running a new Medicare premium support program more like OPM and less like HCFA. Critics say that HFCA too often micromanages Medicare and that its regulatory culture is at odds with private market operations. They also say it is rigid and unresponsive to changing market conditions. That view is reflected in a proposal by the Commission to fashion the administrative structure for the restructured Medicare along the lines of OPM. A “Medicare board” would be established and given extensive authority to manage the competition. It would ensure financial and quality standards, protect against adverse selection, oversee benefit packages, negotiate premiums, compute pay-
ments to plans, and provide information to beneficiaries (Commission 1999b).

Such powers are more extensive than those given to HCFA, especially with respect to negotiating premiums and overseeing packages. Not specified by the Commission is the extent to which the board could contract with health plans selectively rather than accept all health plans that meet contractor standards. Also not specified is whether the board would be subject to the same types of administrative and due process procedures that apply to Medicare. For example, a Commission paper says that the government fee-for-service program (i.e., traditional Medicare) would be placed under the jurisdiction of the board. Does that mean that traditional Medicare would come under an entirely new set of rules? Indeed, significant questions relating to the structure and operation of the board would need to be addressed. It would also be important to anticipate how that particular approach to managing the competition would measure up to concerns about accountability to beneficiaries and providers, fair administration, and the free, open exchange of information. Additional questions about the Board include:

- **Selection.** Who selects the board? How large is it? What interests (e.g., consumers, health plans, and providers), should be represented on the board? What are the qualifications for the board? How long do members serve? How are they compensated?¹⁴

- **Operation.** How does the board relate to Medicare’s existing administrative structure? To what extent do current Medicare policies related to trust fund operations and enforcement against fraud and abuse (such as currently carried out by the Office of the Inspector General) apply to the board and the new premium support program? Is the program run at the national level or are some responsibilities delegated to regional/state subunits? How do such units fit into the board structure?

- **Responsibilities.** What are the duties of the board? How much discretion does the board have to make program changes?

- **Budget and Financing.** How much does the board cost to operate? How is the board financed? Is the amount allocated from the Medicare trust funds or appropriated?
• Governance. To whom is the board accountable? Congress? The Department of Health and Human Services? Are its decisions subject to review by the White House and Office of Management and Budget? What if it should go beyond the scope of its authority? Are its decisions appealable? Can and to what extent should board decisions be insulated from politics?

• Information. How much information about the plans would the board make public?

**Standards for Plan Participation**

*Federal versus State Regulation.* Once the administrative structure of a premium support program was established, the rules of competition would have to be specified. If Medicare were being created entirely anew, this might be relatively easy. Uniform national standards could be established through statute and regulation, and plans meeting those standards would be considered qualified to participate in the Medicare program. The main issue then would be whether Medicare accepted all qualified plans or contracted on a selective basis.

But a reformed Medicare presumably would be built upon the current program and existing federal-state relationships. By law and tradition, the federal government has deferred to the states with respect to the regulation of health insurance. Although the situation has been gradually changing, the states retain a primary role in the regulation of health plan solvency, organization, marketing, underwriting and rating, grievances and appeals procedures, and other aspects of plan operation. In the past, the federal government has preempted state law from applying to traditional Medicare, although some state laws (such as state laws against balance billing) have survived legal challenges. But Medicare+Choice and the risk-contract program that preceded it allow for a more divided regulation. For example, under the Medicare+Choice program, health plans have to be licensed by the states to participate in the program, which means that they are subject to state solvency requirements. Other state laws may apply to Medicare+Choice plans to the extent that they are not explicitly preempted or are inconsistent with Medicare standards. State laws related to benefits, for example, are explicitly preempted, but state laws related to plan governance are not. Cost-sharing is another aspect of plan design that may
not be preempted, although interpretation of the Medicare statute is being litigated.

The role of states in regulating private health plans that participate in Medicare is thus one issue that would arise in setting up competition; tradeoffs between federal uniformity and state flexibility, and federal versus state capacity to qualify and oversee health plans, would need to be resolved. Should state laws that may be more reflective of local market conditions and consumer preferences prevail over laws and regulations developed in the capital? Conversely, as was argued in the case of health maintenance organizations in the early 1970s and provider-sponsored organizations during the debate over the BBA, what if state laws impose unreasonable barriers to innovative health care arrangements? Should there be a process by which Medicare can help such organizations get around state laws? In the event that a plan goes out of business or reneges on its contractual responsibilities, who is responsible? Should it be the state in which the plan is located or the federal government?

In summary, key questions include these: Should health plan standards be established at the federal level, or should existing state laws apply? If state laws are allowed to apply, which state laws? All, or only those that are not in conflict with federal law? Once it is determined which standards apply, who determines whether the plan is in compliance? The federal entity, the state, or both? What is the process for establishing that the plan is qualified to participate? What are the procedures for appealing an adverse decision?

**Plan Standards.** To ensure that plans compete on the basis of cost and quality and not risk selection, certain standards would be necessary. Especially important would be standards related to beneficiary enrollment, underwriting, and marketing.

Such requirements are likely to look like those that are already in place for Medicare+Choice or FEHBP. For example, each plan would have to agree, within its capacity, to accept every individual seeking enrollment; no one could be excluded from coverage on medical or other grounds, nor could premiums vary on the basis of health status or similar characteristics. Individuals would enroll in their selected plans through an annual enrollment process, with special enrollments allowed for changes in eligibility status, family status, or other reasons out of the beneficiary’s control. Marketing by individual plans would be regulated to guard against abuses.
Medicare (HCFA, the board, or some other external entity) would collect and disseminate comparative information on quality (process and outcomes data) and costs of the participating plans. Ability to furnish these data would be a key factor in a plan’s eligibility for participation.

Some related issues that policymakers might want to consider include these:

- What rules would govern beneficiary plan switching? For example, would beneficiaries be locked into their plan choices for a full year, as under FEHBP? Alternatively, would they be able to switch month-to-month, as has been the case for Medicare risk plans, or would they be locked in for a year but with an opt-out during the first three months, as will eventually be the case under Medicare+Choice? The rules have implications for risk selection, administrative costs, and the comfort level of beneficiaries with private plan options.

- Could plans use agents to market their choices? If so, would there be any limits on commissions? Many private plans rely heavily on agents for marketing and enrollment. However, agent commissions can be structured to encourage agents to “cherry pick” enrollees.

- To what extent would Medicare publicize the private plan options? Some believe that the government cannot fairly market private plan options. Others worry about aggressive marketing techniques by private plans. What rules would govern direct marketing by health plans?

- What kinds of assistance would be available to help beneficiaries (especially the frail and sick) understand their options and navigate the market? Would there be special protections for all or some beneficiaries to opt out of a plan at times other than the open enrollment periods and enroll in a different plan?

- What kinds of rules would be needed to deal with enrollment transitions that might result from plan terminations? This has proved to be a major issue for the existing Medicare risk-contract and Medicare+Choice programs.

**Plan Participation.** In addition to plan qualification is the issue of plan participation. Should all plans that meet program qualifications be allowed to participate or should the program have the authority to contract more
selectively? Currently, the Medicare+Choice program allows any plan that meets specified standards to participate. The requirements for plan participation under FEHBP are more complex, but OPM must contract with any federally qualified HMO (Merlis 1999).17 Beneficiaries indicate “with their feet” which plans are the best; those that fail to meet beneficiary preferences lose enrollment. Such an approach also means that the administering agency is not put in the awkward political position of choosing among plans.

The other possibility would be for Medicare to contract selectively with a limited number of plans in each area. That would track the approach taken by many employment-based health benefit plans, including the California Public Employees Retirement System (CalPERS). Selective contracting would give program officials considerable leverage over plans seeking access to the Medicare market. Priority could be given to those plans, for example, meeting certain quality standards.

Such an approach, however, could severely limit the choices available to beneficiaries. Moreover, many analysts doubt that a program as large as Medicare could negotiate effectively with multiple plans in each market area. As observed by the National Academy of Social Insurance, selective contracting by a program as large as Medicare “could have serious economic and political consequences. Its dominance can actually limit Medicare’s ability to use its market power. Loss of Medicare patients could seriously damage a plan’s viability.” It further points out that restricting participation “could create barriers to the entry of new plans into the market. Instability in plan participation triggered by Medicare policy could, over time, undermine the development of efficient markets; the exit of even one major plan could destabilize remaining plan options” (NASI 1998).

**ANALYZING THE OPTIONS: STRUCTURING THE COMPETITION**

Some of the most challenging design issues for a premium support approach relate to structuring the competition. How is the government premium contribution determined? How are plan premiums determined? What happens to traditional Medicare? These issues are at the heart of transforming premium support from theory to practice.
Setting the Government Contribution

The effects of a shift to a premium support system on beneficiaries and the Medicare program would depend greatly on the level at which the government’s contribution is set. Among other things, it would affect the magnitude of any budgetary savings achieved by such a shift, the level of beneficiary out-of-pocket costs, the number of health plans serving the Medicare market, the number of plans from which beneficiaries with limited incomes may choose, the offering of extra benefits, and the long-term stability of plan offerings.

There are two approaches to setting the level of government contribution. The first is to base the amount of contribution on an array of bids submitted by the competing health plans. The second is to base the level of government support on a defined or budgeted amount of dollars, which can be implemented in a variety of ways depending on the policy goals. The effects of the two approaches on government and beneficiary spending over time would differ.

Competitive Bidding/Market Approach

Under this approach, each plan would bid a premium sufficient to cover the costs of providing the benefit package to its enrolled Medicare population as well as the profit and administrative overhead. The bid for traditional Medicare would be based on its expected per capita costs. The government’s contribution would then be set at some share of the resulting array of bids.

Options for setting the government contribution level include (1) the lowest bid premium; (2) the national weighted average premium (the average of the premiums bid for all plans, weighted by each plan’s number of enrollees); (3) the median-priced premium (an amount so that no more than 50 percent of beneficiaries would pay above the amount contributed by the government); and (4) an amount sufficient to ensure that at least one plan is available to enroll beneficiaries at a zero premium.

In illustrating the effects of these different ways of setting the government contribution, certain assumptions are made. One is that beneficiaries would not pay a separate monthly Part B premium for their Medicare coverage, as they do now. Instead, their total share of the premium would be paid directly to the plan. Also, to keep things simple, it is assumed that the government would provide no subsidy to beneficiaries to purchase
plans costing in excess of the level at which the contribution is set. Finally, the beneficiary would realize the savings from picking a plan costing below the government contribution level but would not receive a rebate in the event that the beneficiary share dropped below a zero-cost premium.¹⁹

In the illustration (see table 4), the government’s contribution is set to equal 88 percent of the cost of the lowest-bid premium plan, the national weighted average premium plan, or the median premium (which is traditional Medicare in the illustration but might not be in the future). ²⁰ The method of setting the contribution level to the lowest-bid premium would create strong financial incentives for beneficiaries to elect plans with premiums at the lower end of the bidding spectrum. It would also guarantee at least one plan costing the beneficiary no more than 12 percent of the premium amount. However, it could raise out-of-pocket costs for many beneficiaries. In this illustration, beneficiaries who elected the highest-priced plan would pay 22 percent of the total cost of the plan. A beneficiary electing traditional Medicare would pay 18 percent of its cost.

Basing the government contribution on the national weighted average premium would result in somewhat different dynamics. In this case, a beneficiary selecting the lowest-cost plan would pay only 7 percent of the premium; a beneficiary electing the highest-cost option would pay about 17 percent of its cost. Traditional Medicare would cost about $746, or about 13 percent of its cost.

Yet still different effects would result from setting the government’s contribution at the level of the median-priced plan. In this instance, a beneficiary would pay $284 for the lowest-cost plan, or 5 percent of the premium. Traditional Medicare, the plan with the most beneficiaries, could be purchased for $684, or 12 percent of the total premium.

Another possibility would be to set the government’s contribution at the cost of traditional Medicare, regardless of whether it remained the median-priced plan. The effect of this option would be to preserve the existing balance of government and beneficiary responsibilities for paying for the traditional program. Conceivably, some plans would be able to bid below this amount and would therefore offer an attractive alternative to traditional Medicare. On the other hand, this option would preserve traditional Medicare as a viable option for beneficiaries living in areas in which the choice of lower-cost private plans did not exist (see the discussion of “Vulnerable Populations” below). It could, however, result in reduced
### TABLE 4. Setting the Government Contribution: An Illustration of Alternative Options

<table>
<thead>
<tr>
<th>Plan</th>
<th>Premium Bid ($)</th>
<th>Percentage of Beneficiaries</th>
<th>In dollars</th>
<th>As percentage of premium</th>
<th>In dollars</th>
<th>As percentage of premium</th>
<th>In dollars</th>
<th>As percentage of premium</th>
</tr>
</thead>
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<tr>
<td>Plan A</td>
<td>$5,300</td>
<td>15%</td>
<td>$636</td>
<td>12%</td>
<td>$346</td>
<td>7%</td>
<td>$284</td>
<td>5%</td>
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<tr>
<td>Plan B</td>
<td>5,500</td>
<td>8</td>
<td>836</td>
<td>15</td>
<td>546</td>
<td>10</td>
<td>484</td>
<td>9</td>
</tr>
<tr>
<td>Traditional Medicare</td>
<td>5,700</td>
<td>75</td>
<td>1,036</td>
<td>18</td>
<td>746</td>
<td>13</td>
<td>684</td>
<td>12</td>
</tr>
<tr>
<td>Plan C</td>
<td>6,000</td>
<td>2</td>
<td>1,336</td>
<td>22</td>
<td>1,046</td>
<td>17</td>
<td>984</td>
<td>16</td>
</tr>
</tbody>
</table>

**Source:** Fuchs, Beth. 1999. Health Policy Alternatives, Inc. Washington, D.C.

**Note:** The premium amounts are illustrative and assume that no government subsidy is provided above the government contribution level.
savings to the government because the government would continue to support 88 percent of the cost of traditional Medicare regardless of how expensive it became.

This simplified illustration shows the wide swings in beneficiary and government liability resulting from the different ways of setting the government’s contribution level. Regardless of the option selected for setting the level of the government’s contribution, the amount of contribution would rise each year as a function of the bid amounts. The level of support would thus be driven by the market. The beneficiary would remain in the same relative position with respect to his or her share of plan premium costs. This is very different from what would happen in the alternative approach, which is described next.

**Fixed or Budgeted Contribution Approach**

Under this approach, the government’s initial contribution would be set at some predetermined level based on the amount of money available to be spent on the program. It could be set to equal the current level of Medicare expenditures, or at a higher or lower level depending on policy goals. Over time, the level of contribution would be linked to some explicit measure of price inflation. Options include the consumer price index for medical care, the growth in the economy (that is, the gross domestic product), or some other measure designed to hold the government’s financial commitment to a predetermined level (for example, a set percentage of federal outlays).

The choice of inflation adjuster would be critical because it would affect the balance of the government’s and beneficiary’s financial risk. The more restrictive the adjuster, the greater the savings to the government. If health care costs continued to rise faster than reflected by the inflation adjustment, beneficiaries would bear an increasing share of the costs of their health insurance.

**Determining the Beneficiary Contribution**

A basic assumption of the premium support approach is that it can hold down the growth in health care costs because it encourages beneficiaries to be price conscious in their choice of health plans. It thus follows that a key design feature in a premium support system is the nature of the incentives for beneficiaries to choose low-cost plans.
One possibility would be a rule requiring beneficiaries to pay any premium amount above the government’s contribution. Such a rule would create strong financial incentives for beneficiaries to avoid high-cost plans. (One issue is whether low-cost plans would be available, as will be discussed under the section on capacity.) It is possible, however, to design a system in which the government would provide a full or partial subsidization of premiums above the government contribution. That might be desirable to ensure, for example, that traditional Medicare remained affordable for low-income beneficiaries. Such an approach, however, would reduce any possible program savings and would affect the plan choices made by beneficiaries.21

What would happen under a premium support approach in the event that a plan premium were below the amount contributed by the government? One option would be to reserve the resulting savings for the Medicare program, an approach that could maximize the budgetary savings associated with a premium support system and help to shore up Medicare’s long-term finances. However, because it would eliminate any financial incentive for beneficiaries to choose coverage options with premiums below the level of the program’s contribution, that approach would also limit the number of beneficiaries pursuing the course. Another option would be to pay beneficiaries a cash rebate equal to the amount of the savings. Although that design would create strong incentives for beneficiaries to select the plan with the lowest possible premium, it could raise concerns that some beneficiaries, particularly those with limited incomes, might select a plan because it increased their disposable income rather than because it met their health care needs. Finally, plans could be permitted to use such savings to provide actuarially equivalent extra benefits (as is the case under Medicare+Choice). While such arrangements would provide strong incentives for beneficiaries to select low-cost plans, the incentives would be improved health benefits coverage, not higher disposable income. Providing coverage for out-of-pocket costs could have an adverse effect on utilization, however, and the option would deny the program savings from increased beneficiary sensitivity to cost.

**Accounting for Geographic Factors**

The geographic definition of market areas affects several dimensions of health plan operations, including whether a plan has the infrastructure
(e.g., participating physicians and hospitals) to serve the area, whether the area crosses regulatory jurisdictions, and how the plan designs and markets its products. But the question of geography has particular relevance to the manner in which plan premiums are established and paid.

This is one of the more challenging design issues for a premium support system. It first requires understanding why a health plan’s expenditures for the same benefits package might vary based on where that plan is located, or, in other words, why geography matters. The question then becomes how geography should be treated in the calculation of the government and beneficiary shares of the premium. If premiums are bid by plans locally, then a problem arises as to how traditional Medicare—the national fee-for-service plan—is handled. If premiums are bid nationally, then the question is how to adjust private plan premiums for local price variations.

**Why Does Geography Matter?**

Health plan premiums reflect the price of health care services and the quantity of health care consumed (as well as other drivers of costs, such as profit and administration). Geographic variations in health care prices reflect differences in local wage rates, prices for such basic “inputs” as supplies and office space, and the supply of physicians, hospitals, and other providers. Some of the factors may be influenced both by measurable differences in cost and by local market forces (e.g., how many plans are competing for the available provider pool). Geographic variations in the quantity or utilization of health care services result from varying demographic and health status characteristics of local populations, local provider practice patterns, and even the preferences of consumers (PPRC 1996). For both price and quantity factors, some of the variations (e.g., rent, physician supply, and the health status of the local population) may be out of a health plan’s control. Other variations, such as prices paid for hospital services or medical practice variations, are controllable, at least in theory, over the long run.

At the retail level, the variations in plan costs are typically passed on to purchasers in the form of premiums that vary widely depending on the market in which the purchaser is located. A health plan operating in rural Utah (where prices and utilization are relatively low) can charge less for the same level of coverage than in Salt Lake City and substantially less
than the same level of coverage sold in New York City. If all insurers competed within the same market areas, those differences would raise fewer issues. When insurers compete in different market areas, however, those who can best spread their costs in large insurance pools have an advantage in pricing their plans over insurers who operate only in high-cost areas. That can be seen in FEHBP, where large national plans, such as Blue Cross Blue Shield, are able to undercut the premiums of locally based plans in high-cost areas. Of course, the opposite is also true. The Blue Cross Blue Shield national plan is at a disadvantage when competing against locally based plans in low-cost areas (Merlis 1999).

If a Medicare premium support system was designed like FEHBP, where the government contribution is not adjusted for geography, then beneficiaries would be placed at risk for geographic differences in price and utilization. Beneficiaries enrolling in New York City would pay more for a locally marketed plan of average efficiency than beneficiaries living in Utah. Beneficiaries in traditional Medicare—the national fee-for-service plan—would pay the same premium regardless of where they lived. In low-cost areas, traditional Medicare would therefore be a more expensive choice than a locally based plan. Conversely, it would be a less costly choice than a locally based plan in a high-cost area.

Another possibility is to design the premium support system so that the government and not the beneficiary is held at risk for geographic differences in price and quantity. To a degree, this is currently done under the Medicare+Choice program. Geographic adjustments are made to the capitation amounts paid by Medicare to the health plans based, in part, on local spending amounts. Beneficiaries in a low-cost area, such as Minnesota, pay a premium for Medicare+Choice plans. In contrast, beneficiaries in a high-cost area, such as Miami, do not pay a premium for the same level of coverage. Moreover, because of the interplay between the plan’s adjusted community rate and the government’s capitation payment, plans in Miami can offer more generous benefits. This creates a significant difference in the generosity of benefits offered by Medicare+Choice plans in high and low capitation payment areas. It is possible to imagine, however, applying this same type of approach in a premium support system in which the benefit package was standardized and plans could not offer any extra benefits that were included in the calculation of the government’s contribution.
other words, plans could offer additional benefits only for an additional premium paid entirely by the beneficiary.

**Adjusting the Government’s Contribution for Geography**

The final question then becomes, To what extent should the government’s contribution to health plan premiums vary for geographic differences in health care prices and utilization under a premium support system? Or, in other words, to what extent should it be adjusted and for what set of factors? What differences in payments are justifiable on policy grounds? These questions raise technical issues about how to measure price and quantity variations as well as concerns about the types of incentives that are built into the plan payment policy.

Most analysts would agree that a premium support system should vary payments to health plans to reflect local variations in overhead prices (e.g., rent, supplies). Those are price variations that reflect local economic conditions and are mostly out of the direct control of health plans or the providers with whom they contract. The effects of provider supply on prices also may be considered. However, that consideration presents technical challenges because labor markets and wages fluctuate. Defining the payment area that reflects local economic conditions then becomes the challenge. Metropolitan statistical areas (MSAs) are one possibility, but some would argue in favor of other measures of local market areas (Merlis 1999).

Whether also to vary government contributions to reflect differences in health care utilization presents more difficult issues. Ideally, plans should be given incentives to manage utilization but not to discourage enrollment of individuals who need health care services. Analysts thus tend to talk about structuring capitation payments to hold plans at risk for utilization differences resulting from practice variations and other so-called discretionary utilization but to hold plans harmless for differences beyond their control resulting from the health status differences of individual enrollees. Health status risk adjustment has already been discussed as one of the ways government contributions to health plans should be adjusted under a premium support system. To the extent that a health status risk adjuster is incomplete, it may be appropriate also to apply geographic adjusters to capitation payments. The difficulty lies in adjusting for geographic variations in utilization in a way that does not inadver-
tently compensate plans for discretionary utilization (PPRC 1996). If the payment is adjusted for the smallest of geographic areas, then local practice styles of medicine will be encouraged regardless of whether they are appropriate. If the area is defined more regionally, then health plans may be discouraged from serving local populations known to be at a higher risk for using medical services. The bottom line is that it may be very difficult to correct for utilization differences without creating the wrong incentives.

**Issues in Setting the Government Contribution**

*Establishing Plan Premiums*

The rules governing how health plans calculate the premiums they charge for coverage under a Medicare premium support system would also have an important effect on the nature and degree of competition. At least three different ways of resolving this issue are possible:

- **Allow the market to establish premiums.** The determination of premiums could be completely up to individual health plans, relying on competition for enrollment to ensure that the premiums are not excessive. The fact that beneficiaries would incur increased out-of-pocket costs for higher-than-average health plans would presumably provide an independent “check” on premium levels.

- **Impose constraints on the market.** Under this approach, program officials would be allowed to negotiate with individual plans regarding their premiums, an approach taken by the Federal Employees Health Benefits Program. In addition to reviewing premium submissions for actuarial soundness, program officials apply an additional test, such as a rate-of-increase limit or a comparison with the plan’s premiums for other large purchasers. It may be more difficult for a program as large as Medicare to pursue that strategy, particularly if program officials have no authority to exclude plans that are unwilling to meet their demands from the Medicare market.

- **Regulate premiums.** Finally, the program could continue its current approach to determining plan premiums. Under the adjusted community rate (ACR) methodology, each Medicare+Choice organization is required to calculate its Medicare premiums using detailed rules designed to adapt to the Medicare market that plan’s method of calcu-
lating premiums for its private-sector customers. The approach is
designed to provide an external check on premium levels, although its
effectiveness has been questioned by many.

**Capacity and Availability of Lower-Cost Plans**

Another design issue arises as a result of the fact that the lowest-cost health
plans in a competitive bidding environment are likely to be the plans that
have limits on their capacity for enrollment. Empirical studies of the rela-
tive health care cost “savings” of different types of health plans have found
that those most able to reduce costs below fee-for-service arrangements
are plans using restricted networks of health care providers, especially
staff and group model health maintenance organizations. Such plans can
enroll only as many beneficiaries as they have providers to serve them.
Accordingly, what would happen if too many beneficiaries want to enroll
in such plans because they offer the lowest-price options? Such plans
would presumably be especially attractive to low-income beneficiaries.
While first-come, first-enrolled rules could be established, the situation
might still arise that beneficiaries seeking the lowest-cost plans could be
closed out. Their range of alternative options might be adequate, or not,
which would cause potential problems of access and cost. (This issue is
discussed in more detail later under “Vulnerable Populations.”)

**Affordability of Traditional Medicare**

As noted, it is assumed that Medicare would be treated the same as the pri-
ivate-plan options in setting the government’s contribution. Its premium
would in effect be experience rated, based on the expected average per-
beneficiary cost. Beneficiaries who selected it would pay the difference
between its premium and the program’s contribution amount. Depending
on the level at which the initial contribution amount was set, how much it
was allowed to increase over time, and how rapidly spending in tradi-
tional Medicare increased, that could raise beneficiary premiums for the
coverage option immediately or over time.

To prevent traditional Medicare from becoming prohibitively expen-
sive, the government’s contribution amount could be set at a fairly gener-
ous level. That could be achieved by setting the government contribution
at the cost of traditional Medicare or providing an additional level of sup-
port for beneficiaries who elect traditional Medicare. The drawback of the
approach is that it would erode any budgetary savings from a premium support approach. Another possibility would be to make changes in traditional Medicare to enable it to limit spending increases. That option assumes the types of cost-containment measures envisioned in the Medicare modernization approach described earlier.

**The Importance of Risk Adjustment**

One of the most important decisions for a premium support system is how the government contribution should be adjusted to reflect the risk associated with a particular beneficiary or group of beneficiaries. While there are strong policy reasons for adopting a risk-adjustment mechanism—most important, to fund the care needed by enrollees with above-average health care needs—current adjusters are based on relatively crude proxies for risk, such as age and gender. Although the use of health status indicators may produce more accurate risk-adjustment mechanisms, such indicators could, in some instances, encourage treatment strategies, such as hospitalizations, that are not medically appropriate but trigger increased payment. That issue currently is being debated for the Medicare+Choice program. Also, for a health status risk adjuster to be effective, it has to be reliable and inexpensive to administer. If plans lack confidence in its predictive accuracy, risk-selection behaviors are likely to persist (PPRC 1997). Risk adjustment is, in fact, critical to the premium support approach; to some, implementation of the approach is contingent upon the existence of an adequate risk-adjustment tool.

**Benefit Packages**

What benefits should the government’s premium contribution pay for? Should it subsidize benefits that may be offered by private plans but are not included in the benefit package offered by traditional Medicare? How should supplemental benefits be treated? How these questions are answered will affect the government’s program costs as well as the dynamics of risk selection and plan selection by beneficiaries. For example, if plans are able to submit bids for a standard core set of benefits but can also include additional benefits in the bid price, then the government’s contribution will be subsidizing that plan’s entire benefit package. That may raise equity concerns if the package is more generous than that offered by traditional Medicare. If the plan is able to offer supplemental benefits and

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While there are strong policy reasons for adopting a risk-adjustment mechanism—most important, to fund the care needed by enrollees with above-average health care needs—current adjusters are based on relatively crude proxies for risk, such as age and gender.
to include some or all of the costs of those benefits in the bid premium, the same concerns may arise. Moreover, such supplemental coverage could influence risk selection.

**Additional Issues and Concerns**

An additional set of issues not discussed here relates to the ways plans, in bidding their premiums, respond to a given set of rules for setting the government’s contribution level. One possibility, for example, is shadow pricing. Another set of issues relates to the ways beneficiaries would respond to the available plan choices. For example, to what extent would factors other than price, such as the quality of the plan or inertia, play a role in their plan selections?

The evolving research on premium support for Medicare suggests how some of the issues discussed in this section may play out under different assumptions. Moon, for example, estimated the effects on beneficiaries and taxpayers of a premium support option requiring either a 15 percent or 20 percent contribution from beneficiaries as a condition of receiving Medicare. In Moon’s simulation, those contributions would replace the existing Part B premium, and the government contribution would be linked to the median-priced health plan. Given various assumptions about the growth in the economy, trends in health care costs, and beneficiary and plan responses, Moon concluded that savings to taxpayers could result from that approach but at the expense of significantly increased costs to many beneficiaries, especially for beneficiaries remaining in traditional Medicare or electing higher-cost private plans. One critical concern would then become whether such higher costs were borne by higher-income beneficiaries or beneficiaries who could not obtain coverage under a lower-cost private plan option (Moon 1999b).

A study by Merlis illustrates the interplay of price quotations (premium bids) and government contribution levels as well as the different effects resulting from different methods of risk-adjusting the government contributions under a premium support system modeled after FEHBP. His general conclusion is that, depending on how the program is structured, enrollees who remain in traditional Medicare could pay more than they do now but enrollees who shift to less-costly plans would pay less. However, he adds, there is no empirical basis for concluding that the Medicare program would save money over the long run if it adopted a premium support
system in which the government’s premium level was linked to the average-cost plan. This is because there is no way of knowing whether competing private health plans would operate more efficiently than traditional Medicare or if a representative cross section of the Medicare population would elect to enroll in such plans. Merlis (1999, p. vii) concludes that “the only way to assure savings under a competitive structure would be for the government to arbitrarily limit growth in its contributions—as FEHBP has not done—leaving beneficiaries at risk of steadily eroding benefits or rising costs.”

**ANALYZING THE OPTIONS: QUALITY OF CARE**

The debate over Medicare reform largely focuses on ways to extend the life of the Medicare program. But another important issue is what happens to the quality of the services provided to Medicare beneficiaries under different reform options? Regardless of whether policymakers are considering incremental program changes or moving to a fully implemented premium support system, decisions about quality ultimately rest on judgments about whether the market is sufficient to ensure adequate quality of care.

**Current Law Requirements**

The fee-for-service Medicare program generally has functioned as a financier of health care services rather than a provider of such services. In addition to provider licensure and accreditation processes, peer review organizations (PROs) review the appropriateness of hospital care. Quality issues have factored into payment policy for heart transplants, which are paid for by Medicare only when they are performed in centers that provide a minimum number of procedures each year.

Quality of care provided to Medicare beneficiaries parallels the overall health care system, with questions raised about underuse, overuse, and misuse of health care services. In fact, Medicare’s extensive claims data system has provided the basis for much of the research regarding geographic variation in the use of services (Dartmouth Medical School 1998). 23

Private health plans participating in Medicare+Choice are required to submit data reflecting their performance on health outcome measures, such as the Health Plan Employer Data and Information Set (HEDIS) measures developed by the National Committee for Quality Assurance (NCQA).
They also are required to report results of member satisfaction surveys using a Medicare version of the Consumer Assessments of Health Plans Study (CAHPS) instrument. As part of its implementation of the BBA requirements, HCFA has promulgated a Quality Improvement System for Managed Care (QISMC). Under this system, plans have to conduct internal quality assurance projects that lead to demonstrable improvements in health outcomes. Eventually, plans may be required to meet minimum performance thresholds on HEDIS or other outcome measures. Medicare+Choice plans must also submit to HCFA various types of information on quality and performance that is incorporated in the comparative plan information that will be distributed to Medicare beneficiaries prior to the start of the annual coordinated election period (i.e., open season).

It should be noted that BBA also required information on satisfaction and outcomes to be reported for traditional Medicare. HCFA is in the process of developing the instruments to do this. Such information is designed to assist beneficiaries in making a choice between traditional Medicare and Medicare+Choice plans.

Reform Options

A “modernized” Medicare program could take more steps to address quality of care. For example, use of a preferred provider or centers of excellence approach would provide an opportunity for Medicare to contract with providers that meet certain quality standards. Other measures that have been recommended include adopting continuous quality improvement standards for providers, giving beneficiaries quality data to help them select providers, improving the dissemination of “best practices” to health care providers, and adopting quality-based standards for approving new technologies (Sheils et al. 1999). It is, however, difficult to apply the same quality measures in a system that is primarily fee-for-service and not managed or coordinated care.

If, under a premium support system, the goal is for plans to compete for beneficiaries on the basis of price and quality of care, then it is important that beneficiaries receive information to allow them to compare the quality of care of the different plans offered in their area.
al protections are warranted, plans can be required to be accredited by an external entity such as NCQA.

Others, however, argue that comparative information is not sufficient for assuring adequate quality of care. One reason is that many purchasers tend to select health plans on the basis more of price than of quality information (Institute of Medicine 1999). Another is that comparative plan information is not yet at the point that it provides an accurate measure of plan quality or that it is sufficiently well understood by consumers to guide choices. Accordingly, this perspective argues for the establishment of quality assurance standards that plans would have to meet.

The clash in perspectives is especially evident in the debate over Medicare reform. Wide disagreement exists over the types of information that are most useful to beneficiaries in making informed plan choices and about the way in which such information can best be communicated. Many market enthusiasts argue that beneficiaries are capable of making informed choices about health plans in the same way that they make choices about cars or household appliances. A Consumer Reports type of format is suggestive of a model medium for facilitating choice. In contrast, skeptics contend that Medicare beneficiaries may require many different forms of information to help them with plan choices and, more critically, that for a significant portion of the beneficiary population, an informed choice about plan choices may not be possible (Institute of Medicine 1999). Under a premium support system, the debate over structuring choices for Medicare beneficiaries could take on greater urgency as a larger portion of beneficiaries moved into the private market.

Given the context, lawmakers may find it instructive to contrast the quality and performance standards currently used for the Federal Employees Health Benefits Program or Medicare+Choice in the design of a premium support system. The requirements for Medicare+Choice are described above. Under FEHBP, plans must demonstrate to the Office of Personnel Management that they have some form of internal quality assurance program. However, no detailed standards are in place for evaluating the plans and OPM does not routinely monitor plans. Instead OPM relies on state licensure and on the ability of enrollees to “vote with their feet,” changing plans at open season if a plan’s performance is unsatisfactory (Merlis 1999; Fuchs and Merck 1998). Plans are required to survey a sample of FEHBP members on access and satisfaction issues. These results are
included in OPM’s annual health plan guide that is distributed to employ-
eses and annuitants. (This survey will be replaced by CAHPS.) OPM is still
studying the possible use of HEDIS or other performance measures.

In contemplating the application of QISMC under the Medicare+
Choice program to a premium support system, the issue comes down to
whether such a regulatory approach is necessary. Free-market proponents
may argue that the premium support system includes sufficient incentives
to encourage plans to compete on the basis of quality as well as price and
that QISMC and similar efforts are both unnecessary and harmful to the
development of private plan options for Medicare beneficiaries.26 Others
believe that regulation is necessary to ensure that health plans provide
high-quality care and that adequate and comparable information is avail-
able to beneficiaries to help them select wisely from the plans available to
them.

ANALYZING THE OPTIONS: TREATMENT OF
VULNERABLE POPULATIONS AND AREAS OF
LIMITED COMPETITION

In this section, concerns are addressed about how the incremental and pre-
mium support approaches treat vulnerable populations served by Medicare
and those populations that live in areas of the country not yet served by
multiple health plans. Such areas of limited competition also tend to be
considered medically underserved areas.27

Vulnerable Populations

Consideration of changes in Medicare raises unique issues for low-income
Medicare beneficiaries, including those who are eligible for Medicaid as
well as for Medicare benefits (“dual eligibles”). Changes in premiums and
cost-sharing would pose particular burdens on poor and near-poor benefi-
ciaries. In addition, dual eligibles are relatively high users of health care
services, and the increased use of managed care plans has made coordina-
tion between the two programs more complex.28

Income plays a central role in the ways in which people relate to the
health care system. Studies have shown that even when insurance status is
held constant, income explains significant differences in use of services,
health care outcomes, and even satisfaction. Surveys in which beneficiar-
ies are asked about their health status find that those with low incomes are more likely to be in fair or poor health, to have certain chronic health problems like diabetes, and to have one or more functional impairments (Schoen et al. 1998). Any evaluation of Medicare reform alternatives therefore may need to be sensitive to the ways they would affect lower-income beneficiaries.

Nearly 30 percent of aged Medicare beneficiaries reported incomes of less than $10,000 in 1995; over 70 percent of this population reported income of $25,000 or less (HCFA 1998c; Moon 1999a). Only a small percentage of Medicare beneficiaries fall under most definitions of high income. These data are important to recall when considering beneficiary liabilities under various proposals.

Federal assistance to poor and near-poor Medicare beneficiaries is currently provided through Medicaid. About 6.5 million Medicare beneficiaries (or 16.5 percent of the 39.3 million) are eligible for Medicaid (HCFA 1998). Simplifying somewhat, that population—known as dual eligibles—qualifies for Medicaid largely by qualifying for Supplemental Security Income (SSI), the cash assistance program for aged, blind, or disabled people with low incomes, or qualifying as medically needy (Moon et al. 1998).

Of the 6.5 million beneficiaries qualifying for Medicaid, about one-half are entitled to full Medicaid benefits. The remaining half of the 6.5 million people are entitled to much more limited Medicaid coverage. About 45 percent are entitled to Medicaid coverage of Medicare’s premiums, deductibles, and cost-sharing requirements under the Qualified Medicare Beneficiary (QMB) program. Such individuals have incomes below 100 percent of the federal poverty level ($8,000 in 1998). About 4.6 percent are entitled to Medicaid coverage of Medicare’s Part B premium under the Specified Low-Income Medicare Beneficiary (SLMB) program. These beneficiaries have incomes between 100 percent and 120 percent of poverty. Under the Balanced Budget Act of 1997, a third category of Qualifying Individuals (QI) was created to assist beneficiaries up to 175 percent of the poverty level on a sliding scale (HCFA 1998). Federal funding to the states for this program is capped and is scheduled to sunset in 2002.
Reform Options

A suggested incremental approach for strengthening the existing low-income protections is to make them part of the Medicare program, rather than to work through state Medicaid programs. Greater participation may be achieved if beneficiaries can enroll directly through Medicare rather than a state welfare office.

If beneficiary contributions are increased as part of a solution to Medicare’s funding problems, more beneficiaries may need financial support. Providing greater support could be accomplished by improving assistance to near-poor beneficiaries currently receiving limited subsidies and perhaps also by raising the income thresholds for assistance to include more low-income beneficiaries.

Lack of coordination between Medicare and Medicaid for dually eligible beneficiaries is an additional area of concern. Because the two programs operate independently, it is possible for a beneficiary to receive both Medicare and Medicaid benefits through two separate managed care plans. The issue will need to be addressed even if the Medicare program remains unchanged (PPRC 1997).

Under a premium support system, special issues arise with respect to vulnerable populations. They include the level of government support for plan premiums and the extent to which low-income beneficiaries have a real choice of plan options. If one accepts the levels of Medicare support (or an approximation of such costs) that exist under current law for the three categories of low-income beneficiaries described, an additional amount of government contribution would be needed, as follows:31

- For SLMBs, a subsidy sufficient to ensure that they paid nothing for a plan providing at least the benefits that are provided today under traditional Medicare.

- For QMBs, a subsidy sufficient to ensure that they paid nothing for a plan that covered any cost-sharing costs (such as direct payments of any required plan copayments).

- For full Medicaid beneficiaries, a subsidy sufficient to ensure that they paid nothing for a plan covering the full range of what is currently provided under both Medicare and Medicaid, or some form of wraparound
coverage of Medicaid-covered services not available through the health plan.

The mechanics for delivering the subsidies present an additional set of challenges. As Merlis suggests, one could borrow from the existing state arrangements for enrolling dual eligibles in managed care programs.32

The level of government subsidy is critical because it not only determines whether low-income beneficiaries would be able to enroll in a private-plan option but also whether they have any choice of plans. Would there be any plans available in an area offering no-cost or low-cost premiums?

Under theories of managed competition, the lowest-cost plans are likely to be those with tightly managed provider networks (e.g., staff and group model HMOs) because they are best able to control the use of services. Such plans are not available in all areas of the country (see below). In addition, they can accept only as many enrollees as can be served by their participating providers. Proposals deal with the problem in different ways. For example, the government could pay an additional subsidy to help low-income individuals buy coverage where the lowest-cost plans are not available. (That was the approach taken by the Clinton Health Security Act.) Access problems could still persist, however. One or more plans might be available on paper but lack providers that are accessible to low-income beneficiaries. That problem could be addressed through aggressive government regulation, but such regulation may be inconsistent with the philosophy behind premium support approaches (Merlis 1999).

Another concern is that low-income beneficiaries could end up being segregated in lower-quality health plans. A market approach assumes that plans would compete on the basis of cost and quality. Poor-quality plans would lose enrollment to higher-quality plans as enrollees “voted with their feet.” But if low-income beneficiaries were locked into a limited set of health plans, the plans might “have no incentive to pursue quality goals beyond the absolute minimum required by regulators (Merlis 1999, p. 71).” There are ways to reduce such “income tiering,” such as requiring each plan to accept some number of low-income beneficiaries at the subsidized price; or to increase the government premium subsidies to allow low-income beneficiaries a wider range of plan choices. Each alternative, however, has drawbacks (Merlis 1999).
Another concern is that low-income beneficiaries could end up being segregated in lower-quality health plans.

Areas of Limited Competition

Another factor that affects access to health care is geography. The problems faced by rural and inner-city Americans in obtaining adequate access to physician and hospital services have been an enduring problem for our health system as a whole. Studies of Medicare beneficiaries have indicated that, in general, few problems of access exist. However, difficulties in obtaining needed medical care in a timely manner are faced by some groups of beneficiaries. They include, for example, the oldest old, those in poor health, and beneficiaries living in rural and poverty areas (MedPAC 1998a; Schoen et al. 1998).

Basic to the theory of competition is the idea that costs will be controlled because health plans will have to compete for enrollment (and thus income) by offering attractive prices and quality services. For competition to exist, however, there has to be more than one plan in the area marketing coverage to Medicare beneficiaries. Too few competitors could lead to anticompetitive tendencies. On the other hand, if there are too many plans, each individual plan might exert less market power over individual providers, reducing their leverage in bargaining for better prices. That could lead to higher prices for plan enrollees. Also, too many plans could lead to consumer confusion and imprudent purchasing in which buying decisions might be guided more by name recognition than by information on price and quality. The critical number of plans needed to support competition is, in fact, contested by the experts.

Data on current Medicare managed care indicate that for many areas of the country, managed care options are limited or not yet available. In March 1998, 62 percent of beneficiaries lived in areas of the country in which they had access to multiple-risk HMOs (the predecessor to Medicare+Choice plans). However, for 28 percent of beneficiaries, no risk HMO was available, and for another 10 percent of beneficiaries, only one risk HMO was available (MedPAC 1998b, 1999). In other words, for close to two-thirds of all beneficiaries, the foundation for a competitive private market was in place. But for the remaining beneficiary population, such a foundation had not yet been established. Moreover, rural areas were especially slow in attracting HMOs and other managed care plans. For January 1999, Medicare+Choice plans were available to 86 percent of beneficiaries living in metropolitan areas but only 24 percent of beneficiaries
living in nonmetropolitan areas (MedPAC 1999). Another indicator of market penetration is that as of March 1998, only 3.1 percent of Medicare beneficiaries living in rural areas adjacent to urban areas were enrolled in risk HMOs; less than 1 percent of those living in remote rural areas (those not adjacent to urban areas) were so enrolled (MedPAC 1998).

The number of areas without managed care plans for Medicare beneficiaries has been declining. For example, in June 1996, only 54 percent of beneficiaries had two or more risk plans available to them (MedPAC 1998b). As noted above, by 1998, 62 percent had a choice of Medicare+Choice plans. But even in areas with managed care plans, it is not clear that such plans are accessible to all enrollees. They may have few providers conveniently located for residents living in the inner-city or accustomed to providing services to inner-city areas. Some believe that such areas could remain unattractive to managed care plans because the residents are on average poorer, or the medical resources (such as primary care physicians) needed to support the delivery system are inadequate. More generally, it may be years before effective competition arrives for some portion of the beneficiaries living in areas that are not yet served by any Medicare+Choice plans (Fuchs 1994).

A more optimistic view is that managed care organizations will become widely available to the Medicare population as they move to build their market shares by attracting older enrollees. Moreover, some believe that provider-sponsored organizations may form in rural areas. Also, once health plans are paid on the basis of competitively bid premiums and not on an administered price, insurers may find it more profitable to move into areas that are unattractive today due to relatively low Medicare+Choice capitation payments. In this light, a diminishing portion of the country might lack the competitive market required to make a premium support system viable.

**Traditional Medicare and Vulnerable Populations**

It is often suggested that traditional Medicare would provide a safety net for vulnerable populations, including those in underserved areas, because it would always remain available. Indeed, if private plans continue to avoid underserved areas, traditional Medicare is likely to remain attractive to their beneficiaries because no other plan is available. For the disabled and end stage renal disease (ESRD) beneficiaries, traditional Medicare would...
may continue to be attractive because of its freedom of choice of physicians and other providers.

That option remains viable, however, only to the extent that traditional Medicare remains affordable. Critical to that goal would be a risk-adjustment system that adequately compensated traditional Medicare for its expected sicker pool of beneficiaries and that shielded beneficiaries from premium variations due to adverse selection. Otherwise, traditional Medicare could experience what is known as a “death spiral.” As per-beneficiary costs increased, so too would its premium. That would encourage the most healthy to exit, leaving an increasingly deteriorating pool of risks and driving up its premium. Only the sickest and least-mobile beneficiaries would remain. Without additional subsidies, traditional Medicare as a competing health plan would no longer be viable.

**Additional Issues**

The private insurance market is constantly changing. The insurance-underwriting cycle can produce large swings in a managed care company’s financial reserves that, in turn, can have dramatic effects on its premiums. New managed care plans may emerge and enter markets; old plans may experience deteriorating risk pools and depart markets. Mergers and acquisitions can affect who the players are and where they want to market their policies. Those and other dynamics may mean that areas that are served today by a plan contracting with Medicare may not be there tomorrow and vice versa. In areas lacking a multiple choice of plans, such market changes could produce dramatic swings in premium costs for beneficiaries.

Imagine, for example, that in the first two years of the premium support system, beneficiaries have elected the locally based health plan because it was much less expensive than traditional Medicare. In the third year, the plan pulls out of the area and the only remaining choice is traditional Medicare. Beneficiaries would then face a significant increase in premiums—and probably without much notice. In addition, if the change in plans meant a change in benefits and providers, disruptions might occur in their health care. The experiences with plan withdrawals for the first two contract years under Medicare+Choice provide illustrations of the types of problems that can arise.
A Framework for Comparing Incremental and Premium Support Approaches

ANALYZING THE OPTIONS: MEDICARE’S OTHER MISSIONS

Today’s Medicare program helps to support various public policy goals, such as the training of interns and residents, and the provision of hospital care for low-income and rural populations. These are missions that reach beyond Medicare’s pure insurance function and help finance goods that benefit the public at large (Fishman and Bentley 1997).35

Most visible of the missions is Medicare’s payments for its share of costs for graduate medical education (GME). That support is channeled through direct medical education (DME) payments (for costs related to teaching interns and residents, such as the salaries of supervising physicians) and indirect medical education (IME) payments for the higher costs of inpatient hospital care in teaching hospitals. Medicare also helps to support hospitals serving low-income patients through its disproportionate share hospital (DSH) payments. In addition, the Medicare program provides a number of subsidies to providers in rural and other underserved areas through adjustments in reimbursement (e.g., Sole Community Providers) and direct cost reimbursement (e.g., Rural Health Clinics). Such subsidies are designed to attract providers and ensure the financial viability of rural hospitals and other health care facilities.

The role of Medicare in supporting GME and DSH payments has come under especially close examination as policymakers look for ways to extend the life of Medicare’s Part A trust fund (Commission undated). The most fundamental issue is whether the Medicare program or the federal government more generally should play a role in financing those goods. That debate is likely to continue for some time. Assuming that policymakers want to continue providing federal support, how would such activities fare under a premium support system?

One option would be to continue financing those activities through traditional Medicare.36 There are, however, two major risks in following that approach: One is that it would impede the ability of traditional Medicare to compete with private plans.37 The other risk, of course, is that as private plan enrollment increased, Medicare’s overall level of support for the activities could decline.

Similarly, the amount of traditional Medicare’s support for health programs serving rural and underserved areas would diminish as beneficiaries
shifted to private plan options. Those that are financed through adjustments to provider payments might erode with the declining number of services reimbursed under traditional Medicare. Moreover, substantial pressure might arise to curb the expenditures so that traditional Medicare could offer more competitive premiums.

For those reasons, many would argue in favor of changing the way in which the activities are financed. One option would be to “carve out” those activities from the calculation of traditional Medicare’s premium. Medicare could pay qualified providers directly for such costs as GME. To an extent, this is the way GME is being handled under the Medicare+Choice program.38 Another option would be to remove those activities from Medicare altogether and finance their costs through some kind of pooled financing mechanism drawing, for example, from general revenues and assessments on private health plans.

**ANALYZING THE OPTIONS: TRANSITION ISSUES**

A significant but little-discussed challenge in reforming Medicare is moving from current law to the system contemplated by the reform proposal. The more comprehensive the change, the less likely full and immediate implementation can occur. This section introduces some of the concerns that may arise.

**Modernizing Medicare**

By design, an incremental approach to Medicare reform raises fewer transition issues than the premium support option. An incremental approach could require transitional planning if it restricts beneficiary access to providers or makes other changes in the way beneficiaries go about receiving their Medicare benefits. Such changes would need to be put in place carefully to minimize confusion and disruption. Recent experience regarding confusion over the Medicare+Choice options highlights the need for ongoing improvements in beneficiary education and communication if even relatively modest changes are to be implemented smoothly. As recommended by NASI, some possible changes in how Medicare purchases services need to be tested in small areas and refined before they are implemented throughout the program.

For the long term, however, an incremental approach could lead to significant disruption if it simply serves to delay an inevitable major pro-
gram restructuring that requires planning, major administrative change, and beneficiary education to succeed. An incremental approach could also be disruptive and destabilizing if changes are made frequently. Moreover, delay in identifying any additional revenue that will be required to maintain Medicare in the future can ultimately affect the distribution of who pays and how much.

**Premium Support**

The provisions that established the Medicare+Choice program in the Balanced Budget Act provided for a variety of transitions from the Medicare risk-contract program. For example, the change from month-to-month enrollment to an annual enrollment is phased in over several years. The national, coordinated election period, similar to the FEHBP’s annual open season, was scheduled for the first time in 1999, although it will not have the consequences of a longer lock-in period for beneficiaries until 2002. For the first wave of Medicare+Choice elections in November 1998, a more limited national information campaign was specified. These and many similar provisions were designed to cushion the effects of change for beneficiaries, health plans, and even the government.

Presumably, a restructuring of Medicare to a premium support system would require even greater sensitivity to transition issues than the change from the risk-contract program to Medicare+Choice. The task of notifying 39 million Medicare beneficiaries of changes to their benefits and new plan options alone presents a formidable challenge. The contrast with FEHBP on this point is telling. The workplace serves as a critical channel of information for FEHBP plans to convey information on plan changes and to address questions and concerns about the health plans, although OPM is responsible for all communications with annuitants. Medicare, on the other hand, generally lacks the employer or other entity as a reliable intermediary. It has to disseminate information directly to each beneficiary.

A significant transition issue relates to changes in beneficiary financial liability. Assuming that a premium support system would apply to all Medicare coverage options, many beneficiaries could experience increased out-of-pocket spending. That is especially likely if the government contribution is designed to produce significant budgetary savings. If that were the case, some consideration might be given to allowing an
appropriate transition period so that beneficiaries could adjust to their new responsibilities.

If policymakers decide that a transition is necessary, they can choose from a number of options. At one end of the spectrum, the new system could remain voluntary and rely on positive incentives, such as additional benefits, to persuade beneficiaries to enroll in private plans accepting capitation payments. (It could be argued that this is already current law given the incentives for beneficiaries to elect Medicare+Choice plans.) At the other end, the new system could take effect immediately and be mandatory for all beneficiaries. Options falling between the extremes include provisions to “grandfather” current beneficiaries in various ways and require only newly eligible beneficiaries to participate under the premium support system (PPRC 1997). Another approach is to limit the size of the financial impact from year to year, modifying the formulas by which premiums are calculated.

Once transitional rules were established, consideration would need to be given to a timetable. How quickly can a change to a premium system be made? Would problems be created by implementing changes in phases as opposed to all at once? Would mechanisms be established to monitor the effects of the many changes? For example, would there be sufficient and timely impact data to gauge the effects of the premium support system on stakeholders, including beneficiaries, providers, and health plans? And would there be a mechanism other than legislation for slowing or freezing the transition if events so warranted?

FINANCING AND FISCAL VIABILITY

The changes in benefits and cost-containment strategies described here as an incremental approach to Medicare reform may not be sufficient to overcome the demographic trends and finance the Medicare program through the retirement of the baby boom and on into the twenty-first century. Natural limits to provider payment discounts and cost-shifting to beneficiaries, along with interest in improving Medicare benefits, make discussion of other financing options unavoidable. While further increasing beneficiary contributions and income-relating beneficiary premiums have been debated, little discussion has occurred to date of adding new revenue from nonbeneficiary sources to help sustain the Medicare program. Options that
could be considered include increasing the payroll tax or dedicating other revenue sources to help finance the Medicare program (Davis and Rowland 1986).

Who finances how much of the Medicare program is an issue as well as the level of financing. Even without any changes to the Medicare program, shifts in the source of Medicare financing are expected in coming years. A growing share of total program costs will be borne by beneficiaries and general revenues and less through the Medicare payroll tax, which funds the Hospital Insurance Trust Fund. This shift will result because Part B expenditures—financed by a combination of beneficiary premiums and general revenue—are expected to grow faster than inpatient hospital payments and other services financed through the Part A payroll tax. Moreover, policy changes in the BBA to increase beneficiary contributions and to shift some home health coverage from Part A to Part B are factors as well.

By 2007, Medicare actuary projections indicate that almost half of all income to the trust funds will come from a combination of beneficiary premiums (12.6 percent) and general revenue (36.7 percent), 47.1 percent will come from Part A payroll taxes, and the remaining 3.6 percent will come from interest and other sources. In contrast, in 1997, about 54.1 percent of income to the combined Medicare trust funds came from payroll taxes and less than 40 percent from beneficiary premiums (9.7 percent) and general revenue transfers (28.4 percent), with the remaining 7.8 percent coming from interest on the trust funds and other sources.

Several proposals in the administration’s fiscal year 2000 budget could serve as financial support for an incremental approach to Medicare reform. Crediting part of the expected budget surplus to Medicare would, if the surpluses materialize, buy time for consideration of the premium support approach or other long-term restructuring proposals. Other features of the budget also would address the program’s financial status. They include the traditional cost-containment proposals to restrain growth in hospital payments and adjust prices for other items and services. The administration’s announced plan to seek payment from the tobacco industry to compensate Medicare for the costs associated with smoking-related illness is another potential source of additional revenue.

In addition to improving the benefits that beneficiaries receive, the main goal of Medicare reform is the ongoing financial viability of the pro-
gram in the face of the baby boom retirement. It is difficult, however, to know whether any particular approach to reform will succeed in sustaining the program, and at what cost. Both the Medicare actuaries and the Congressional Budget Office have pointed out the perils of such long-term forecasting (CBO 1999). Even without program changes, when demographic trends are relatively well known, small differences in economic factors and unknowable changes in medical technology and costs make predictions problematic. Savings from incremental reforms are somewhat easier to predict, as there is historical experience from which to extrapolate. But the more sweeping changes included in the premium support model require assumptions about the behavior of health plans, beneficiaries, and health care providers in a new environment. Each policymaker must make choices based on the set of assumptions that seems the most plausible.

Estimates are therefore unlikely to resolve the policy debate about premium support. The preliminary CBO analysis of the Breaux proposal states that a premium support approach could be designed to reduce program expenditures. The Medicare actuaries were more quantitative, estimating that the premium support aspect of the Breaux proposal would generate about $75 billion in savings over the fiscal year 2000–2009 period. That represented only one-fifth of the total savings estimated, however. The income-related premium and extension of the BBA update factor reductions were the other two large savings components in the actuaries’ estimate of the Breaux plan (Commission 1999a). Thus, the actuaries’ estimate supports the claims of both advocates and critics of premium support. On one hand, the estimate assigns considerable savings to premium support, encouraging the direction of that approach. On the other hand, the savings are smaller than those achievable through more familiar, incremental cost-containment tools, a result that suggests that other approaches could be tried first.

NOTES

1. This will result because Part B expenditures—financed by a combination of beneficiary premiums and general revenue—are expected to grow faster than inpatient hospital payments and other services financed through the Part A payroll tax.
2. An example is the attempt by the Health Care Financing Administration (HCFA) to implement a demonstration program in Maryland and then in Colorado to test the effectiveness of a competitive bidding approach to establishing payments for risk-contract plans. Political pressures prevented the demonstrations from occurring. A new competitive bidding demonstration, authorized by the Medicare portion of the Balanced Budget Act of 1997 (BBA), is now being developed but is facing significant opposition in the selected sites.

3. Even under this approach, however, beneficiaries could be at risk for increased out-of-pocket costs if benefits do not keep pace with changes in health care delivery.

4. For the most common type of plan (coordinated care plans), Medicare+Choice requires qualified plans to provide at least the same benefits as are provided under traditional Medicare. Plans are then required to provide additional benefits, to the extent that their adjusted community rate is less than the Medicare payment rate. Flexibility in beneficiary cost-sharing and premium amounts (above and beyond the Part B premium) are permitted but on average cannot exceed the actuarial value of the cost-sharing applicable under traditional Medicare. Different rules apply for the medical savings account and private fee-for-service Medicare+Choice plans.

5. Medicare beneficiaries enrolled in Part B pay a monthly premium of $45.90 in 1999. This amount is generally deducted from the beneficiary’s monthly social security check. The premium rate is derived annually based on 25 percent of the projected costs of the program in the coming year.

6. Benefits are provided for a “spell of illness” benefit period.

7. About two-thirds of Medicare managed care plans offered drug coverage as a basic benefit, covering about 95 percent of enrolled beneficiaries.

8. In fact, the statute governing FEHBP does not require that health plans cover specific services, but instead says that plans may provide specified services such as hospital, surgical, and ambulatory care. The only
requirement is that all plans “must include benefits for costs associated with care in a general hospital and for other services of a catastrophic nature.” 5 USC 8904(a). The Office of Personnel Management (OPM) periodically requires the coverage of certain benefits, but generally the plans develop their benefit packages. Plans are allowed to propose annual changes in benefits, which are subject to approval by OPM. Unless OPM has required the benefit change, any modification in benefits is expected to be budget neutral.

9. This has been the experience of the Blue Cross Blue Shield High Option plan under FEHBP. About 92,000 people were enrolled in this plan in 1998, 83 percent of whom were annuitants, according to OPM data. For many of those enrollees, the standard option would be far more cost effective.

10. Concerns have been raised that if county-by-county variations are not permitted, plans may drop counties with low payment rates where they previously were able to offer fewer benefits or charge higher premiums. For the first two years of Medicare+Choice, HCFA has responded to these concerns by, in effect, waiving the statutory requirement.

11. Network plans are HMOs or other arrangements in which services are covered only if they are furnished by physicians and other providers who have contracted to participate in the plan’s network.

12. For a complete discussion of these issues, see Caplan and Gross (1999).

13. Currently, Medicare beneficiaries are not penalized for late enrollment if they do not elect Part B at the time they turn age 65 because they are covered under an employer plan. If Parts A and B are merged, a policy decision would have to be made about whether automatic enrollment would apply to the entire benefit package, with Medicare acting as secondary payer to employer coverage. Alternatively, working beneficiaries could be permitted to delay enrollment in the entire benefit package.
14. One possibility is that the president would appoint the board. Some would suggest Congress, but that would present separation-of-power problems under the Constitution.

15. See, for example, the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-91).

16. A temporary waiver of state law is available to provider-sponsored organizations.

17. Federal law requires that FEHBP may contract with one government-wide service benefit plan (Blue Cross Blue Shield), one government-wide indemnity plan (formerly Aetna, but there is no such plan currently), and any number of employee organization plans. The law also states that FEHBP shall contract with any federally qualified HMO and may contract with other “competitive medical plans,” which are basically HMOs. This means then that the only plans that FEHBP has to contract with are federally qualified HMOs. Plans have to be licensed under state law and must, in addition, meet standards issued by OPM. While OPM has a lot of discretion to limit new plans participating in FEHBP, it seems to have less in terminating them. Plans can be terminated only for failure to meet “reasonable minimum standards” or if enrollment drops below 300 in two successive years.

18. Another possibility would be to continue the approach used today to establish Medicare’s contribution to the Medicare+Choice plans, that is, the Medicare+Choice capitation payment or what used to be the adjusted average per capita cost (AAPCC). It is sometimes referred to as administered pricing because the payments are based on a statutory formula, but it is really just a way to set the government contribution with certain constraints. Beneficiaries cannot pay less than the Part B premium. The effect of the restraints is that the competition is over benefits and not premium dollars.

19. Actual proposals tend to be more complicated. See the appendix to this volume for a discussion of the Breaux-Thomas approach.

20. The 88 percent is based on the government’s current share of the costs of the traditional plan.
21. The Commission considered that option as well as others that would have dampened incentives to choose the lowest-cost plan.

22. Fee-for-service payers of health care tend to vary payments to providers to reflect local variations in wage and input prices, as is illustrated by the provider payment methodologies used in traditional Medicare. Prospective payments to hospitals, for example, are adjusted by a measure of wage and input differences called the area wage index. Adjustments to the Medicare physician fee schedule also account for input price differences. They typically do not vary payments based on utilization factors.

23. See, for example, Dartmouth Medical School (1998).

24. A recent study suggests that in making choices among health plans, Medicare beneficiaries are most interested in whether they will save money and whether their physician is in the plan.

25. The difficulties in using this information may result from age, sickness and disability, illiteracy, and other factors. Nearly 30 percent of the Medicare population has no more than eight years of education; 40 percent are over age 75; 5 percent live in a long-term care facility; and 5 percent of Medicare beneficiaries have Alzheimer’s disease. Nearly two-thirds of all elderly have two or more chronic conditions. About 12 percent of the population over age 65 speak primarily a language other than English. See Institute of Medicine (1999).

26. The managed care industry has argued that QISMC takes a “one size fits all” approach that makes it difficult or impossible for all but HMOs to comply. For example, plans are required to achieve levels of improvement relating to health care outcomes (and other matters). Large PPOs may not be able to meet the requirement because they have little control over their participating providers. The industry also says that HCFA should adopt parallel requirements for traditional Medicare, another effort to level the competition. HCFA is, in fact, working on it.

27. Although there are statutory definitions of medically underserved areas, the term is used more generally here to mean areas in which ben-
eficiaries may face difficulties in obtaining medical care because of the scarcity of health care providers and facilities in their areas.

28. Not included in this discussion are Medicare beneficiaries with disabilities and chronic illnesses, groups for whom managed care may raise a special set of concerns. See MedPAC (1998, ch. 9).

29. In 1998, the median income of a Medicare beneficiary 65 and older was $13,300.

30. The medically needy in this context are the aged and disabled who are ineligible for SSI but whose expenditures on health care are so high that their new incomes place them near or below the poverty level (about $8,000 for a single person in 1998).

31. The following draws extensively on Merlis (1999).

32. On problems with coordinating managed care services for dual eligibles, see PPRC (1997, ch. 19).

33. Because of plan withdrawals, this percentage changed to 29 percent for January 1999.

34. However, with the pullout of a number of plans at the end of 1998, the number of beneficiaries without a plan in their area actually rose to 29 percent (MedPAC 1999).

35. On the rationale for Medicare support of these goods, see Fishman and Bentley (1997).

36. As of this writing, the Commission recommendation is to continue current law for indirect medical education and DSH but to remove funding for direct graduate medical education from the Part A trust fund.

37. If traditional Medicare’s premium were to be based on its expected expenditures, the cost of GME and DSH would be built into the premium. Private health plans, on the other hand, are less likely to support GME and DSH and would therefore not have to pass the same level of costs through the premiums charged to beneficiaries. That means that
private plans would have a competitive advantage over traditional Medicare.

38. Starting in 1999, an increasing portion of Medicare+Choice capitation payments attributable to GME (both DME and IME) are being “carved out” of those rates and paid directly to teaching hospitals caring for Medicare+Choice plan enrollees. Previously, hospitals were being paid according to the same formulas used to pay for Medicare patients enrolled in the traditional Medicare program. The policy was established in the BBA to deal with the concern that Medicare was paying capitation amounts to Medicare managed care plans that included underlying fee-for-service expenditures for GME even if such plans were not passing such amounts along to teaching hospitals.

39. The additional year may not prove to be enough time to iron out the information and plan contracting problems that have arisen.

40. Options for transitioning to a defined contribution approach are outlined by the Physician Payment Review Commission in its 1997 annual report. Similar options could be applied to a premium support system. See PPRC (1997, ch. 9).

41. The experience with Medicare+Choice is instructive. For some aspects of the program, the legislation gives the government little or no latitude in design or implementation. “Midcourse corrections” therefore will require statutory changes, which may not come in time to avoid problems for both plans and beneficiaries. Other provisions give the government flexibility to respond to changing conditions without requiring an act of Congress.

42. By 2008, Medicare actuary projections indicate that payroll taxes will generate less than half of all income to the combined trust funds (49 percent), compared with 55 percent in 1998. Some 47 percent of income will come from general revenue, beneficiary premiums, and taxes on Social Security benefits, compared with 39 percent in 1998.

43. This estimate was for the variation of the proposal that allowed plan benefits to vary by 110 percent.
PART II

Perspectives on Premium Support
Proposals to restructure Medicare as a premium support program are often accompanied by plans to shift program administration from the Health Care Financing Administration (HCFA) to some new entity, such as a Medicare board, and to give that entity greater flexibility or discretion in managing the program than HCFA now has.

The essential difference between a Medicare premium support system and the current Medicare+Choice program would be in the way that government and beneficiary contributions to the Medicare fee-for-service program and competing private plans are calculated. This change aside, there is nothing intrinsic in the premium support concept that would dictate any change in the way the program is currently administered. HCFA already performs all the basic functions required, such as certifying and contracting with plans, reviewing plan benefit and premium proposals, informing beneficiaries of their options, and processing enrollments.

Some people question how well HCFA performs some of its functions. There are claims, for example, that HCFA has an internal culture oriented toward regulation and that it is ill-suited to manage a competition-based program. More objectively, HCFA has suffered recently from limited resources, broadened responsibilities, and high staff turnover (U.S. General Accounting Office [GAO] 1998). These issues aside, the apparent impetus for proposing a shift of responsibilities to a new entity is a perception that some form of freestanding board or commission might be less bureaucratic and could more closely resemble the plan sponsor—or alliance or cooperative—contemplated in the various managed competition plans advanced in the early 1990s.

A secondary issue is that there might be some conflict if the same entity managed the entire competitive structure and also operated the fee-for-service plan. This is an argument for separating the two activities, par-
particularly if some degree of negotiation between the Medicare program and individual health plans (including the fee-for-service plan) is contemplated. But it is not immediately clear which of the two functions should remain with HCFA. That is, a board or other entity could administer the Medicare program and HCFA could operate the fee-for-service plan; or HCFA could administer the program and the fee-for-service plan could be operated elsewhere in the Department of Health and Human Services (DHHS), or even contracted out to a private administrator (as is the practice with large employers and their self-insured plans).

Even if the goal is a less bureaucratic and more flexible administration, the goal does not necessarily determine how an administering entity should be structured. The Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits Program (FEHBP), is an executive branch agency just as HCFA is, subject to the usual rules governing such agencies, such as civil service law and due process requirements. However, the authorizing legislation for FEHBP is much less specific and detailed than the Medicare statute; for example, it does not establish a basic benefit package. Accordingly, OPM has greater flexibility or discretion in operating the program. The question of the degree of flexibility to be granted to the program administrator may therefore be considered separately from the exact structure of the administering entity.

**HOW MUCH AUTHORITY SHOULD THE ADMINISTRATOR HAVE?**

Table 1 lists functions to be carried out by the administrator of a premium support program. The list focuses on core purchasing functions—activities that will determine the kinds of health plan choices beneficiaries are going to have and what those choices are going to cost. It therefore omits activities that occur after the menu of choices has been established—such as educating beneficiaries about those choices, processing enrollments, and collecting premiums. Those functions are obviously important but also rather mechanical; the issue of administrative discretion seems less pertinent. (One other key activity, resolution of grievances or appeals, is considered later in this paper.)
TABLE 1. Core Functions of the Administrator of a Premium Support System

<table>
<thead>
<tr>
<th>Least discretion</th>
<th>Most discretion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Plan selection</strong></td>
<td>Administers statutory standards for participation (e.g., contracts with any plan licensed by state insurance commissioner, or any plan with private accreditation)</td>
</tr>
<tr>
<td>OPM</td>
<td>HCFA</td>
</tr>
<tr>
<td><strong>Service areas</strong></td>
<td>Approves plan’s proposed area, relying on evidence of capacity or other standards.</td>
</tr>
<tr>
<td>HCFA</td>
<td>OPM(?)</td>
</tr>
<tr>
<td><strong>Benefits</strong></td>
<td>Specified in statute, no variation permitted. Or package(s) developed by third party, such as NAIC.</td>
</tr>
<tr>
<td>HCFA</td>
<td>OPM</td>
</tr>
<tr>
<td><strong>Premiums</strong></td>
<td>Accepts plan bids</td>
</tr>
<tr>
<td>HCFA</td>
<td>OPM</td>
</tr>
<tr>
<td><strong>Government contribution</strong></td>
<td>Computes using statutory formula</td>
</tr>
<tr>
<td>OPM</td>
<td>HCFA</td>
</tr>
</tbody>
</table>

Source: Author’s analysis.
The table presents, for each function, a range of levels of discretion that might be granted to the administrator, from the least discretion on the left hand to the most discretion on the right. There are at least two other ways of characterizing this range. One is in greater to lesser legislative direction. At the left extreme, key program rules are established by Congress; at the right, the administrator makes the rules within a broad statutory mandate. Alternatively, one might think in terms of different ways of characterizing the administrator: as a neutral referee at the left extreme, or as an “active purchaser” at the right. The table attempts to indicate approximately where HCFA and OPM now stand on the spectrum for each function. The characterizations are open to debate; what is notable is that OPM is not consistently given greater flexibility than HCFA.

**Plan Selection**

OPM has no firm criteria for FEHBP participation; in general, it appears that any state-licensed HMO may enter the program (with some scrutiny of solvency and reserves), but no new fee-for-service plan can enter. HCFA establishes standards, not only financial but also in areas such as access and quality. It has discretion in setting those standards. Once they are established, however, any plan that meets them has to be granted a contract. There is no limit to the potential number of competing health plans.

Alternatively, the administrator might be given the authority to limit the number of available plans through some form of selective contracting. Some state Medicaid programs, as well as some private purchasers or purchasing groups, use a request for proposals (RFP) process in contracting for managed care plans. Health plan proposals are scored on price, quality and/or other criteria; not all bidders may be offered contracts, even if they meet minimum participation standards. While this method presumably involves some formal standards for evaluating proposals, scoring is likely to be subjective.

Selective contracting and entry limitations for plans might accelerate the trend toward concentration in the managed care industry. At least some managed competition theorists might regard this as desirable. Alain Enthoven and others have argued that health plans cannot operate with maximum efficiency if health care providers contract with multiple plans. Instead they envision a system in which each provider would ideally be
affiliated with a single highly integrated plan, with minimal overlap in plans’ provider panels (Enthoven 1993). On the other hand, it is not clear whether concentration so far has actually promoted greater integration of financing and delivery, or whether it has merely enhanced the negotiating power of certain carriers.

**Service Areas**

An often overlooked area of health plan purchasing is the definition of individual plans’ service areas. Medicare has allowed contractors to pick the specific counties in which they choose to accept Medicare enrollees; a plan may actually add and drop counties each year, depending on where it finds the Medicare payment rates most favorable. This arrangement has led not only to instability but also to a concentration of plans in a few areas; 71 percent of counties, with 29 percent of beneficiaries, have no Medicare+Choice plan available in 1999 (Medicare Payment Advisory Commission 1999). OPM may have somewhat more authority than HCFA; it might at least require that a plan’s FEHBP service area coincide with the area used for its commercial contracts.

A premium support system for Medicare might raise equity issues, as well as have a limited potential for savings, if there are not at least some competing options available in all areas. The administrator could be given the authority to define service areas and require plans wishing to serve any part of the area to develop a service capacity in the entire area. However, that approach might promote further concentration by favoring plans with the resources to expand their networks.

**Benefits**

Under Medicare+Choice, every plan must provide the Medicare benefits defined in statute. However, plans are free to design their own supplemental benefits, subject to a showing that the benefits meet a minimum-value test. Under FEHBP, there are no basic benefit standards. OPM is free to negotiate benefits with each plan; generally its aim in recent years has been to limit variation among plans.

Most competition advocates favor greater standardization of benefits, to make it easier for beneficiaries to compare prices and benefits, as well as to prevent plans from manipulating benefit design to attract healthier enrollees. However, such standardization does not require or preclude dis-
While OPM is often spoken of as negotiating premiums for FEHBP plans, it actually uses a method similar to HCFA’s in reviewing premiums for most HMOs; their FEHBP rates are supposed to be derived from their commercial prices.

**Premiums**

An administrator could simply accept whatever premium a plan chose to establish for its defined benefits, or it could negotiate premiums with plans. HCFA requires plans to show that their proposed Medicare premiums (including the preestablished government payment as well as any supplemental premium to be charged to beneficiaries) are equal to the estimated amount they would charge commercial members for equivalent benefits, after adjusting for differences in population characteristics. While OPM is often spoken of as negotiating premiums for FEHBP plans, it actually uses a method similar to HCFA’s in reviewing premiums for most HMOs; their FEHBP rates are supposed to be derived from their commercial prices. For the fee-for-service plans and a few “experience-rated” HMOs, premiums are based on each plan’s projected cost for providing its defined benefits to FEHBP enrollees. To the extent that there is “negotiation,” it is largely confined to haggling over technical assumptions.

Some other purchasers negotiate more actively. One example is the California Public Employees’ Retirement System (CalPERS), which contracts with health plans to serve state and some local government employees. CalPERS has on occasion limited the rate increases it would accept from given health plans. Its ability to do so, of course, is directly related to the fact that it represents the single largest employer group in the state; a threat to withhold a contract is a compelling negotiating tool (offset to some extent by participants’ desire for stability of health plans). However, there have been at least some claims of cost-shifting—that health plans might have offered favorable rates to CalPERS and made up their losses by charging more to other, weaker purchasers (Findlay 1993).

What would it mean to give comparable authority to the administrator of a Medicare premium support program? On one hand, Medicare beneficiaries would make up an enormous share of the market, suggesting that
the administrator might act almost as a monopsony (as Medicare does now in the fee-for-service program). On the other hand, not all health plans may find Medicare beneficiaries desirable.

Whatever the desirability of allowing premium-negotiating authority, the issue does illustrate one important point about administrative flexibility. It is not necessarily the case that less discretion—the left-hand side in table 1—amounts to a regulatory or micromanagement approach, while greater flexibility equates to a market or competitive approach. On several of the functions discussed here, giving greater authority to the administrator may actually be the inverse of relying on competition alone.

**Government Contribution**

HCFA actually has somewhat greater discretion than the OPM in determining the portion of premiums to be paid by the government. OPM uses a fixed formula based on weighted average plan premiums. HCFA also follows a fixed formula but makes its own decisions about technical aspects of the computation, such as determining geographic and health risk-adjustment factors. It is difficult to see how an administrator might be given still greater authority in this area without simply delegating to it the overall budgetary authority for the program.

As it is, the administrator’s authority even to resolve technical questions may depend on just how much money is redistributed by decisions of this kind. The experience with Medicare’s prospective payment system (PPS) for inpatient hospital services is instructive. HCFA was originally given considerable discretion to establish annual rate changes, geographic adjustments, and payments for special cases, such as hospitals serving a disproportionate share of low-income beneficiaries. Because these technical decisions had a large impact on individual hospitals or whole regions, Congress gradually intervened, specifying in statute more and more details of the system.

Similar developments might be expected under a premium support system. Whatever the initial grant of authority to the administrator—in setting contributions or any of the other functions described in this paper—the grant will always be revocable, depending on the administrator’s ability to satisfy multiple constituencies. Nor is it clear that congressional intervention is inherently undesirable. The sorts of distributional questions that led to “micromanagement” of PPS were inherently political—pitting
urban against rural areas, teaching hospitals against other hospitals, and so on. It may be that Congress is better equipped to arrive at a balance on questions of this kind than any administrative entity.

WHAT KIND OF ENTITY SHOULD THE ADMINISTRATOR BE?

As the discussion so far has suggested, the degree of flexibility or discretion granted to the administrator may in some senses have little to do with how the administrator is structured. In effect, whether a Medicare premium support system were to be operated by HCFA, another agency within DHHS or another department, or a board or some other type of entity, Congress would determine just how specific the statutory instructions to that entity were and could change those instructions over time. This overall limit aside, what kinds of administrative structures are available? And is there some reason to prefer one kind of administrative structure to another?

Federal entities include executive departments and agencies that operate under the direction of the president; various types of boards and administrations that have varying degrees of freedom from presidential authority; government corporations, such as the Government National Mortgage Association or the National Railroad Passenger Corporation (Amtrak); and “government-sponsored” entities, such as the Corporation for Public Broadcasting, that receive federal funds but operate as private enterprises. There is no firm typology of government organizations. The name of an entity tells nothing about the extent of its independence; there are “corporations,” for example, that operate entirely within executive departments.

It may be helpful to think of organizations as varying on at least three key dimensions:

- The extent to which the organization is subject to various general laws affecting government operations, such as civil service rules, procurement requirements, and freedom of information or sunshine laws. (One other type of bureaucratic requirement—due process rules—is considered separately in the next section.)
The extent to which the organization is answerable to the president (Garcia 1999). Is the governing body appointed by the president? Are its terms coextensive with the president’s, and may members be removed by the president without cause? What kinds of decisions (regulations, budget requests, congressional testimony) are subject to approval by the Office of Management and Budget?

The extent to which the organization is subject to the annual appropriations process.

Applicability of Procedural Requirements

One reason that some people have argued for a board or other alternative to HCFA is a perception that the rules usually governing executive branch agencies may be barriers to efficient or responsive operations. For example, exemption from civil service recruitment rules and pay schedules might allow an entity to move rapidly to hire the most qualified staff.

Of course, this argument could be made for almost any federal activity. Bureaucratic requirements may often impede efficiency but are adopted in pursuit of some other policy goal—civil service rules to reduce political patronage, procurement requirements to prevent graft, and so on. Is there a particular reason to exempt the Medicare administrator? Perhaps there is, with respect to at least some requirements. One might, for example, argue that expertise in health care contracting is so highly valued that appropriate personnel cannot be hired at usual federal pay rates.

Even if there were a reason to exempt the administrator from some requirements, the exemption would have little to do with the structure or name of the entity. A GAO study of government “corporations” found that, given a list of 15 laws imposing management requirements on federal agencies, different corporations reported that they were subject to as few as 2 and as many as 14 of the laws (GAO 1995). The preference for something called a “board” may reflect a view that it sounds more private and efficient, but a board will operate however Congress says it will.

Presidential Oversight

Cabinet departments and other agencies wholly answerable to the President are necessarily subject to political interference. To the extent that their authorizing statutes give them administrative discretion, they
exercise that discretion in pursuit of the President’s policy agenda. Some other entities, while still technically in the executive branch, are shielded from presidential oversight in various ways. The Federal Reserve Board is an obvious example; while the board may choose to coordinate economic policy with that of the Department of the Treasury, it may just as easily pursue policies entirely different from those of the administration.

The usual argument for removing a function from the political process is that it is technical and is better managed by experts. However, if an entity is freed from politics, if it does not answer to the president, just whom does it answer to? This is not just a question of accountability, but rather of the entity’s own sense of its constituency and hence of its mission. It may be clear, for example, that the Federal Thrift Savings Board works for the federal employees whose retirement funds it is managing; its job is to maximize returns safely. But it is much less clear who the constituency of a Medicare board might be—current beneficiaries, working taxpayers, insurers, providers?

If there is a conflict between, say, spending constraints and access or quality of care, how is the board to balance those objectives? Some form of balance might be promoted by specifying the membership—so many representatives from different industries or professions, so many beneficiaries, and so on. That may be a sensible way of structuring advisory committees, so that all points of view may be heard from. But to use the same kind of balancing for an entity that must actually make decisions would be to specify in advance the degree of weight to be given to each constituency’s concerns.4

**Funding Authority**

Although any federal entity or even any federally sponsored private program is ultimately governed by legislation, the degree to which an entity is routinely answerable to Congress depends in part on the extent to which it is subject to the annual appropriations process. An entity that generates its own revenues can set its own spending priorities and may be subject to less constant oversight in other ways. This could be true of a Medicare administrator if, for example, it were allowed to fund its operations through a percentage assessment on health plan premiums.5
DUE PROCESS

One distinction between any form of governmental organization and a private enterprise is that government is expected to accord certain procedural rights to individuals or entities affected by its decisions. A private firm that offers health benefits to its employees is free to drop one health plan and contract with another without having to explain its decision or allow any appeal. And preemption of state regulation under the Employee Retirement Income Security Act (ERISA) has left enrollees in employer plans with only a limited ability to contest plan benefit or coverage decisions.

HCFA and OPM, on the other hand, have formal appeal mechanisms for both health plans and enrollees. Under Medicare, for example, a health plan that is refused a contract or whose contract is terminated has a right to request reconsideration and then a right to a hearing before an administrative law judge. For beneficiaries, Medicare requires plans to have an internal appeals system for service or payment denials and a separate grievance system for resolving other kinds of complaints. Plans must resolve service appeals within 60 days and must have an expedited procedure for services an enrollee believes are urgent. Enrollees can appeal plan decisions through a HCFA contractor, the Center for Health Dispute Resolution. Further appeal within DHHS is allowed for claims of over $100; judicial review is permitted for claims over $1,000. In a suit against the federal government, the beneficiary may not obtain punitive damages. However, a beneficiary injured by a health plan decision might have a cause of action in a state court, subject to state law. (The ERISA preemption does not apply to state regulation of insurers serving Medicare beneficiaries.)

A full consideration of due process and appeal rights is beyond the scope of this paper. As the debate over bills of rights for private plan enrollees in the 106th Congress has shown, beneficiary appeal mechanisms are a particularly difficult political issue, requiring balancing of patient protection against health plans’ prerogatives to manage care. Even if administration of a Medicare premium support program were delegated to some form of quasi-private board, Medicare would still constitute an entitlement in a way that private health plan benefits do not. Any dilution of the rights currently enjoyed by Medicare+Choice enrollees would be
highly controversial, and it seems likely that external appeal mechanisms would continue to be available.

The rights of health plans may be a different matter. As was suggested earlier, some proponents of a premium support approach contemplate some degree of informal negotiation between the program administrator and health plans. This negotiation probably implies some ability on the part of the administrator to act arbitrarily. If the administrator must justify each position it takes in the course of negotiation (including a decision to leave the table) by reference to some form of regulation or other objective standards, it is not negotiating but enforcing. On the other hand, if there are no objective standards, there would be no basis for an appeal mechanism. The entity hearing an appeal would simply be arbitrarily second-guessing an arbitrary initial decision. Administrative flexibility in selective contracting or other dealings with health plans may therefore entail some relaxation of current due process requirements.

CONCLUSION

The key administrative issues in designing a premium support system—who will administer the program and what degree of flexibility the administrator will have—are to a considerable extent questions about how much should be left to “experts,” as opposed to the political process on one hand and the free market on the other. These questions are largely philosophical ones that cannot be answered simply by reference to existing competitive programs such as FEHBP or CalPERS.

Medicare is much larger than the other programs; its policies affect the operations of nearly every health care provider and the economy of every community. Because adoption of a premium support system might represent a major departure from the current system and could pose real risks for beneficiaries and the health care system as a whole, it may be important that administrators have the ability to respond rapidly to unforeseen developments during the transition. This would argue for maximum flexibility and independence. At the same time, however, precisely because Medicare affects so many stakeholders so deeply, its administration will inevitably continue to involve political judgments and some degree of bureaucracy.
NOTES

1. In theory, a plan must offer free supplemental benefits to the extent that its Medicare profit margin would otherwise exceed its commercial profit margin.

2. There is some degree of negotiation over the extent to which a plan will add to or draw down its reserve funds in a given year, thus increasing or decreasing its premium.

3. For a review of these issues, see Garcia (1999).

4. It may not be entirely cynical to suggest that one of the attractions of a Medicare board for some of its advocates is a hope that the political influence of beneficiaries might somehow be reduced.

5. OPM’s administrative costs for FEHBP are actually funded in this way. However, OPM may spend only what Congress appropriates; any amounts remaining from the premium assessments go into general FEHBP reserves.
A premium support approach to Medicare reform hinges on inducing a level of health plan participation that is sufficient to provide alternatives to beneficiaries nationally. This paper first reviews why health plans would want to participate. It then addresses what plans seek in both payment considerations and the regulatory structure. Finally, it addresses government and consumer concerns. The term “health plans” refers to both traditional insurance and network-based plans such as health maintenance organizations (HMOs), point-of-service plans, and preferred provider organizations (PPOs). It also includes the residual Medicare program, which would be available as an alternative to enrollment in a private health plan.

**REASONS FOR PRIVATE HEALTH PLANS WANTING TO CONTRACT WITH MEDICARE**

The most obvious reason for private health plans wanting to contract with Medicare under premium support is financial, which is no different from the vast majority of entities that contract with the federal government. If the plans can make a profit (or at least break even), participation will be forthcoming; otherwise, it will not. However, plans will differ in what they view as a profit level sufficient to induce participation, and at the margin their decision will be influenced by other factors as well.

A second reason for participating is to enlarge the enrollment base over which administrative costs can be allocated. The importance of this factor will depend on the size and internal cost structure of the health plan. Very large health plans, for example, may not realize significant economies of scale, particularly as participation in Medicare requires the assumption of new administrative functions, and economies may lie prin-
A Medicare contract represents a source of leverage in negotiating reimbursement levels for non-Medicare enrollees and in obtaining cooperation with the health plan’s utilization controls and other aspects of medical management.

A Medicare contract represents a source of leverage in growing the Medicare product, unrelated to the size of the rest of the plan.

For network-based plans such as HMOs and PPOs, a third, and in some cases very important, reason to contract is provider relations. Medicare accounts for 30 percent or more of the revenues of many providers, whether physicians, hospitals, or other. A Medicare contract represents a source of leverage in negotiating reimbursement levels for non-Medicare enrollees and in obtaining cooperation with the health plan’s utilization controls and other aspects of medical management.

Finally, some plans regard serving Medicare as part of their mission, although it may be difficult in practice to distinguish the importance of this objective from that of not wanting to lose Medicare as a source of revenue.

**WHAT HEALTH PLANS SEEK IN ENTERING INTO A CONTRACT WITH MEDICARE**

**Payment Issues**

Health plans are a means of achieving a public policy objective, and their well-being is not an end in itself. However, their decision to participate, and the premiums and benefits they are prepared to offer enrollees, will be affected by the contract terms, including the costs of regulatory compliance and the business uncertainty that they face.

Plans would like to have prices limited by exclusively marketplace competition, not by government price controls or oversight. Currently, for the Medicare+Choice program under which Medicare contracts with HMOs, the HMOs compete on the premiums that they charge enrollees and the benefits that they offer. However, the government also exercises oversight on these premiums and benefits. Depending on one’s perspective, the type of oversight is an important aspect of consumer protection and is necessary for a purchaser as large as Medicare. Alternatively, it can be regarded as ineffectual, expensive administratively, and subject to both gaming by the health plans and arbitrary decisions by government officials because the accounting requirements will always be open to interpretation.

Related to being able to set prices competitively, health plans are generally willing to be judged on performance such as consumer satisfaction,
patient care outcomes, and whether access standards are met, but not whether profits are judged to be excessive by some external standard. From a health plan perspective, profitability should not be a consideration—any more than consumers care about profitability in purchasing, say, a computer or an automobile—short of it being too low as to raise a concern with the plan’s financial viability.

Another issue for health plans is being able to operate in a stable business environment, including there being some level of predictability in payment. Unfortunately, government is limited in its ability to respond to this concern as neither the Clinton administration nor Congress can bind its successors. On the other hand, regulatory policies that are unclear or not well thought out can generate avoidable uncertainty, as can sudden policy shifts.

Finally, private health plans regard payment parity with the residual government-administered Medicare program envisaged under premium support as essential for a viable system. They prefer such an arrangement to having the residual program be advantaged financially, which they believe would result in unfair competition. Although the concept of parity is easy to articulate, achieving it is complicated by technical difficulties in measuring enrollee health risk in the various participating health plans, an issue that is at the heart of the debate on risk adjustors.

**Regulatory Issues**

Health plans seek a sensible regulatory structure, an objective with which no one would quarrel. However, many plans that participate in the Medicare+Choice program feel that major aspects of the regulations and the way they are implemented day-to-day focus on the wrong variables or are administered inconsistently. In this regard, the devil is truly in the details, which are beyond the scope of this paper. Other problems relate to the sheer volume of regulations—some of them vaguely stated or incompletely thought out, making the standards for compliance unclear—that have characterized the implementation of Medicare+Choice.

**Consistency in administration** is a critical issue. For example, in the review of marketing materials, if health plans are not held to consistent standards, or some health plans are able to obtain reviews in a more timely manner than others, then one health plan may be competitively advantaged over the other. The requirements can relate to such matters as the
prominence required for telephone numbers for the hard-of-hearing and the precise wording with which benefits are described. However, consistency is something that can be strived for but can never be fully achieved.

Avoidance of duplicative or contradictory federal and state standards is another desire of health plans. The federal government inevitably will have standards with regard to benefit packages, provider access, quality assurance, member rights in grievances and appeals, and so forth. Most health plans contend that states should be precluded from having conflicting or tougher requirements. Another overlap relates to private-sector standards, such as those promulgated by the National Committee for Quality Assurance (NCQA), the leading accrediting organization for HMOs. Health plans would like the federal government to collaborate with NCQA and other organizations in setting standards and then promulgate requirements that are consistent with the standards as well as avoid duplicating the reviews conducted by the organizations.

Health plans also prefer informed regulators, who understand the operational issues they face. They believe that they are hurt when the government staff who are responsible for writing and implementing regulations and other policy issuances are ill-informed or inexperienced.

Finally, health plans seek flexibility in benefit package design, although many support standardizing the descriptions of the benefits. Their desire is to design benefits that meet the need of the marketplace and enhance their ability to compete with each other. However, that desire may be at variance with the public policy objective of ensuring that beneficiaries can understand and compare the various offerings, which can be highly confusing, even if the wording describing the benefits is standardized.

PUBLIC POLICY CONCERNS

This section summarizes some of the many public policy issues. Premium support is premised on beneficiaries’ having the ability to choose among multiple health plans. Thus, an important question is whether competition in fact occurs and on what basis. Ideally, plans would compete on such factors as price, benefits, quality of service, ease of access to service, and enrollee satisfaction. However, other potential forms of competition are undesirable, such as achieving financial success by enrolling dispropor-
tionate numbers of healthy enrollees or being able to charge higher premiums as a result of artificial product differentiation.

Competition may not be realistic in sparsely populated areas or even in some midsize communities with populations of, say, under 500,000. In those communities, there may be a paucity of providers overall or, more frequently, for some important services such as inpatient care and certain physician specialties, one provider may be dominant. In that situation, the provider often can set the terms of the contract. Competition among health plans is at best muted in the absence of competition among providers, especially if the providers are not restricted in what they charge private plans (as opposed to the residual Medicare plan operated by the federal government, which would have to establish reimbursement levels). In addition, a single health plan could become dominant. To the extent that health plans or providers consolidate, the potential for competition is lessened. Thus, competition might not occur everywhere, a situation that raises the question of what to do where it is absent.

Inherent in private markets is market entry and exit. For some products, a company that ceases to operate is at most a minor inconvenience to consumers, particularly if loyalty is weak and the cost of switching to the product of another seller is minimal. However, a health plan that ceases to participate in Medicare may result in enrollees’ having to choose a new set of doctors, which can be difficult for elderly and disabled persons with severe chronic illness. To be sure, in many communities physicians participate in multiple plans, which lessens the problem. Dramatic increases in premiums or reductions in benefits can also hurt beneficiaries, as is true now for both HMO enrollees and beneficiaries who purchase Medicare supplement (Medigap) policies. Competition requires a dynamic market, and there is no easy way to avoid plans’ making changes, although stability in payment and regulation can help.

The manner in which plans are paid is always a salient public policy issue. Underlying any payment scheme is how to risk adjust, i.e., adjust for health care needs that differ because of variations in health status, demographic factors such as enrollee age, and other variables. Payment levels could be set through an administered pricing scheme, as is now done under Medicare+Choice as well as most Medicare fee-for-service reimbursement such as to hospitals and physicians. Payment levels also could be set through a bidding process. Finally, they could be set through nego-
tiation subject to federal guidelines. Some favor giving the federal government some latitude in negotiating payment rates with health plans, pointing to the success of the California Public Employees’ Retirement System (CalPERS) and individual state Medicaid programs in doing so. However, the scale of Medicare is many times that of these other payers, and allowing the Medicare program to conduct similar negotiations could lead easily to standards being applied inconsistently as well as to heightened uncertainty, both of which are barriers to plan participation.

Another issue, and one that is likely to be contentious, is the drawing of boundaries for payment, benefit levels, and plan participation purposes. Under the Medicare+Choice program, payment levels are county-specific. Health plans determine their service areas, subject to some limitations to prevent obvious redlining of certain communities. However, they are required to have uniform benefits and premiums within a given market area. The definition of what constitutes a market area has proven difficult, and the resulting cross-subsidies depend on whether or not the health plan elects to serve the full market area. One option is that Medicare draw market areas and that health plans be required to serve the full area. Doing so would have some equity advantages in ensuring that everyone within the area has access to the same offerings. It would also reduce beneficiary confusion in knowing what was available. However, it would prevent many smaller plans that are not prepared to cover the full market area from contracting with Medicare, and the boundaries are inevitably somewhat judgmental or arbitrary.

Last are a myriad of consumer protection issues. With regard to marketing, rules need to be established that promote beneficiaries’ being informed, recognizing that beneficiaries differ in their literacy levels, eyesight, knowledge of English, and comprehension. Rules need to be established to ensure that the information provided is understandable and that prevent health plans, including the residual governmentally administered plan, from disproportionately attracting healthy enrollees.

Access and quality are also of paramount concern. Do beneficiaries have access to the full range of services that they need? What should be the minimal quality standards? Can plans be induced to compete based on quality, and if so, how?
CONCLUSION

Inherent in a premium support program is competition among health plans. However, competition of the kind that benefits consumers is unlikely to occur independent of a regulatory structure. One challenge is making that structure productive. One consideration is that a highly complex regulatory environment particularly disadvantages smaller plans, which may lack the resources to come into compliance, especially if the requirements are unclear or change frequently.

Some aspects of plan performance require tight regulation. Examples include marketing and grievances and appeals. On the other hand, inherent in a competitive model is the acceptance of health plans’ competing with each other on the basis of premiums, among other variables. Thus, significant regulation of premiums is contrary to the philosophical underpinnings of the premium support approach.

Debate will continue regarding many aspects of regulation. To what extent should access and quality be regulated? Should benefits be standardized, in whole or in part, to make the choices less confusing, even though standardization lessens the number of choices available to consumers and may reduce innovation in plan design? What should be the role of the government in obtaining information on health plans and ensuring its dissemination, including information on enrollee satisfaction and quality of care? The tension between a market-driven strategy and competition that is tightly constrained by regulation is likely to be a permanent part of the landscape under a premium support approach to Medicare reform.
Market forces can be channeled to serve the Medicare program well, but they can also do harm. Despite the risks, I argue that it is wiser to learn to recognize, nurture, and manage the kinds of competition that Medicare needs rather than to oppose the introduction of market forces across the board. We are not ready, either politically or technically, to hand Medicare beneficiaries fixed-dollar vouchers and let them wend their way into an unfettered market for health insurance coverage. At the same time, learning how to manage competition better within the Medicare program will serve only to expand the range of policy choices as we balance social commitments to the elderly and to the prosperity of future working generations.

Despite my general support for introducing managed competition into the Medicare program, the subtitle was chosen to convey caution, as it is possible to design a market-oriented Medicare program that could serve many beneficiaries badly. The subtitle also serves as an admonition to those who praise the market in general but retreat when confronted with local realities that competition produces losers as well as winners. I will return to that phenomenon later, for it is relevant to our current policy predicament.

The discussion about restructuring Medicare, inside and outside the recent Bipartisan Commission deliberations, can be interpreted as questions about whether and how to channel market forces to serve both Medicare beneficiaries and taxpayers. Sadly, the answers are not as simple as setting the market absolutely free, for unregulated health insurance markets have not performed well for the elderly in the past and there is no reason to expect laissez faire to work better now. All insurance markets need a few structural safeguards to work well for anyone other than the continuously healthy.
But with those safeguards, to be outlined in some detail, modern insurance markets can work well. Although we must be careful, harnessing the tremendous power of a well-structured private market to serve the Medicare program may be the best way to achieve politically acceptable tradeoffs among our long-run goals of quality, choice, and an affordable public price tag.

This paper is organized into three sections. First is a description of motivations for relying upon a competitive health plan market to serve more Medicare beneficiaries. That is followed by a discussion of each of six major design choices that must be made to define and shape that health plan market. Included are the rationales behind each of the choices made for the proposed competitive bidding demonstrations outlined in the Balanced Budget Act of 1997 (BBA). The conclusion is a discussion of long-run issues that must be addressed satisfactorily if Medicare and the health plan market are to remain friends over time.

**MOTIVATION**

Medicare began with the goal of providing retirees with the same type of access to health care that most of the working population had. In 1965, the private-sector norm was indemnity insurance and fee-for-service medicine. Today that norm is some form of managed care. Managed care has many appealing features that some Medicare beneficiaries may find particularly attractive. Coordinated care has the potential to improve outcomes, longevity, and well-being for seniors and their families. And managed competition—the structuring of health plan market rules to facilitate explicit price and quality competition—has proven to be effective in a number of settings across the United States.

At the same time, choice in any health insurance context engenders a danger that price and quality competition will be swamped by risk-selection behaviors by insurers. Thus, the choice process may need to be “managed.” In addition, the health and financial risks of incompletely informed choices are great, and the challenges of enabling the Medicare population to make truly informed choices among health plans may be greater still. Those concerns argue for structuring the Medicare managed care market carefully, but not for abolishing that market by administrative fiat.
Given that the ratio of workers to retirees will fall dramatically next century, we must either reduce the rate of growth of Medicare costs per beneficiary or learn to accept much higher tax rates than we have today. But despite all the recent policy focus on costs, quality matters too, maybe more, to most Americans. Therefore the cost-quality *tradeoff* is most important for health policy. Discovering the contours of the tradeoff have proven difficult under fee-for-service medicine with no institutionalized accountability requirements for providers and unorganized health plans or loose networks. Basically, cost containment in fee-for-service (FFS) medicine has amounted largely to price cuts along with continued hope for the best, because quality was never (and is not yet) systematically measured.

For cost-quality tradeoff purposes, the best managed care evaluation tools hold more promise, for each health plan has a self-interest in demonstrating the adequate or superior quality of its services. Otherwise the plan will lose market share to those who do demonstrate quality. If the techniques prove to be as successful as some think they are already, then informed buyers will someday be able to choose their preferred point along the evolving cost-quality tradeoff. That is exactly what the public discussion of Medicare’s future should be about: What level of quality are we collectively willing to pay for and guarantee for all? Because of resource constraints, the collective quality guarantee is not likely to be at the highest level imaginable, but neither is it likely to be the lowest level, either. It will surely be nearer a more desirable level sooner if we begin to define it, measure it, and hold health plans and providers accountable for providing it, rather than ignore quality altogether and just hope for the best, as we do now in FFS medicine.

As a final inspiration for the market-based effort to reform Medicare, we should recognize that some organized purchasers of health insurance, in both the private and the public sectors, are doing a commendable job today holding health plans accountable for quality and cost performance. Given their documented record of successes (Meyer et al. 1996; Enthoven and Singer 1996; Maxwell et al. 1998; Feldman and Dowd 1998; Robinson and Powers 1998), I see no analytical reason to doubt that Medicare could do at least as well for many, and maybe most, beneficiaries.
MAJOR DESIGN CHOICES

There are six major design choices for the Medicare health plan market. I consider each in turn and also discuss the choices that are being made for Medicare’s upcoming competitive bidding demonstration projects. But I must first explain a bit about how the demonstrations came to be.1

Currently, Medicare pays health plans according to an administrative formula based mostly on the average costs in fee-for-service Medicare in a given locale. Widespread evidence indicates that this payment method has resulted in substantial overpayment to health plans, which they partially dissipate by providing extra benefits to beneficiaries at low or zero out-of-pocket premiums. The overpayment has created an alliance of beneficiaries and health plans in high fee-for-service cost areas (e.g., Miami) where benefits well beyond the basic Medicare package have become the norm (e.g., low or zero copayments, prescription drugs, eyeglasses, hearing aids). The payment system also has created resentment in low fee-for-service cost areas (e.g., Minneapolis) where extra health plan benefits can be had only at substantial out-of-pocket costs. Thus the current system of paying Medicare health plans is both inefficient and unfair, but some benefit from it and therefore naturally oppose change.

To learn how to pay health plans more as other market payers do, over the last several years HCFA tried to initiate two different competitive bidding demonstrations, one in Baltimore and one in Denver. In both cases, local health plans and beneficiaries pressured their state’s congressional delegations to intervene and stop the demonstrations before they started. Health plans opposed competitive pricing because they feared lower prices would result, and lower government payments would require them to reduce the amounts of extra benefits they currently provide at zero extra premium to beneficiaries. That situation could chase beneficiaries back to FFS Medicare, in the extreme. Beneficiaries opposed the demonstrations because they did not want to see zero-premium benefits reduced.

However, there is no way to rein in cost growth in the long run without paying plans less than the current baseline and ultimately without decoupling managed care plan payments from the unmanaged fee-for-service costs in the Medicare program. Given the active and bipartisan intervention of the legislators in both states, it is reasonable to conclude...
that Congress may be more supportive of bringing the market to Medicare in the abstract than in practice in someone’s specific backyard.

To the members’ credit, Congress faced up to this problem in the Balanced Budget Act of 1997, for that bill created a Competitive Pricing Advisory Commission (CPAC) that was charged with designing the demonstrations and selecting up to seven sites. Vesting site selection authority with the independent CPAC was an acknowledgment that otherwise local political pressures could prove too strong to permit a demonstration in which one goal is to learn how to save money. The BBA expressed Congress’s intent to improve the Health Care Financing Administration’s (HCFA’s) capacity for managing a competitive bidding process and gave CPAC the statutory teeth to carry it out. CPAC made its design choices, to be described here, and selected the first two sites (Phoenix and Kansas City, Missouri).

In the last appropriations bill passed in November 1999, senators from the affected states succeeded in preventing implementation of competitive bidding demonstration in their states in fiscal year 2000. Since CPAC had already voted to delay implementation until 2001, and since the Medicare bill that also passed included provisions designed to save the demonstrations, it is not clear how this will ultimately play out. The designs are not perfect, as they reflect judgment about complex tradeoffs, and they would surely need midcourse corrections. But to refuse to conduct them leaves each polar position in the larger Medicare reform debate without evidence to counter or confirm their greatest fears or strongest ideological claims. Will beneficiaries find health plan price competition a net improvement over the current form of benefit competition? Can HCFA manage a market-oriented purchasing process so that health plans, providers, and beneficiaries are willing to participate? Does competitive bidding lower cost growth vs. baseline projections or contemporaneous experience elsewhere in the country? Is quality of care reduced, improved, or unchanged when plans have to bid competitively for Medicare business and reveal more comparative information to Medicare beneficiaries? If Congress stops the competitive bidding demonstrations once again, it would in effect deny itself answers to policy questions that are fundamental for long-term Medicare reform. To refuse to allow a competitive bidding demonstration while insisting on moving to unfettered competition nationwide is to advocate taking a huge risk with our most vulnerable beneficiary population.
That kind of risk is unnecessary and seems unwise on both political and policy grounds.

**Design Choice #1: What about Fee-for-Service Medicare?**

The BBA made this simple for CPAC by stating explicitly that fee-for-service Medicare should be left outside the demonstration. Congress thus agreed with most analysts’ judgments that we are simply not prepared for FFS Medicare to compete against managed health care plans. The reason is partly that FFS Medicare is so big. It has 87 percent of all 39 million beneficiaries today; abrupt, wholesale departures from FFS could overwhelm many Medicare managed care plans. Another reason is that FFS Medicare serves the most vulnerable beneficiaries. More than 4 million Medicare enrollees are over 85, 5 million are disabled, and over 6 million have low enough incomes to be on Medicaid as well as Medicare. Most health plans do not know how to serve the oldest and frailest beneficiaries profitably at current fixed government payment rates and have been reluctant to enroll them. This is one reason states have been slow to shift disabled Medicaid enrollees (who are often Medicare enrollees, too) into Medicaid managed care plans. Tellingly, this pace contrasts with the speed with which states have moved the relatively healthy cash-recipient population (Temporary Assistance for Needy Families [TANF] mothers and children) and the Medicaid expansion population (pregnant women and children) into managed care.

Another reason to move slowly into pitting FFS against managed care directly is the current state of risk-adjustment techniques. Although there has been progress, risk adjusters are much worse at fairly compensating FFS plans faced with aggressive health maintenance organization (HMO) competition than at dividing revenues among similar managed care plans. The short-run reality is that if FFS Medicare was forced to “bid” against HMOs at the present time, its premium would have to be high to cover the higher (and unadjusted) costs of its relatively sicker enrollees. That would mean that people would likely have to pay an extra premium out-of-pocket (beyond the current Part B premium) to remain in FFS Medicare, which would drive the healthiest out of FFS and into HMOs and exacerbate the adverse selection under which FFS Medicare continues to labor. That could destroy FFS Medicare. Thus, it is much safer to keep a firewall between FFS Medicare and the managed health plan competition we are
trying to engender until risk-adjustment techniques are better and until the
types of health plans that are going to win the Medicare+Choice competi-
tion are more clearly revealed and understood. Then, and only then, can
free competition between FFS Medicare and private health plans take
place on anything close to a level playing field.

President Clinton’s Medicare reform plan\(^2\) stakes out an interesting
middle ground between keeping FFS separate and full-fledged FFS vs.
managed care competition. It guarantees that a beneficiary can always
stay in FFS, and get prescription drugs, for the price of the Part B premi-
um. If a managed care plan offers the basic Medicare package (including
drugs) for less, the beneficiary could join it and pay a lower Part B premi-
um, but not as much lower as the health plan’s bid. This in essence
anchors the government payment to FFS costs, while sharing any efficien-
cies that managed care plans might achieve among beneficiaries, health
plans, and taxpayers. At the same time, efficiencies that FFS attains over
the years will also serve to lower government payments, to FFS Medicare
providers and to all health plans alike. The incentives for health plans to
achieve efficiency are thus strong, though not as strong as in a scheme
without an FFS anchor and in which beneficiaries keep all the savings.
Still, the right kinds of incentives are present—and at considerably less
risk to beneficiaries and FFS providers than immediate full-fledged com-
petition would present. That kind of option is certainly worth exploring as
the larger Medicare reform debate moves forward.

**Design Choice #2: What Kind of Purchasing Agent/Competition
Manager Do We Want Medicare (HCFA) to Be?**

There are two schools of thought, passive and active. The passive theory
is that markets work best when managed least. That would mean HCFA
would coordinate enrollment and practice as much laissez faire toward the
bidding health plans as possible. The extreme case would be a hands-off
voucher approach.

The active theory is more in tune with managed competition theory
and with the practical experience of successful organized buyers. They
negotiate with plans and retain the power to exclude them if their report-
ing, performance, or prices are beyond the acceptable range. Though local
purchasing discretion and the power to exclude providers or plans have not
been hallmarks of the Medicare program, they may be essential tools for
market-based reforms to work as well. Local discretion also raises complex issues of geographic variation. That kind of authority will require new legislation, and thus Congress will have to decide explicitly to give HCFA the tools to drive and manage competition—or not. In the absence of new discretionary power, however, Medicare is at a distinct disadvantage vis-à-vis the most effective private-sector purchasers of health services.

To maximize plan participation, CPAC took a relatively passive position for the upcoming competitive bidding demonstrations, allowing all plans that meet basic qualification standards to offer their product to Medicare beneficiaries regardless of price or recent quality performance. If that performance or pricing structure is seen to be unacceptable, however, CPAC might grant HCFA more discretionary authority to exclude health plans in future demonstrations.

**Design Choice #3: Should the Benefit Package(s) Be Standardized?**

Standardizing benefits is an essential part of the managed competition framework, for it enables consumers to compare health plans easily and thereby narrow the competition to the more manageable dimensions of price and quality. However, there is a solid theoretical argument against standardization as it would prevent some voluntary exchanges from occurring. The prevention is most likely if the standard package is more comprehensive than some low-risk individuals would prefer. They might gladly take less coverage for lower premiums. The economic welfare loss from being unable to purchase and sell the particular packages is the cost of standardization.

But there are costs from not using standard benefit packages as well, the most important of which is that plans would use benefit design as a risk-selection device. They would be reluctant to offer benefits that attract sicker-than-average enrollees. Thus adverse selection has welfare costs, as well, the most important of which is the absence of comprehensive benefit plans even though there is a collective willingness to pay for them that would cover their costs. The policy question then boils down to which kind of imperfection—either healthy enrollees forced to buy plans that are more comprehensive than they would choose on their own or unhealthy consumers unable to find coverage for some of their health care needs—
policymakers most want to avoid. Most, but not all, successful managers of health plan purchasing arrangements come down on the side of standard benefit packages, and those that do consider them to be essential tools to facilitate competition. This plus Medicare beneficiaries’ experiences with the switch to standardized A–J Medigap products suggests to me as it did to CPAC that standard benefit packages are more likely to help health plan competition in Medicare than to hurt it.

This does not mean that a single “one-size-fits-all” standard benefit package is ideal, nor that the standard package has to be the current Medicare statutory package. CPAC decided to add a prescription drug benefit to the current package as the minimum national standard package. And local area advisory councils were given the power to add benefits to each area’s standard package if they choose to. Furthermore, plans will be allowed to offer additional benefits beyond the local standard, as long as they reveal the prices of each of their supplemental packages separately from their standard bid. In this way, HCFA can learn the cost structure of health plan delivery systems through revealed bids. Plans also have incentives to bid low, as the lower they bid, the more likely their bid on the basic package will be below the government contribution, which means they could offer additional benefits at zero premium or pocket the difference themselves. CPAC’s conclusion was that allowing local benefit package variation above a standard national core of benefits that includes prescription drugs strikes the right balance between competitive incentives and heterogeneous preferences.

Design Choice #4: Setting the Government Contribution Level

This is perhaps the most difficult issue, for it is obviously central to the incentive structure and to the distributional implications of competitive bidding in practice in the Medicare program. The only economic theory here is straightforward: setting a defined contribution at the level of the lowest bid would put maximum incentives in place for beneficiaries to select efficient health plans. That is also the contribution scheme most likely to engender the lowest cost growth over time.

The difficulties with that efficient contribution scheme are three. First, the lowest bidders may not have enough capacity to handle their new demand, and that situation could force some beneficiaries to pay extra out-of-pocket payments for plans that were not their first choice. Second, that
kind of contribution policy could lead low-income beneficiaries to con-
gregate in low-bidding plans while higher-income beneficiaries gravitate
toward higher-cost plans. This raises the specter of a two-tiered Medicare
program that has been largely avoided to date, by design. Finally, and
pragmatically, the reality is that many Medicare+Choice beneficiaries
today have access to zero-premium plans that provide benefits beyond the
statutory package. Moving to an efficient pricing strategy precipitously
would mean that most current managed care enrollees would experience
competitive bidding first as a premium increase for the same or lower ben-
efits than they get now. That does not seem like a smart way to engender
beneficiary support for competitive bidding experiments.

For those reasons, CPAC decided to eschew maximum efficiency and
search for a middle ground. Unfortunately, there is little theory to guide
policy once the lowest-bid strategy is rejected. CPAC settled on two alter-
atives, with the proviso that each be tried in at least one site (seven sites
are authorized in the BBA, to be selected over the next two years). The
first method is the median bid, adjusted upward if the enrollment capacity
of the lowest bidder is low and downward if the enrollment capacity of the
lowest bidder is high. It preserves incentives to bid low while also guar-
anteeing that low-income beneficiaries would have some choice of zero-
cost plans (zero extra cost, beyond the Part B premium).

The second alternative is the enrollment-weighted average bid
(excluding FFS). That method was chosen because it is perceived to be
less threatening to current health plans. The danger is that the rule attenu-
ates practically all incentives to bid low in the name of health plan
market share stability. But that is why Medicare should conduct demon-
strations—to test the practical results of theory and thereby explicate real
policy choices.

Design Choice #5: Should Plan Payments Be Adjusted for Relative
Risks, and If So, How?

Stuart Guterman’s article in this collection treats this question in detail, so
I will merely state that for a competitive health plan market to work, this
is not a question of whether but of how. Especially for public program
beneficiaries like Medicare enrollees, we want all plans to accept all com-
ers willingly. That will be an equilibrium outcome only if enrollees who
are expected to engender higher costs also generate commensurately
higher payments from the government. The new risk-adjustment mechanism HCFA will implement in 2000 is an improvement, but it is not perfect. Still, it is important to remember that perfection is not required; rather, the risk adjuster needs to be good enough only to make health plan profitability uncorrelated with plan composite health risk profiles. Thus HCFA has to be only as good at predicting costs as the health plans are. Over time, with more extensive reporting requirements, this should be an attainable goal.

Given the overriding need to keep plans participating in an increasingly risky environment, CPAC decided to postpone the new risk-adjustment mechanism for one year in competitive bidding sites. This was done to reduce health plan’s uncertainty as they prepared to deliver competitive bids to HCFA for the first time. Other interim adjustments, like combining prospective and retrospective risk adjustment (Newhouse 1994), should be considered as pragmatic ways to balance efficiency concerns with reduced incentives to aggressively select enrollees.

**Design Choice #6: Information Collection and Dissemination**

Without a foundation of health plan quality reporting and assessment, no market-based purchasing strategy can ever perform well. Accountability requires timely data, subject to audits, on measures that matter to patients. Most successful private and public buyers require and receive data that guide both consumer choices among plans and employer-sponsored negotiations with plans and provider groups. Outcomes measures cannot be perfect, and the admonition “be careful what you wish for” is particularly apropos for health plan quality measures. But enormous progress in outcomes measures has been made in the last few years, and the sooner the reporting and dissemination of plan comparison data become institutionalized, the greater impact that comparative information is likely to have in the future. Medicare has been late to act on this, but HEDIS 3.0 measures are now required of all plans and are a good place to start. For the competitive bidding demonstrations, CPAC decided not to require more reporting than is currently required of all Medicare+Choice plans.

Dissemination to the elderly is not easy, as the recent Medicare+Choice comparison booklet mailing showed. Still, it is important to remember that not all buyers have to use this information for it to be useful. Experience in other markets has clearly shown that providers...
will react to the public release of data in ways that enhance performance overall, even if only a critical mass (which could be well short of half) of patients or their families/agents act upon it directly.

LONG-RUN ISSUES

This essay has focused on ways to design a competitive health plan market that can serve most Medicare beneficiaries and taxpayers very well in the twenty-first century. If the principles outlined are followed, I believe a Medicare system that uses market forces more than it does today would most likely be successful at our main goals of high-quality care for all Medicare beneficiaries at an acceptable social resource cost. However, five important questions perhaps should be answered before the market is adopted as the only vehicle for the journey to the future Medicare program, and this section raises them for the reader’s consideration.

1. How much geographic diversity should be tolerated?

There is considerable diversity today, in use, prices, and de facto extra benefits that some beneficiaries get because of where they live. Local deviations, however, do stretch the credibility of the claim that we are providing a national entitlement, and with more market freedom the geographic diversity could become greater and more visible over time. Such considerations need not erase local diversity, but the tension between the entitlement’s promise and local realities will be permanent and needs to be carefully monitored.

2. Are health plan quality measures highly correlated with “real” health service quality?

This is a crucial question, which may not be known or accepted for 10 years or more. One difficulty with the question is that so many vested interests have incentives to argue that the answer is no. Considerable research, both in and outside the Medicare program, will need to be done before a critical mass of individuals are convinced that the answer is close enough to yes to proceed with full-speed managed competition for Medicare beneficiaries.
3. Can HCFA risk-adjust as well as private-sector health plans?

Another way of asking this question is, Can HCFA convince health plans it is adjusting payments based on health risks in such a way that no plan is disadvantaged relative to its rivals? The answer to this must be yes for full-fledged managed competition to work. The difficulty, once again, is that some plans may have strong incentives to refuse to be convinced. How they react, and who ultimately wins the public relations battle, may determine whether market experiments are allowed to go forward.

4. Is it smarter to focus on one price—that of a health plan’s package of services—than the more than 10,000 prices of FFS Medicare?

There are obvious efficiencies in “hiring” a health plan to organize the providers and negotiate the 10,000 prices and protocols for Medicare. Those efficiencies are the primary reason so many employers and other organized buyers have embraced managed care in recent years. But there are also risks to beneficiaries in pursuing those efficiencies—risks that are linked to quality. If Medicare, by administrative fiat, underpays for one price out of 10,000, then providers can “make it up” through other prices that might be higher than costs. But if Medicare underpays for the single price out of a complete package of benefits, then quality across the board may have to be cut to remain financially viable. Thus, getting the one price right is more important than getting any one of the 10,000 FFS prices right, and appropriate quality monitoring and accountability must be built into the new contracts between Medicare and health plans. Numerous private- and public-sector examples show that it can be done, but it is not easy and it will represent a departure from current HCFA purchasing practices.

5. Will Congress let Medicare be an aggressive purchaser?

There is much talk now about having Medicare emulate the private sector and implement recent lessons learned from the private sector. This essay in one sense is a blueprint about how one might do this while minimizing risks. But note that if Medicare is going to use its market power to drive good bargains and be the type of purchaser that exemplary private-sector groups and some states have become, then more than likely some plans are going to lose business, some hospitals are going to be forced to close, and some physicians will have to either improve their performance or be banished from the Medicare program.
Organized buyers searching for value in health insurance markets have to be ruthless about such outcomes. Congress has not shown the willingness to allow HCFA (on the Medicare program’s behalf) to be so aggressive in the past. If Congress is not prepared to do so now, then the ultimate wisdom of trying to manage a private health insurance market for Medicare beneficiaries may be as questionable as waging an air war alone with ostensibly humanitarian objectives: the moral sentiment is laudable but the execution leaves a lot of collateral damage and refugees on the ground. Half-measures and private health plan markets may work worse in combination than feasible alternatives for long-run Medicare reform. Congress should seriously measure its will and consider the likely consequences of market competition before saddling the HCFA with yet another impossible mission and inadequate tools.

NOTES


As demonstrated by the recent deliberations of the National Bipartisan Commission on the Future of Medicare, designing a system in which a variety of plans compete in a market for Medicare enrollees involves a number of important decisions. As indicated by the Commission’s failure to reach the required consensus, many of those decisions are controversial. One of the most important, and most controversial, elements of such a system is the mechanism for determining the payment to be received by each plan. Any discussion of payment mechanisms (regardless of whether the payments come solely from the government or partially from individuals, whether they go to health care providers or plans, or whether they are for a unit of service or a person-year) actually involves two sets of issues. One of them concerns the aggregate level of payment (including who is to be responsible for how much of it) and the other the distribution of payments (including how to recognize differences among markets and among plans within each market). The former set of issues is key to defining the system and the latter is crucial in determining the incentives faced by the parties involved and the outcomes that can be expected. Among the factors that determine the distribution of payments is risk adjustment—the adjustment of the price of health insurance to reflect the individual enrollee’s expected cost to the plan.

This paper describes how risk adjustment could be used in the context of a competitive system with premium support to set the payment that each plan would receive for each enrollee, so that plans are not rewarded for avoiding sicker beneficiaries and are not penalized for providing services that are attractive to those groups. It begins by describing risk adjustment, why it is important, and why it is likely to increase in importance as reliance on market forces grows and more alternatives to traditional fee-for-service Medicare coverage become available. It then briefly discusses
if not “the state of the art” then “the state of the policy,” focusing primarily on the system that the Health Care Financing Administration (HCFA) has proposed for Medicare+Choice payments beginning January 1, 2000, and potential improvements in that system. Finally, it describes an approach that could be used to set payments in a competitive Medicare program to accomplish certain basic objectives relating to the roles of government, beneficiaries, and plans.

**WHY RISK ADJUSTMENT IS IMPORTANT**

In most markets, risk adjustment and risk selection are commonly accepted and even encouraged. As Newhouse (1998) points out, insurers routinely adjust the premium they charge for car insurance to reflect certain factors that are thought to be associated with higher or lower levels of risk, including demographic characteristics (age, sex), location, and prior experience (speeding tickets, accidents), and even can deny coverage based on those factors. There appears to be little concern about the high premiums faced by precisely those individuals who are most likely to incur the expenses against which they would like to be insured. In fact, the correspondence between premiums and risk is seen as a good thing that prevents the rest of us from having to share the costs incurred by less careful drivers.

Health insurance, though, is different in several ways. One major difference is that, although it is associated with higher costs to the insurer, poor health status (as opposed to accident-prone driving) is viewed as a condition that ought not to be penalized in the market. The vast majority of private health insurance is obtained through employer-based group policies, which generally do not distinguish among enrollees except for broad classes that usually are related to family structure rather than health status. Although premiums may vary widely across employers in part because of differences in the risk presented by the insured group, the notion of community rating—everyone in a given group facing the same premium—is a popular one.

The problem with community rating, though, is that it distorts the incentives faced by insurers. If every enrollee in a group pays the same premium, plans that attract the lower-cost enrollees in the group will profit and those with the higher-cost enrollees will lose. Even if insurers can-

Although it is associated with higher costs to the insurer, poor health status (as opposed to accident-prone driving) is viewed as a condition that ought not to be penalized in the market.
not explicitly select or exclude individuals based on their health status, they can try to attract healthier enrollees by offering benefits that would be more attractive to them and avoid sicker enrollees by not offering benefits that they would want. With the growth of managed care relative to traditional indemnity insurance, the incentives faced by the insurer are even more important, because managed care plans have more control over the amount, mix, and quality of care available to enrollees with the same benefits package.

The incentives in place under community rating could lead to several types of adverse outcomes. They could hinder access to care for sicker individuals, by discouraging plans from offering the services that might be needed by them. Further, plans that did offer those services (and consequently attracted sicker enrollees) would be more likely to experience financial losses, which could affect their ability to maintain the quality of care; as a result, the sick would be more vulnerable to quality problems. In the longer run, those plans would have to either cut back their services (or go out of business), which would further restrict access to care for the sick, or raise their premiums, which would effectively undo community rating. Moreover, the higher premiums required by plans with sicker enrollees could drive away their healthy enrollees, to whom their more expensive mix of services offered would be less valuable. The growing mismatch between premiums and plans’ expected costs would increasingly distort the allocation of society’s resources, as plans spend more of their resources to attract healthy enrollees and fewer on providing care to sick ones.

To preserve the concept of community rating while avoiding the potential for adverse consequences, risk adjustment must be accomplished by some mechanism separate from that used to determine the base premium. That mechanism is needed to adjust the base premium for each plan (which is the same for all its enrollees) by the appropriate amount and to determine how the adjusted amounts are to be distributed among the plans. The adjusted amounts should reflect the costs each plan would expect to incur in providing its benefits package efficiently to its enrollees. If risk adjustment is applied appropriately, plans will be paid fairly and access to care will be supported.
RISK ADJUSTMENT IN MEDICARE

For the first 25 years under the Medicare risk contracting program (before implementation of the Balanced Budget Act of 1997, or BBA), the premium that plans received for each enrollee in each year was based on projected Medicare fee-for-service spending per beneficiary in the enrollee’s county of residence for that year. Plans were required to submit an Adjusted Community Rate proposal that contained an estimate of the costs of providing the basic Medicare benefits package to their enrollees. If a plan’s average payment rate exceeded its average estimated costs, the plan was required to offer additional benefits (broader coverage or reduced cost-sharing) equal in actuarial value to the difference.

Plans that attracted enrollees healthier than the average Medicare beneficiary were advantaged in two ways: first, although they were required to offer additional benefits, they could use them as a (Medicare-subsidized) marketing device to increase their enrollment; second, to the extent that their healthier enrollees allowed them to keep their costs below their projections, they could keep the difference as profits. Moreover, to the extent that plans in general attracted healthier enrollees than the traditional fee-for-service program, total Medicare expenditures would rise, because plans would be paid more than their enrollees would have cost under the traditional fee-for-service program.

The BBA created the Medicare+Choice program, which expanded the risk-contracting program to include a broader array of coordinated care plans as well as other financing arrangements. The determination of plans’ payment rates also was changed, breaking the direct link with the annual increase in the adjusted average per capita cost. Although the new methodology was intended to reduce the discrepancy between payments to plans and the costliness of enrollees in the aggregate, it did nothing to adjust payments to reflect differences in risk faced by each plan. To address that need, HCFA was required to implement a risk-adjustment mechanism by January 1, 2000. (HCFA’s proposed approach is discussed briefly hereafter.)
Risk adjustment would be even more important in a system like the one discussed by the Commission, in which traditional fee-for-service Medicare would compete for enrollees with managed care and other types of plans. It has been asserted that risk selection diminishes as managed care enrollment rises, because plans are less able to avoid sicker beneficiaries. Although it is true that the average costliness of managed care enrollees would be expected to rise under those circumstances, the difference between the managed care population and the fee-for-service population actually could increase (U.S. General Accounting Office 1997). The impact of the phenomenon depends to a great extent on the system under which it occurs.

To illustrate the issue more clearly, let us use a numerical example based in part on actual Medicare data. Medicare beneficiaries differ widely in the amount the program spends on their behalf (see table 1). In 1994, the Medicare program spent $146.5 billion on covered services for 37 million beneficiaries, or a little under $4,000 per beneficiary. However, 19 percent of all beneficiaries had no Medicare expenditures, whereas the 4 percent in the most expensive group cost the program an average of more than $44,000. With such a skewed distribution of expenditures, a plan that

**TABLE 1. Distribution of Medicare Expenditures, 1994**

<table>
<thead>
<tr>
<th>Per-Beneficiary Spending Category</th>
<th>Average Spending per Beneficiary</th>
<th>Percentage of All Beneficiaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>$0</td>
<td>18.6%</td>
</tr>
<tr>
<td>1–99</td>
<td>43</td>
<td>10.9</td>
</tr>
<tr>
<td>100–499</td>
<td>269</td>
<td>21.8</td>
</tr>
<tr>
<td>500–999</td>
<td>717</td>
<td>11.3</td>
</tr>
<tr>
<td>1,000–1,999</td>
<td>1,423</td>
<td>9.2</td>
</tr>
<tr>
<td>2,000–4,999</td>
<td>3,260</td>
<td>10.3</td>
</tr>
<tr>
<td>5,000–9,999</td>
<td>7,102</td>
<td>6.7</td>
</tr>
<tr>
<td>10,000–14,999</td>
<td>12,305</td>
<td>3.5</td>
</tr>
<tr>
<td>15,000–19,999</td>
<td>17,335</td>
<td>2.2</td>
</tr>
<tr>
<td>20,000–24,999</td>
<td>22,346</td>
<td>1.5</td>
</tr>
<tr>
<td>25,000 and over</td>
<td>44,281</td>
<td>3.9</td>
</tr>
</tbody>
</table>

received a fixed payment equal to the average per-beneficiary cost could do either very well or very badly, depending on its ability to attract the healthiest enrollees.

Suppose, given that distribution of Medicare spending, that plans that offer some alternative to traditional fee-for-service Medicare could attract the least expensive beneficiaries with perfect success. As often is asserted, the average cost of enrollees in the alternative plans would increase rapidly with their share of the total Medicare population (see table 2). In our extreme example, at 30 percent penetration the average cost is very low; as stated above, the majority of these enrollees have no Medicare spending at all, and the group as a whole averages only $20. Increasing the alternative plans’ enrollment share to 50 percent increases their average cost sixfold, and at 70 percent the average cost is $356—almost 18 times as high as when their enrollment share is 30 percent.

### TABLE 2. Spending per Enrollee as Enrollment in Alternative Plans Grows—An Extreme Example

<table>
<thead>
<tr>
<th>Enrollment Share in Alternative Plans (in Percent)</th>
<th>Average Cost per Enrollee (in dollars)</th>
<th>Alternative Plans</th>
<th>Remainder (Fee-for-Service)</th>
</tr>
</thead>
<tbody>
<tr>
<td>30</td>
<td>20</td>
<td>4,955</td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>120</td>
<td>5,655</td>
<td></td>
</tr>
<tr>
<td>70</td>
<td>356</td>
<td>12,385</td>
<td></td>
</tr>
</tbody>
</table>


However, as enrollment in the alternative plans grows, a higher proportion of the beneficiaries remaining in the traditional fee-for-service program are from the most costly group. Although the proportional increase in average costs among this remainder is much smaller than among the alternative plans (150 percent compared with 1,680 percent in the example), it is much greater in absolute terms. Consequently, the difference between the two groups in spending per beneficiary rises sharply (in the example, from $4,935 at 30 percent penetration to $12,329 at 70 percent penetration).

As mentioned, the implications of the widening discrepancy would depend on the system in effect. Under the old risk-contracting program, the alternative plans would have been paid according to the average cost
in the fee-for-service program. The absolute differential between plan payments and plan costs would grow rapidly as their enrollment share increased. The difference would be used to fund additional benefits for Medicare enrollees—as was observed in the years immediately preceding the BBA (ProPAC 1997). Those additional benefits fueled an acceleration in risk plan enrollment.

Under the methodology enacted in the BBA (and in effect since 1998), the payments received by Medicare+Choice plans no longer are determined by per capita spending in the fee-for-service program alone. Instead, the annual increase in aggregate plan payments is based on (actually, 0.5 percentage point below) the growth in overall Medicare spending. Other things equal, plan costs should rise relative to payment rates as enrollment increases, making it more difficult for plans to offer additional benefits. This may be some of what plans are experiencing in these early days of Medicare+Choice.

Under a system with alternative plans competing against traditional Medicare fee-for-service coverage, the discrepancy described would place the traditional plan at a significant and worsening disadvantage without adequate risk adjustment. In our extreme example, if the government contribution were set at the average level of spending per beneficiary ($3,965), enrollees would have to contribute an additional $990 per year for the traditional plan (assuming 20 percent of beneficiaries start out with the alternative), compared to no additional contribution (or a substantial refund, if that were allowed) for the average alternative plan. If, as would be expected, many beneficiaries switched to the alternative plans, the additional premium for the traditional plan could rise substantially (in the example, if the alternative’s share of enrollment rose to 70 percent, the required contribution would be $8,420 per year). The example is extreme, but it illustrates the problem that could be faced by the traditional plan and the enrollees that remained in it in the absence of an adequate risk-adjustment mechanism.

In addition to the potential discrepancy between traditional Medicare and alternative plans, individual plans also may need the protection of risk adjustment more under a competitive system. With a wider range of plans available and more choices available to beneficiaries, it becomes more likely that some plans will be greatly advantaged or disadvantaged by random risk selection. Moreover, under a competitive system, both plans and
beneficiaries become more financially vulnerable to the consequences of their choices, compared with the limited exposure to such consequences under the current system. Risk adjustment also would help in that regard.

**ARE CURRENTLY AVAILABLE RISK-ADJUSTMENT METHODS GOOD ENOUGH?**

Given the need for an adequate risk-adjustment mechanism, there is a fair amount of concern about how well the available alternatives work and how well they need to work.\(^{12}\) The current adjusters, which were carried over from the risk-contracting program to Medicare+Choice, are based on age, sex, and a few other individual characteristics. They have the advantage of being directly obtainable from Medicare administrative data, but they explain little of the variation in spending for individuals in a given year. The payment rates in the current system therefore do little to reconcile each plan’s payments with the costliness of its enrollees.

As mentioned above, the BBA mandated that HCFA implement a health status–based risk adjustment by January 1, 2000. The method that HCFA has proposed is based on the Principal Inpatient Diagnostic Cost Groups (PIP-DCG) system, which classifies patients into risk groups based on the diagnostic information contained on the hospital inpatient record.\(^ {13}\) This system does better at predicting the costs of an individual in a given year, but it requires accurate inpatient encounter data not only for fee-for-service beneficiaries (to calculate the adjustments) but also for Medicare+Choice enrollees (to apply the adjustments). Moreover, in focusing solely on inpatient diagnoses, it not only fails to capture the information that could be obtained from ambulatory encounter data but also biases the risk adjustment toward conditions for which patients tend to be hospitalized.

Nonetheless, the proposed method does seem to do a better job of predicting costs, especially for beneficiaries in specific illness groups (see table 3). This indicates that, unless the PIP-DCG approach is found to introduce some bias that distorts payments for some types of plans or enrollees, it is an improvement over the current system. Managed care plans have, in fact, argued that the approach does bias the payment system against them, because they do not hospitalize some patients who are hospitalized in the fee-for-service program. To the extent that this is true,
payments can be adjusted to compensate for the bias. But the distribution of payments across Medicare+Choice plans would reflect the costliness of enrollees better under the proposed system than under the current one.

Moreover, it could be argued that the primary objective of risk adjustment is not so much to predict the costs of every enrollee as to adjust payment appropriately for groups so that there is no incentive to avoid them and no penalty for enrolling them. However, HCFA’s results indicate that there is some way to go before that objective is realized; even under the proposed approach, risk-adjusted payments for enrollees in several major disease categories would be less than their expected costliness, which means that plans that enroll disproportionate numbers of enrollees in those groups would face losses as a result.

Further work is being done to improve the state of the art in risk adjustment (HCFA 1999). HCFA is collecting encounter data representing a broader range of settings, with plans to implement a methodology based on the Hierarchical Co-existing Conditions (HCC) model. The model has been shown to improve substantially the explanatory power of the risk adjuster. Other approaches have been suggested that would moderate the systematic risk faced by plans that enrolled more expensive groups of enrollees and the random risk of losses on individuals that might imperil their financial viability.14 As the debate on Medicare reform moves us toward more reliance on the forces of the competitive market, mechanisms that can be used to adjust prices appropriately become even more crucial.

### TABLE 3. Predictive Ratios (Predicted/Actual Costs) under the Current Medicare+Choice Risk-Adjustment Method and the Method Proposed by HCFA, for Selected Disease Groups

<table>
<thead>
<tr>
<th>Disease Group</th>
<th>AAPCC-Like</th>
<th>PIP-DCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pancreas/Lung Cancer</td>
<td>0.35</td>
<td>0.62</td>
</tr>
<tr>
<td>Acute Myocardial Infarction</td>
<td>0.45</td>
<td>0.79</td>
</tr>
<tr>
<td>Breast Cancer</td>
<td>0.68</td>
<td>0.78</td>
</tr>
<tr>
<td>Hip Fracture</td>
<td>0.59</td>
<td>0.85</td>
</tr>
</tbody>
</table>

*Source: Health Care Financing Administration (1999), p. 32.*
HOW MIGHT RISK ADJUSTMENT ACTUALLY WORK IN A COMPETITIVE MEDICARE SYSTEM?

The notion of a competitive system with premium support is that the government payment should be the same regardless of the plan in which the beneficiary enrolls. That way, the beneficiary can choose a plan that offers additional coverage, more amenities, or just plain inefficiency, but he/she has to bear the financial consequences of that choice in the form of higher premiums. With community rating, each beneficiary would pay the same amount for any plan, regardless of health status. This arrangement implies that, although the beneficiary should bear all the costs of differences between plans that are related to the plans themselves, the individual should bear none of the costs related to his or her own health status or differences in the plans’ mixes of enrollees.

How could risk adjustment be implemented? One approach is described in the following example. Assume that there are three plans in an area. Each plan is required to submit a bid containing four types of information: the premium it plans to charge to its enrollees for its benefits package (raw bid), the actuarial value of its package relative to that offered in the traditional Medicare plan (relative actuarial value), its projected enrollment, and the anticipated costliness of its enrollees relative to the average Medicare beneficiary (average risk score).

The standardized bid for each plan would then be calculated by dividing its raw bid by its relative actuarial value and then its average risk score. The standardized bid indicates the (hypothetical) premium the plan would charge to offer benefits equivalent to the traditional Medicare package. A weighted average standardized bid for the area would be calculated by multiplying each plan’s standardized bid by its share of projected enrollment (see table 4). The weighted average standardized bid, or base premium, then would be used to set the government and enrollee base contributions. Assume for this example that the government and enrollee base contributions are 90 percent and 10 percent, respectively, of the base premium.

The base contributions are the amounts that would be paid by the government and the enrollee to an average plan for an average beneficiary for the standard benefits package. But none of the plans in the example is an...
average plan. The sum of the government and enrollee base contributions is less than the bid for Plan A and greater than the bids for Plans B and C. To enroll in those plans, an average beneficiary would have to pay an additional amount or be eligible for a rebate, depending on the plan.

Moreover, every beneficiary is not an average beneficiary. Therefore, the base premium varies to reflect each enrollee’s expected costliness (see table 5). For providing the basic benefits package to an enrollee with a risk score of 0.5 (i.e., one-half as costly as an average beneficiary), each plan in the example would receive 0.5 times the base premium for the area, or $52.09. For providing the same benefits package to an enrollee with a risk score of 1.5, the plan would receive 1.5 times the base premium, or $156.26. All of the variation in the risk-adjusted base premium is reflected in the government contribution; the enrollee’s share of the base premium is the same, regardless of his or her expected costliness.

The total cost to the enrollee, however, can vary substantially by plan. This variation reflects not the enrollee’s health status or the plan’s success

### TABLE 4. Example: Determining the Government and Enrollee Base Contributions

<table>
<thead>
<tr>
<th>Plan</th>
<th>Raw Bid</th>
<th>Average Risk Score</th>
<th>Standardized Bid</th>
<th>Government Base Contribution</th>
<th>Enrollee Base Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>$150.00</td>
<td>1.2</td>
<td>$125.00</td>
<td>$93.75</td>
<td>$10.42</td>
</tr>
<tr>
<td>B</td>
<td>100.00</td>
<td>1.0</td>
<td>100.00</td>
<td>93.75</td>
<td>10.42</td>
</tr>
<tr>
<td>C</td>
<td>70.00</td>
<td>0.8</td>
<td>87.50</td>
<td>93.75</td>
<td>10.42</td>
</tr>
</tbody>
</table>

Average standardized bid 104.17

*Source: Author’s example.*

### TABLE 5. Example: How the Government Contribution Varies with the Enrollee’s Risk Score

<table>
<thead>
<tr>
<th>Enrollee Risk Score</th>
<th>Risk-Adjusted Base Premium</th>
<th>Enrollee Base Contribution</th>
<th>Risk-Adjusted Government Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.5</td>
<td>$52.09</td>
<td>$10.42</td>
<td>$41.67</td>
</tr>
<tr>
<td>0.8</td>
<td>83.33</td>
<td>10.42</td>
<td>72.91</td>
</tr>
<tr>
<td>1.0</td>
<td>104.17</td>
<td>10.42</td>
<td>93.75</td>
</tr>
<tr>
<td>1.2</td>
<td>125.00</td>
<td>10.42</td>
<td>114.58</td>
</tr>
<tr>
<td>1.5</td>
<td>156.26</td>
<td>10.42</td>
<td>145.84</td>
</tr>
</tbody>
</table>

*Source: Author’s example.*
in avoiding potentially expensive beneficiaries, but the premium charged by the plan relative to its risk-adjusted base premium (see table 6). The premium charged by Plan A in the example is higher than the base premium for the area, even when it is adjusted by the higher average risk score of Plan A’s enrollees. The $25.00 difference is borne by the enrollees in that plan, who presumably find some aspect of the services it offers or the way it offers them to be worth the additional payment. The total payment for each enrollee in Plan A, regardless of risk score, is equal to that difference plus the $10.42 base contribution, for a total of $35.42. By contrast, enrollees in Plan C would receive a rebate, because the difference between the actual premium for that plan and its risk-adjusted base premium is $13.33, which exceeds the $10.42 base contribution by $2.91.

### TABLE 6. Example: Government and Enrollee Payments to Each Plan

<table>
<thead>
<tr>
<th>Plan</th>
<th>Premium</th>
<th>Average Risk Score</th>
<th>Risk-Adjusted Base Premium</th>
<th>Average Government Contribution</th>
<th>Total Enrollee Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>$150.00</td>
<td>1.2</td>
<td>$125.00</td>
<td>$114.58</td>
<td>$35.42</td>
</tr>
<tr>
<td>B</td>
<td>100.00</td>
<td>1.0</td>
<td>104.17</td>
<td>93.75</td>
<td>6.25</td>
</tr>
<tr>
<td>C</td>
<td>70.00</td>
<td>0.8</td>
<td>83.33</td>
<td>72.91</td>
<td>(2.91)</td>
</tr>
</tbody>
</table>

*Source: Author’s example.*

Under this approach, the roles of the government, beneficiaries, and plans are clearly defined. The entire cost or benefit of the individual’s relative riskiness accrues to the government. The government’s contribution on behalf of a beneficiary is the same, regardless of the plan in which he or she enrolls. Each beneficiary bears the entire difference between the plan’s risk-adjusted base premium and actual premium, regardless of his or her health status. The beneficiary thus is responsible for choosing a plan. The plan bears the risk that individual enrollees will be more or less costly than anticipated, and it is responsible for managing enrollees’ care.

## CONCLUSIONS

Risk adjustment is an important and controversial part of the Medicare program. Although experience with it on a large scale is limited, HCFA’s analysis indicates that risk adjustment should improve the correspondence
between payment rates to each Medicare+Choice plan and the relative
costliness of its enrollees. Better techniques are being developed and bet-
ter data are expected to become available as the system evolves over the
next several years.

Risk adjustment promises to become substantially more important and
more controversial with increasing emphasis on competition as a method
of allocating Medicare’s resources. Under the current system, risk adjust-
ment would affect the amount that Medicare+Choice plans receive, but the
traditional Medicare program, which covers the vast majority of benefici-
aries, is unaffected. Under a competitive Medicare system such as that dis-
cussed by the Commission, an accurate risk-adjustment mechanism would
be essential. Without it, plans (such as traditional Medicare) that attracted
disabled or less healthy enrollees would be at a competitive disadvantage
and subject to financial losses, and beneficiaries who might be expected to
require more care would face higher premiums and severe access prob-
lems.

As this paper shows, the technical means exist to implement a risk-
adjustment mechanism in the context of a competitive Medicare system.
The real question is whether the available methodologies are adequate to
appropriately adjust plan payments and avoid the adverse incentives that
otherwise would result. HCFA just now is preparing to risk-adjust pay-
ment rates for the first time in a much more limited context, using an
approach that it intends to modify as it collects and examines additional
data, and with a four-year phase-in period. As the approach is imple-
mented and evaluated, we will learn much more about how well risk
adjustment works in a Medicare context.

As the future of Medicare is debated over the next several years, the
methodology of risk adjustment and the data needed to improve them will
receive increasing attention. The outcome of processes currently under
way will be crucial in determining our level of comfort with competitive
mechanisms and the ability to implement them appropriately.

NOTES

1. See Fuchs and Potetz (1999) for a review and discussion of the issues
   raised by the Commission’s discussions.
2. In 1995, 67 percent of individuals under age 65 had employer-based coverage, while only 7 percent had individual coverage. (The rest either were covered under a public program or were uninsured.) See Prospective Payment Assessment Commission (ProPAC) (1997), pp. 28–29.

3. Group policies tend to be experience rated, so miners cost more to insure than teachers, for example. The extent to which health insurance is risk adjusted in this way, however, is limited to differences across employee groups, and there generally is no adjustment for the risk presented by individuals within each group.

4. Throughout this paper, health status generally is used to refer to expected costliness of an individual or group to the plan. Thus, “sicker” refers to individuals with higher expected costs and “healthier” refers to individuals with lower expected costs.

5. In this context, the base premium is defined as the community-rated premium charged by the plan for its benefits package.

6. The risk-adjustment mechanism may take any of several forms, ranging from a tax/subsidy on plans to correct for risk selection to an explicit adjustment to the premium charged by each plan. See Luft (1995). The entity responsible for the mechanism can be private, quasi-public, or public, and the level of involvement of the affected plans in the entity may range from complete control to complete exclusion.

7. Risk adjustment can be applied either to a standard benefits package or to different benefits packages standardized by an index of actuarial value.

8. The premium was set equal to 95 percent of the adjusted average per capita cost (AAPCC), based on age, sex, and a few additional characteristics, but not health status. See Palsbo (1991).

9. Plans had other options as to what to do with the difference, but they were seldom, if ever, used. See Medicare Payment Advisory Commission (1998), chapter 4.
10. Although Medicare paid only 95 percent of the AAPCC, the expected costliness of risk plan enrollees was found to be less than that. See Brown et al. (1993).

11. This example takes the fact that the sickest Medicare beneficiaries are least likely to leave traditional fee-for-service coverage to its logical extreme. See HCFA (1998), p. 73. A more realistic analysis would assign continuous rather than discrete probabilities of enrollment to each group, but the underlying point is still the same: risk selection does not cease to be a concern as enrollment in the alternative plans increases.

12. See the discussion in HCFA (1999), chapter 1.

13. For a more complete description of this and alternative systems that were and are being considered, see HCFA (1999).

14. Newhouse (1998) suggests a partial capitation approach, under which the plan’s payments would be a blend of its premium with its actual per-enrollee costs. Other approaches include outlier payments, which would defray the risk of large financial losses on individual enrollees, and reinsurance, which would provide a means for protecting against transitory losses at the plan level.

15. The converse, of course, also is true: narrower coverage, fewer amenities, and less inefficiency would correspond to lower premiums.

16. This example resembles that used by Merlis (1999), but the approach described here differs from the alternatives presented in that report.

17. All of this information is either explicitly or implicitly taken into account in each plan’s decisions as to what benefits to offer, how much to charge, and whether to enter the market in the first place. The data would, of course, have to be subject to audit.

18. For simplicity of presentation, it is assumed in this example that the plans have equal projected enrollment and that all of their benefits packages are equal in actuarial value.
Projections of future insolvency make it necessary for the Medicare program to undergo fundamental reform, ideally before the baby boom generation begins to retire. A number of leading reform proposals would restructure Medicare in ways that increase the role of private health plans, managed care, and market competition. Advocates of a “managed competition” or “premium support” approach typically point to large employer-sponsored benefit programs as examples of the way their proposals would work in practice. The Federal Employees Health Benefits Program (FEHBP) is the most commonly cited example. One difficulty in interpreting the experience of the FEHBP and other similar programs is that the research (and anecdotes) about them is based exclusively on the behavior of nonelderly workers. Although that evidence is surely relevant to the Medicare reform debate, there are potentially important differences between active employees and (retired) Medicare beneficiaries. For one, as they are more likely to have strong ties to particular physicians, Medicare beneficiaries are likely to face higher switching costs and therefore may be less willing than younger workers to change health plans in response to small differences in premiums.

This paper provides evidence of the behavior of Medicare beneficiaries in a setting that closely resembles the premium support reform proposals. The data come from the health benefit program of the University of California (UC) and consist of the health plan choices made by both retirees and active employees over several years. I focus on three main aspects of the UC experience: the effect of price on plan choice and switching decisions; the incidence of premium contributions; and the issue of adverse selection. For each of these outcomes, I contrast results for UC retirees with those for active UC employees and, when possible, other nonelderly workers in similar settings.
The main finding is that although price does influence the health plan choices of UC retirees, the retirees are much less price sensitive than are active employees at the UC and elsewhere. That difference, which cannot be explained by differences in age alone, has implications for the other outcomes considered. Because the UC’s retirees have been less likely than active employees to switch plans rather than pay higher premium contributions, the adoption of a fixed premium contribution policy has led to a greater increase in out-of-pocket payments for the retirees. On a more positive note, the lower rate of price-induced plan switching among retirees has also meant that adverse risk selection has not been a problem in that population, whereas it has been among active employees.

THE UNIVERSITY OF CALIFORNIA HEALTH BENEFITS PROGRAM

In addition to its nine campuses, the UC manages three Department of Energy laboratories, two located in California and one in Los Alamos, New Mexico. The UC is the third-largest purchaser of health care in California; more than 90,000 active employees and 33,000 retirees from those locations are eligible for health benefits. Slightly more than half the retirees are Medicare beneficiaries or have a Medicare-covered spouse.

Until 1994, the UC’s premium contribution was based on a weighted average of the active employee premiums of the four plans with the highest enrollment. Because the group included the menu’s highest-cost (indemnity) plan, the UC contribution exceeded the premium of all the health maintenance organizations (HMOs). Thus, although there were differences in the gross premiums the HMOs charged to the UC, none required monthly premium payments from enrollees. The state fiscal crisis of the early 1990s led to major budget cuts at the UC. In an effort to reduce the cost of its health benefit program, the UC in 1994 adopted a fixed-dollar premium contribution policy. Under the new policy, the UC’s contribution is set equal to the active employee premium for the least-expensive plan available statewide. Enrollees choosing a more expensive plan pay the difference between the total premium for that plan and the UC contribution.

Active employees are offered a choice of health plans that includes a traditional indemnity plan, several HMOs, and a point-of-service (POS) plan.
plan, called UC-Care. The indemnity plan, Prudential High Option, has an individual (family) deductible of $200 ($400), a 10 percent coinsurance rate for a large network of providers, and a 20 percent coinsurance rate for out-of-network care. However, as will be detailed, virtually no active employees are enrolled in it because of prohibitive premium contributions. The HMOs provide a standard benefit package that includes copayments of $5 for office visits and prescription drugs. As is typical of POS plans, cost-sharing for UC-Care depends on the provider a patient chooses. For in-network providers, the plan resembles an HMO, with $10 copayments for office visits. Unlike HMO enrollees, however, UC-Care members can self-refer to nonnetwork providers, though they face higher out-of-pocket costs when they do so.

UC retirees choose from the same menu of plans as active employees. For retirees with Medicare, Prudential High Option provides Medigap coverage with a coordination-of-benefits design. The plan covers Medicare deductibles and coinsurance, leaving retirees with essentially no out-of-pocket costs for Medicare-covered services. The plan’s drug benefit has a $50 annual deductible and a 20 percent coinsurance rate. HMO benefits are identical for active employees and Medicare beneficiaries. UC-Care’s Medigap plan offers “carve-out” coverage, which is significantly less generous than that of Prudential High Option.

Because premiums for Medicare-eligible retirees represent either the cost of supplemental coverage or the incremental cost of HMO benefits beyond the standard Medicare risk plan, they are substantially lower than active employee premiums. Nonetheless, the UC contributes the same amount for retirees as it does for active employees. When that contribution exceeds the cost of a Medicare beneficiary’s chosen plan (as has always been the case for those in HMOs), the difference is applied to the beneficiary’s Medicare Part B premium.

**HOW REPRESENTATIVE ARE UC RETIREES?**

Although there are strong similarities between Medicare reform proposals based on the premium support model and the actual UC health benefits program, it is important to note that in several ways UC retirees are not representative of Medicare beneficiaries more generally. The differences should be kept in mind when considering what lessons the UC experience
has to offer. The most obvious thing is that UC retirees are highly educated. That, combined with the fact that the basic structure of the UC health benefits program has been in place for many years, means that UC retirees are probably better able than many current beneficiaries to play the role of the informed consumer that is central to the managed competition model.

Though no direct information is available on their income, because of their high levels of education and the fact that the University of California has a fairly generous pension plan, UC retirees are probably also more affluent than the average Medicare beneficiary. Indirect evidence of this comes from where they live. Using data from the 1990 census, I assigned to each UC retiree the 1989 per capita income for their ZIP code. For UC retirees living in California in 1992, the mean for this variable was 33 percent higher than the per capita income for the state as a whole ($21,975 vs. $16,409). Thus, the experience of UC retirees offers little insight on the important question of how lower-income beneficiaries would fare in a premium support environment.

Finally, UC retirees are similar to other Medicare beneficiaries in California—and hence different from the rest of the country—in the percentage enrolled in HMOs. In 1997, 46 percent of UC retirees living in California were enrolled in an HMO. More than 90 percent of the retirees live in one of 18 (noncontiguous) counties. In 1997, the HMO penetration rate for all Medicare beneficiaries in the counties was 42 percent. In contrast, just 13.5 percent of Medicare beneficiaries nationwide were in HMOs that same year. Thus, the UC experience is reflective of a mature managed care market and may be less relevant to other parts of the country in which managed care is less entrenched.

**THE EFFECT OF PRICE ON PLAN CHOICE AND SWITCHING BEHAVIOR**

A primary argument for the premium support approach is that it will create incentives for price-conscious plan choices by consumers. This, in turn, will lower system spending by shifting enrollment to less expensive plans and giving plans a greater incentive to compete on price. The recent experience of the active employee portion of the UC program provides support for this argument.
The change in the UC’s contribution policy between 1993 and 1994 caused premiums to increase for roughly a third of active employees. The price increases set off significant shifts in plan enrollment. Thirty percent of HMO enrollees facing premium increases of between $4 and $27 switched into less expensive plans. Half the Prudential High Option enrollees switched plans rather than make monthly contributions that increased between $52 (for single coverage) and $88 (for family coverage). In contrast, only 5 percent of employees in plans that remained free switched plans between 1993 and 1994.

In 1994, Health Net reduced its premiums by 7 percent to become the low-cost plan and, therefore, the basis of the UC contribution. That strategy paid off as Health Net’s UC enrollment increased by over 8,000 employee contracts (nearly 40 percent of its initial enrollment) between 1993 and 1994. In the following years, the other HMOs also lowered their premiums. In 1996, PacifiCare, a relative newcomer to the UC program, lowered its premiums 10 percent to displace Health Net as the low-cost statewide plan. Again, a large number of affected employees switched plans. Roughly one-quarter of Health Net enrollees switched into PacifiCare rather than pay monthly premium contributions of $6 to $20.

The combined effect of employees migrating from more expensive to less expensive plans and the reduction in HMO premiums was that the UC’s per-employee health care costs fell by 26 percent in real terms (Buchmueller 1998). Though the reduction in premiums partly reflects increased competition marketwide, the fact that HMO premiums fell more for the UC than for other payers in California suggests that the move to a fixed-dollar contribution policy induced participating plans to compete more aggressively on price within the UC program.

The adoption of the fixed-dollar contribution policy generated a similar pattern of price increases between 1993 and 1994 for Medicare-eligible retirees, though they responded differently than active employees. Less than 2 percent of California retirees enrolled in the Prudential Medigap plan left the plan when monthly contributions went from zero to $33 for single coverage and $62 for two-party coverage. Price increases were larger and plan switching more common for the Medigap plan offered at Los Alamos. There, 24 percent switched plans rather than pay monthly premiums that increased from zero to between $65 and $121 per month. The same HMOs that increased in price for active employees also
begun requiring monthly premium contributions of $22 to $57 for retirees. Retirees in those plans were more likely to switch than were those in HMOs that remained free, though the difference—6 percent vs. 2 percent—was much less pronounced than in the active employee population.

The contrast between active employees and retirees is illustrated in figure 1, which presents simulated switching rates for HMO enrollees in response to various increases in employee contributions. When HMO and indemnity enrollees are pooled, the difference between retirees and active employees is even more pronounced. However, focusing on HMO enrollees allows for a much cleaner comparison as the results are not confounded by differences in plan benefits or other unmeasured factors. To provide a sense of how differences between retirees and active employees are related to age, I present separate simulations for the following groups: active employees under age 35, active employees age 55 and over, retirees under age 73, and retirees age 73 and over.

Two main findings emerge from the simulations. First, holding price and other factors constant, there is a strong negative relationship between age and the probability of switching plans. This is seen by the differences in the intercepts for the four graphs. Younger employees are most

Figure 1. Differences in Probability of Switching Health Plans in Response to Change in Monthly Premiums for Active Employees and Retirees

Source: Author’s calculations from University of California Health Benefits Program data.
likely, and older retirees least likely, to switch plans when premiums are constant; the baseline switching rate for older employees (3.2 percent) lies roughly halfway between those for younger employees (5.9 percent) and younger retirees (0.8 percent). Second, age does not appear to be the primary reason for the difference in price sensitivity between active employees and retirees. The graphs for the two groups of active employees are essentially parallel; although there is a slight difference between the two groups of retirees, younger retirees look more like older retirees than like the workers who are approaching retirement age.

After 1994, the choice of plans offered at the New Mexico location was replaced with a single POS plan. In California, the retiree contribution for the Prudential Medigap plan increased by roughly 25 percent in each of the next three years. Figure 2 plots the trend along with the trend in Prudential’s market share from 1992 to 1998. The data show that the percentage of Medicare-eligible retirees fell 11 percentage points between 1992 and 1998. Using individual-level data for this period, I estimate regressions in which the dependent variable equals one for retirees choosing indemnity coverage. The regressions predict that a $10 increase in monthly premiums will cause the market share of the indemnity Medigap plan to fall by between 0.9 and 1.3 percentage points. Put in percentage

**Figure 2. Trends in Indemnity Medigap Retiree Premiums and Enrollment of UC Retirees, 1992–1998**

*Source: Author’s calculations from University of California Health Benefits Program data.*
terms, these results imply that a 10 percent increase in price reduces Medigap enrollment by between 1 and 2 percent (i.e., the price elasticity of demand is between 0.1 and 0.2, depending on the exact sample and specification).

Again, the price sensitivity of UC retirees can be put in perspective by comparing them to nonelderly workers in similar settings. Active UC employees are not a good comparison group when it comes to analyzing the demand for indemnity coverage. As will be discussed in more detail, the switch to a fixed-dollar contribution set off an adverse selection “death spiral” for Prudential in the active employee portion of the UC program. Employee premiums skyrocketed and enrollment among active employees plummeted. Three recent papers on the price sensitivity of active employees in other managed competition programs provide better points of comparison.

Dowd and Feldman (1994–95) use data from another mature managed care market, the Twin Cities of Minneapolis and St. Paul. Their results imply that a 10 percent increase in out-of-pocket premiums will reduce a health plan’s enrollment by between 5 and 10 percent. Royalty and Solomon (1999) analyze the health plan choices of Stanford University employees for the years 1993 to 1995. Not only are the time period and locations similar, but several health plans are offered at both universities. Their results imply that a 10 percent increase in out-of-pocket premiums will cause a plan’s enrollment to fall by between 4 and 8 percent. Finally, Cutler and Reber (1998) analyze the health plan choices of yet another academic population, the employees of Harvard University. Similar to the regressions for the UC retirees, they estimate the effect of price on the choice between a preferred provider organization (PPO) plan and several HMO options. In their data, a 10 percent increase in price corresponds to an enrollment decline of between 3 and 6 percent.

Thus, it appears again that Medicare beneficiaries are less price sensitive than nonelderly workers facing similar choices and similar prices. The policy implications of this result depend on how similar UC retirees are to Medicare beneficiaries elsewhere and how similar a transformed Medicare would be to the current UC program. On one hand, there are reasons to suspect that were Medicare made to look just like the UC program, the average price sensitivity of all beneficiaries would be higher than that of the UC retirees. First, even before UC retirees were required
to pay monthly premiums for indemnity Medigap coverage, the percentage of retirees in HMOs was quite high. Thus, it may be that by the time price became an issue the most price sensitive retirees were already in HMOs, while those remaining in the indemnity plans were individuals with a strong aversion to managed care. Price sensitivity may be greater in a less “saturated” market. Of course, this explanation does not account for the low degree of price sensitivity among UC retirees enrolled in HMOs.

A second alternative explanation, which would also apply to the demand for HMO coverage, is that the low price sensitivity of UC retirees is due to their relative affluence. Lower-income beneficiaries may be more likely to switch HMOs to avoid out-of-pocket premiums, even if it means switching providers and/or bearing other nonpecuniary costs. Indeed, it is a common perception that Medicare risk HMOs are most popular among seniors of moderate means who do not have retiree health benefits and who find individually purchased Medigap coverage to be prohibitively expensive. To the extent that price sensitivity does fall as beneficiary income rises, policymakers face a tradeoff between two important objectives: generating price-elastic demand to discipline participating health plans, and limiting the exposure of lower-income beneficiaries to out-of-pocket premiums.

On the other hand, certain design aspects of the UC program are known to increase consumer price sensitivity but will not necessarily be incorporated into a reformed Medicare. One example is standardized HMO benefits, which are a feature of some premium support proposals but not others. The more benefits vary across plans, the harder it will be for beneficiaries to make meaningful price comparisons. Similarly, there is a high degree of overlap in the provider panels of the HMOs offered at the UC, though this will not necessarily be the case in other markets. Like standardized benefits, overlapping panels heighten the salience of price in beneficiaries’ comparisons of competing HMOs. Finally, it is important to point out that the question of how price sensitive Medicare beneficiaries might be is relevant only for geographic areas with sufficient population density to support multiple competing health plans in the first place.
THE INCIDENCE OF PREMIUM CONTRIBUTIONS

A key issue pertaining to any Medicare reform proposal is its impact on beneficiaries’ out-of-pocket expenditures. The experience of the UC program in the years since it adopted a fixed-dollar contribution policy provides some sense of the way, in a premium support setting, the distribution of beneficiary premium payments is related to the degree of consumer price sensitivity. (Unfortunately, as there is no information on retiree income in the UC database, important questions of the way the burden of premium payments is distributed across different income groups cannot be addressed here.)

Because many UC employees were willing to switch plans rather than pay even modest premium contributions, the fixed-dollar contribution policy has had a relatively minor impact on employee premium payments. In 1993, before the change in the contribution policy, the mean premium contribution paid by UC employees was $11.61 per month; the median contribution was zero, as 90 percent of employees were in plans requiring no contribution. In 1998, the mean employee contribution was $10.49, though this figure is slightly misleading as it is affected by a small number of Prudential enrollees paying extremely high contributions. The median employee contribution in 1998 was $1.60; 40 percent of active employees were in free plans, and three-quarters were paying $5 or less per month for their insurance. Thus, while the new contribution policy had the potential to shift premium expenditures from the UC to employees, that has not occurred.

Most retirees with Medicare are also paying very little for their coverage, though this is mainly a result both of the UC’s contribution being set so high relative to Medicare HMO premiums and of changes in the menu of plans. Because of mergers, those HMOs that required premium contributions from retirees in the mid-1990s are no longer on the menu. The HMOs that remain all have premiums that are substantially below the UC contribution, so their Medicare enrollees do not even have to pay their Part B premiums. Between 1993 and 1998, the percentage of Medicare-eligible retirees choosing UC-Care increased from about 1 percent to just over 6 percent. In 1998, those individuals were paying a small portion ($3 to $5) of their Part B premiums. Overall, roughly half of UC retirees with Medicare were paying $5 or less per month in premium contributions. As
shown in figure 2, the situation has been different for the retirees who maintained indemnity coverage. Between 1993 and 1995, Prudential’s gross Medigap premium actually fell, but because the UC contribution fell even more, retiree contributions increased. In 1995, Prudential enrollees with Medicare were paying nearly all of their Part B premium, and the next year they were paying their Part B premium plus an additional $11 per beneficiary per month to Prudential. By 1998, the total monthly contributions for Prudential’s Medigap plan (inclusive of Part B premiums) were $87 for single coverage and $166 for couples.

**THE EFFECT OF PLAN SWITCHING ON RISK SELECTION AMONG PLANS**

Another significant concern with premium support Medicare proposals, and competition-based strategies more generally, has to do with the potential for adverse risk selection. The fear is that without an effective risk adjustment mechanism, plans that are more attractive to higher-risk beneficiaries will be at a significant disadvantage. In the extreme, adverse risk selection may lead to a death spiral that ultimately drives such plans from the market. That possibility blunts incentives for plans to compete on quality or to enhance services in ways that benefit high utilizers of medical care. In a multiple-option setting, policies that tie the sponsor’s contribution to the premium of lower-cost plans have the potential to exacerbate the risk selection problem. The experience of the UC program for both active employees and retirees provides useful, if somewhat mixed, evidence on the issue.

As noted, active-employee enrollment in the Prudential indemnity plan was cut in half after the employee contributions required for that plan increased in 1994. Because employees switching out of Prudential were younger and healthier on average than those who remained, the action set off an adverse selection spiral. The left panel of table 1 documents the dynamic. Although gross premiums for the Prudential plan remained constant between 1992 and 1995, because the UC contribution was falling, the net cost of Prudential to employees more than doubled over this period, causing the plan’s enrollment to fall by 61 percent.10 Prudential’s gross premiums increased substantially in each of the next three years, inducing a further decline in enrollment. By 1998, only 136 active employees were

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Because employees switching out of Prudential were younger and healthier on average than those who remained, the action set off an adverse selection spiral.
still in Prudential, and they were paying monthly contributions of between $744 (for single coverage) and $1,760 (for family coverage).

Between 1993 and 1998, the difference in mean age between Prudential enrollees and other UC employees increased from 4.6 years (44.4 vs. 39.8) to 11.6 years (53.3 vs. 41.7); in percentage terms, Prudential enrollees went from being 12 percent older than other UC employees to being 28 percent older. Additional data on hospitalization and cancer rates provide further evidence of the adverse selection against Prudential within the UC program. In 1993, adults enrolled in Prudential (employees and spouses) were 46 percent more likely to have been hospitalized in the 22 months before open enrollment than were adults in the other UC plans. By 1996 (the latest year for which the discharge data are available), the difference was 122 percent. The differentials are smaller, though still statistically significant when controlling for age and sex. The cancer data paint a similar picture. In 1993, Prudential enrollees were a little more than twice as likely to have been recently diagnosed with cancer. By 1996 (the most recent data available), the cancer rate for active employees (and their spouses) in Prudential was nearly three times the rate for the other plans.

Prudential’s experience within the UC risk pool is not unique. Cutler and Zeckhauser (1998) describe how a similar scenario unfolded at
Harvard University, which also adopted a fixed-dollar contribution policy in the mid-1990s. As in the UC case, a decline in the university’s contribution caused employee contributions for PPO coverage to increase even though gross PPO premiums did not increase. Employees who switched out of the plan were younger and healthier than those who remained, and within three years the PPO was driven from the Harvard menu.

Another similar example is the Health Insurance Plan of California (HIPC), a state-sponsored purchasing cooperative for small employers established in 1993. The HIPC, which has a managed competition structure similar to that of the UC program, incorporates several additional safeguards against adverse selection. Inasmuch as premiums are allowed to vary by seven age categories, plans are not penalized for attracting older enrollees. Also, since 1995 the HIPC has used a risk adjustment mechanism that incorporates data on costly health conditions to redistribute funds among plans. In spite of these protections, all the PPOs that were initially in the HIPC have quit because of adverse risk selection (Yegian et al. 1998).

Because there was much less plan switching among UC retirees, the distribution of risk across plans has been more stable for that population. As shown in the right panel of table 1, even before there were price differences between the retiree plans, the average age of retirees in the indemnity Medigap plan was 5 percent higher than that for the entire pool of retirees with Medicare. In the years following the introduction of the fixed-dollar contribution, this differential increased, but only slightly, to 7 percent.

The hospitalization and cancer data also suggest that if the Prudential Medigap risk pool worsened in the years following the change in the contribution policy, the change was minimal. Controlling for age, the percentage of retirees and retiree spouses hospitalized in the 22 months before open enrollment is slightly (2 percent) but significantly higher for Prudential than for the other plans. This is consistent with the conventional wisdom that Medicare beneficiaries selecting into HMOs are healthier on average than those remaining in the fee-for-service sector (and perhaps also reflects an effect of HMO coverage on hospital admissions). However, the differential did not change significantly in the years following the increase in Prudential’s retiree contributions. No significant
difference occurred in cancer rates between retirees (and spouses) in Prudential and the other plans during the period analyzed.

**DISCUSSION**

Although controlling the growth in program expenditures is not the only goal of competing Medicare reform proposals, given the impending funding crisis, it is arguably the most important one. The premium support model offers an attractive approach to the cost control problem, which essentially is to harness the incentives of market competition to promote efficiency. The experience of large employer-sponsored health benefits programs suggests that the strategy can be effective. However, a key question that has been largely left unaddressed is how well that evidence translates to the Medicare program. If Medicare beneficiaries are significantly less price sensitive than active employees (say, because they face higher switching costs), the expected expenditure savings and efficiency gains of moving to a competition-based system may not be fully realized and, in fact, may be less than the additional administrative and regulatory costs required to manage competition.

The results of this paper suggest that Medicare beneficiaries are, in fact, significantly less price sensitive than nonelderly workers. The precise implications of this result for premium support Medicare proposals are not clear, however. First, it is not known exactly how sensitive consumers must be on average to induce the type of price competition and cost control envisioned by premium support advocates. It may be that although price matters less to retirees than to younger consumers, it matters enough to generate the desired incentive effects. Second, the behavior of Medicare beneficiaries in a premium support setting will likely vary across different socioeconomic groups and geographic areas, and will depend on the exact way that the premium support model is implemented. There is reason to suspect that the plan choice decisions of less affluent beneficiaries will be more strongly influenced by price. At the same time, a reformed Medicare may differ from the UC program in ways that lessen the importance of financial incentives. With these caveats in mind, an important implication of the UC experience is that caution should be taken in basing assumptions about Medicare beneficiaries on what we know (and think we know) about the behavior of nonelderly workers.
However representative UC retirees are, comparisons between them and their active-employee counterparts do shed some light on the relationship between consumer price sensitivity on two other important issues related to premium support plans: the distribution of out-of-pocket premiums and the potential for biased risk selection. Where consumers are quite price sensitive, like active UC employees, the adoption of a fixed-dollar contribution need not dramatically alter the distribution of premium payments. Plans with substantially higher premiums will simply not enroll many beneficiaries. In contrast, when consumers are less price sensitive, as in the case of UC retirees, a fixed-dollar contribution combined with large differences across plans in gross premiums will produce large differences in what enrollees pay. The policy implications of these differences will depend on who is paying what and the extent to which lower- and higher-cost plans are providing different standards of care.

The contrast between active UC employees and their retired counterparts also suggests a positive relationship between the degree of price sensitivity on the part of consumers and the potential for biased risk selection. When price-induced switching is uncommon (as was the case for UC retirees), changes in the risk composition of competing plans will be gradual, leading to greater market stability. However, if switching is more common and there are large differences in the price elasticity of demand for low-risk and high-risk consumers, then biased risk selection becomes a problem. The experience of the UC and other similar programs suggests that under such circumstances plans that offer enrollees greater freedom to choose their own providers will be at a distinct competitive disadvantage and ultimately may be driven from the market.

NOTES

1. This research was supported by grant number 030561 from The Robert Wood Johnson Foundation’s Changes in Health Care Financing and Organizations Program. The opinions expressed are those of the author and do not necessarily represent the views of The Robert Wood Johnson Foundation. The author wishes to thank Judy Boyette and Michelle French of the University of California Human Resource and Benefits Department for their helpful comments and suggestions.
2. Just having retiree health benefits is positively correlated with income. Data from the 1993 Medicare Current Beneficiary Survey presented by Gross et al. (1999) indicate that 78 percent of beneficiaries with retiree benefits had incomes exceeding 200 percent of the poverty level, compared with only 55 percent of those without insurance through a former employer.

3. Figures for median household income present a similar, though somewhat less pronounced, contrast. In 1992, the mean UC retiree living in California was in a zip code with a median household income of $41,834; the median value of the variable among UC retirees is $39,225. The figures are 17 percent and 10 percent higher than the median household income for the state ($35,798).

4. Figures on Medicare HMO penetration are from the Health Care Financing Administration (HCFA) public use data files available on the HCFA Web site.

5. See Buchmueller and Feldstein (1997) for more details.

6. The simulations are based on probit regressions in which the decision to switch plans during open enrollment is modeled as a function of the change in price for a person’s original plan, and a set of demographic and geographic control variables. See Buchmueller and Feldstein (1997) and Buchmueller (1999) for details on the regression specifications and full results.

7. When Prudential enrollees are excluded, the mean contribution for active UC employees is $8.66 per month.

8. It is important to note that premium payments are an imperfect index of employee well-being. For example, most UC employees who were in Prudential in 1993 are now in UC-Care, the POS plan. Although their premium contributions were lower in 1998 than five years earlier, their choice of providers has been restricted. It is likely that many of these individuals feel themselves worse off as a result.

9. Because UC-Care’s Medigap coverage is less comprehensive than Prudential’s, individuals who switched from the latter to the former are
now facing higher cost-sharing at the time they receive care. Sufficient data are not available for estimating the magnitude of this change.

10. Prudential’s experience underscores the potential volatility of managed competition. Because it is relative premiums faced by enrollees, rather than absolute premiums charged by plans, that determines enrollment patterns, plans that keep premium increases to a minimum may still lose market share (and suffer adverse selection) if new entrants come in with even lower prices.

11. The cancer data are from the California Cancer Registry (CCR) and the hospitalization data from the California Office of Statewide Health Planning and Development (OSHPD). Both sources were merged with the UC data by researchers at the CCR.
Appendix
Appendix:  
The Breaux-Thomas Proposal¹  
Beth C. Fuchs and Lisa Potetz

The National Bipartisan Commission on the Future of Medicare (hereinafter referred to as the Commission) held its last meeting on March 16, 1999. By a vote of 10 to 7, the Commission failed to achieve the 11-member supermajority required by law to report a recommendation to Congress. A proposal sponsored by the two Commission chairmen, Senator John Breaux and Representative Bill Thomas, was the only one voted on by the Commission. A description and brief analysis of the proposal is provided below. This appendix is organized similarly to the text of the report and uses concepts that are explained in the text. Senator Breaux and Representative Thomas have indicated that they will soon be introducing legislation incorporating their proposal. This will provide them with an opportunity to flesh out the details and respond to some of the questions that have been raised.

OVERVIEW

The proposal calls for restructuring Medicare along the lines of a premium support model. The federal government would pay part of the premium for an approved health plan selected by the beneficiary. Traditional Medicare would be offered as the “government-run, fee-for-service plan” and would compete for enrollment of Medicare beneficiaries with private-plan options. (It is referred to as traditional Medicare hereafter.)

This system of premium support would be administered by a newly established Medicare Board (hereafter referred to as the Board). Cost estimates of the proposal assume that it would be enacted in 1999 and that the premium support system would be fully operational in 2003. The proposal also calls for immediate changes to traditional Medicare, as described below. Transition rules are not specified (other than for the low-income prescription drug coverage).
ELIGIBILITY AND BENEFITS

The proposal would phase in a change in eligibility from 65 to 67 consistent with that of Social Security. In general, individuals ages 65 to 67 could buy into Medicare on a nonsubsidized basis. Individuals with special needs, such as those unable to work and otherwise get health insurance, could obtain an exemption and become eligible for Medicare at age 65.

Both traditional Medicare and private-plan options would have to provide a standard benefit package that would be specified in law. This package would consist of the services currently covered under traditional Medicare, although plans would be able to vary benefits within a limited range, perhaps no more than 10 percent of the actuarial value of the standard package. The Board would be required to ensure that the overall value of the package was consistent with statutory objectives and that benefit variation would not lead to selection problems. Private plans could employ any delivery system (e.g., health maintenance organization [HMO], preferred provider organization [PPO], fee-for-service, etc.) that is consistent with the benefit package requirements.

The benefit package required under traditional Medicare would be modified. The Part A and Part B deductibles would be dropped and replaced with a $400 combined deductible. A coinsurance amount of 10 percent would be charged for home health and laboratory services. No coinsurance would apply for inpatient hospital care and preventive services. The 20 percent or higher coinsurance associated with other services would remain in place.

Private plans would be required to offer a high-option benefit package including at least Medicare-covered services plus coverage for outpatient prescription drugs and stop-loss protection. Copayments and deductibles could vary. Minimum drug benefits for high-option plans “would be based on an actuarial valuation.” It is unclear whether a private plan could elect to offer only a high-option policy and not a standard-option one. No further specifications are provided regarding the stop-loss coverage.

Traditional Medicare would be required to offer a high-option plan and a standard-option plan. Government contracts for the prescription drug coverage “would be based on prices commonly available in the market, without recourse to price controls or rebates.” As described below
(“Vulnerable Populations”), assistance would be provided to low-income beneficiaries in buying high-option plans.

Benefits would be updated through an annual negotiation process between plans and the Board. The Board could not require new standard benefits without congressional approval. Both the standard-option and high-option plans offered by private plans and traditional Medicare would have to be self-funded and self-sustaining. Only standard benefits would be used to determine the government contribution.

Under the proposal, the National Association of Insurance Commissioners (NAIC) would be directed to develop new Medigap state model legislation immediately. All private supplemental plans sold as Medigap policies would have to include “basic” coverage for prescription drugs. One plan would be a prescription drug-only plan. The NAIC would also be directed to “achieve more affordable and efficient supplemental insurance and to minimize Medicare outlays.” Medigap policies would be able to insure Medicare cost-sharing amounts.

**Discussion**

**Age of Eligibility**

According to Commission estimates, phasing in an increased age of eligibility consistent with Social Security would result in an estimated $11 billion in savings for 2000–2009 and significantly more in later years. The general arguments for and against raising the age of Medicare eligibility are presented elsewhere. An overriding concern is whether people ages 65 to 67 would be able to obtain adequate health insurance at an affordable price while they are waiting to become eligible for Medicare. The Breaux-Thomas proposal responds to this concern in two ways.

In the first instance, individuals could buy into Medicare at their own expense. Presumably this means that they could elect traditional Medicare or any private-plan option available in their area. An issue that would have to be resolved is whether the premiums to buy into Medicare would be community-rated (priced based on Medicare’s population as a whole) or priced based on the experience of that pool of individuals. If experience-rated, the premium may be higher because only those individuals who could not obtain a less costly policy in the private-market plan would want to buy into Medicare.
Under the second part of this proposal, individuals with special needs, such as those unable to work and otherwise get health insurance, could become exempt from the increased Medicare eligibility age. The exemption would be based on specific needs-based criteria, such as selected activities of daily living. The mechanics of this process are not specified.

**Benefit Package**

Under the proposal, private health plans would have to offer a benefit package consisting of existing Medicare services (as modified by this proposal) or a modification of such package that does not vary more than 10 percent in actuarial value. (The 10 percent is used as an example but, according to the Health Care Financing Administration [HCFA] actuaries, any variation could produce a higher cost to the government for its amount of the premium.) Managed care plans might find this benefit requirement difficult to meet since many do not employ deductibles or coinsurance for most benefits. Much of the 10 percent variation in actuarial value could be consumed by reducing or eliminating the cost-sharing. Also, while the 10 percent limit on variation might encourage plans to increase the generosity of their benefit package, it could also be read to allow plans to offer benefits that are 10 percent less generous than the traditional Medicare benefit package, an option that a plan might elect in order to offer a more competitive premium.

The requirement on traditional Medicare and private plans to offer a high-option benefit package is intended to expand the availability of insurance coverage for outpatient prescription drugs and provide stop-loss protection. It would enable beneficiaries who want to remain in traditional Medicare to elect a government-sponsored, outpatient prescription drug benefit. Whether the resulting benefit would be adequate or affordable is unknown, because the proposal provides little detail. It states that HCFA would be prohibited from imposing price controls or rebates, but it does not address whether HCFA’s contractors could negotiate volume discounts, use formularies, and other cost-containment tools. A related issue is the extent to which such coverage would be more or less expensive than the coverage offered by Medigap carriers. The proposal also implies that variation in the drug benefit would be permitted. To what extent could this create selection bias? Another issue needing clarification is whether high-
option plans could offer additional benefits, such as vision and dental coverage, and whether such benefits could affect risk selection.

The proposal’s requirement that all Medigap plans include basic coverage for prescription drugs raises several issues. Today, three of the standard Medigap policy types (H, I, and J) include coverage of outpatient prescription drugs. The price of such policies can be as high as $3,200 a year (Soumerai 1999). Less than one-third of beneficiaries with individually purchased Medigap coverage have coverage for prescription drugs (Davis et al. 1999), in part because such coverage is so expensive. Adding prescription drug coverage to the other Medigap plans would drive up their costs, pricing many beneficiaries out of the market. Beneficiaries seeking lower-cost options might find a Medigap plan offering only prescription drug coverage to be attractive. Another complication is that if existing Medigap policyholders were charged for the added drug coverage, they might be unwilling or unable to pay the additional premiums. If it was required that carriers offer prescription drug coverage only to new policyholders, rates for the “grandfathered” policies would rise as the pool aged with no healthier beneficiaries entering the pool.

Finally, it is not clear what is intended by the proposal’s requirement that both private plans and traditional Medicare be self-funded and self-sustaining. One interpretation is that plans would not be allowed to cross-subsidize their Medicare policies with funds from other product lines in order to drive out the competition. Traditional Medicare would have to sustain both the standard-option and high-option plans independently, funded by beneficiary premiums and government contributions. Details are not provided on what would happen in the event of annual overspending, since Medicare has no reserves.

**STRUCTURE OF THE PROGRAM**

A Medicare Board would be established to administer the new premium support system. It would operate under a government charter describing its responsibilities and standards. It would be given the ability to hire staff without regard to civil service requirements and salary restrictions. The Board would have the authority to:

- Direct and oversee periodic open enrollment periods;
• Provide comparative information to beneficiaries regarding the plans in their areas;

• Transmit information about plan selections and corresponding premium obligations to the Social Security Administration to permit premium collection as occurs today with Medicare Part B premiums;

• Enforce financial and quality standards;

• Review and approve benefit packages and service areas to ensure against the adverse selection that could be created through benefit design; delineation of service areas, or other techniques;\(^5\)

• Negotiate premiums with health plans; and

• Compute payments to plans (including geographic and risk adjustments) (Commission 1999a).

Discussion

No additional information is provided on the Board. The manner of its selection, its membership, and the other questions raised in the text of this paper (see “Managing the Competition”) are not specified. Perhaps most significant is the issue of accountability. Would its members be unelected officials? To whom would they be accountable? Would there be a process for appealing Board decisions? Also unclear are the extent to which the Board would manage traditional Medicare and its relationship to HCFA, the Department of Health and Human Services, and the White House.

Details on how plan standards would be enforced are not provided. The only guidance given is that “[h]ealth plans would establish rules and procedures to assure delivery of benefits in a manner consistent with prevailing private standards and procedures offered to employer groups and other purchasers.” Again, the Board would be charged with enforcing quality standards and monitoring performance capacity.

COST CONTAINMENT

Under the Breaux-Thomas proposal, traditional Medicare would be allowed to implement certain cost-containment measures. The provisions of the Balanced Budget Act of 1997 (BBA) would be extended or compa-
rable savings achieved. Also, “in any region where the price control structure of the government-run, fee-for-service plan is not competitive, [the plan] could operate on the basis of contracts negotiated with local providers on price and performance, just as is the case with private plans. . . . The Board should have powers to assure that the government-run plan would not distort local markets.” No additional details are provided.

**Discussion**

It seems reasonable to assume that what is envisioned in areas in which traditional Medicare is not competitive is to allow traditional Medicare to engage in activities such as selective contracting. Restricting modernization of traditional Medicare to these areas reflects a concern that if Medicare dominates the market in the area and is allowed to select providers and negotiate discounts through PPO-like arrangements, then providers that are turned away will be forced out of business. The proposal relies on the Board to prevent such results, but one question is whether the Board could make fair and timely determinations about whether traditional Medicare is distorting a local market. Would there be any avenue of appeal of the Board’s decision by affected stakeholders? What would happen if an area becomes noncompetitive because plans leave the area?

**STRUCTURING THE COMPETITION**

As discussed in the text of this report, the premium support approach is based on the idea that competition can be structured to ensure that health plans compete for enrollment on the basis of price and quality and not on risk selection. The Breaux-Thomas proposal describes a premium support system in which the government would contribute 88 percent of the premium of the average-cost health plan.\(^6\) Beneficiaries would be responsible for the remaining amount. Low-income beneficiaries would receive greater government assistance in purchasing coverage, as described below.

**Setting the Government Contribution**

Traditional Medicare would “bid” a *national* premium based on its projected claims costs for the *standard-option* plan. The private health plans would bid their premiums presumably based on rules similar to those described below (see “Adjustments for Risk and Geography”).
In general, the government contribution would be set to equal 88 percent of the national weighted average plan price for standard-option plans. For plans with premiums that do not exceed 85 percent of the national weighted average plan price, there would be no additional cost to the beneficiary (i.e., there would be a zero-dollar premium). For plans between 85 percent and 100 percent of the average weighted premium, the government would pay part of that portion of the premium between 85 percent and 100 percent and the beneficiary would pay the remainder. For plans with prices above 100 percent of the national weighted average, beneficiaries would pay the full cost of any amount in excess of the national weighted average premium. In other words, the government would pay exactly 88 percent of the national weighted average bid for these high-priced plans. This is illustrated in the table below and assumes no risk or geographic adjustments.

The government’s contribution would change each year consistent with the change in the weighted average premium. For example, if the weighted average premium increased in the second year by 5 percent, so too would the government’s contribution. Therefore, government cost increases would become more and more a function of plan bidding as private plan enrollment grew.

Only the cost of the standard package (plus the allowed 10 percent variation of that package) would count toward the computation of the national weighted average premium. Traditional Medicare and private plans with a high option would separately identify the incremental costs of benefits beyond the standard package in their submissions to the Board, and the government contribution would be calculated without regard to the costs of these additional benefits. In addition, the premium for traditional Medicare would not include the costs of Medicare’s other missions (referred to as its “non-insurance functions and special payments”), such as subsidies for graduate medical education, disproportionate share hospitals, and rural providers.

The contribution amount paid to the plans (private and traditional Medicare) by the government would be adjusted for geography and beneficiary risk factors, including health status.

Adjustments for Geography and Risk

The March 16th Commission document describing the proposal does not
TABLE. 1 Illustration of Premium Support under the Breaux-Thomas Proposal

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<td>104</td>
<td>4,998</td>
<td>902</td>
<td>85</td>
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<tr>
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<tr>
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<tr>
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<td>4,998</td>
<td>1,502</td>
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Source: Letter to members of the National Bipartisan Commission on the Future of Medicare from Senator John Breaux. Includes staff estimate of Breaux proposal. February 17, 1999. Schedule 2. These amounts are purely illustrative and do not reflect geographic or risk adjustments. In this table, it is assumed that a $1.00 government contribution is made for every $3.00 increase in premiums between 85 percent and 100 percent of the national weighted average premium.

detail the process for adjusting the government contribution for geographic and risk variations. Earlier drafts, however, revealed a process that might work as follows:

- Plans would be required to bid a premium based on local costs.

- The government would then adjust each plan’s premium to correspond to what would be charged for a nationally representative population.

- The resulting adjusted amount would be used to establish bids among plans that were comparable, regardless of whether the plan’s service area was local or national.

- The plan’s adjusted bid would, in turn, determine what the beneficiary paid. Depending on how the adjustment was structured, this would reduce the extent to which the beneficiary’s premium payment was affected by local price and utilization variations.
The government’s payment to the plan would then be based on the amount that the plan actually bid to reflect its local costs. For example, the government’s payment might reflect a payment that is based on a blend of 75 percent of local area costs and 25 percent of national costs.

The government’s payment to traditional Medicare and the private plans would further be adjusted for the risk profile of the plan’s enrollees. Assuming that the risk adjustment would be the same as used for Medicare+Choice, payments would be adjusted for beneficiary demographics (age, gender, Medicaid status, etc.) as well as health status.

Vulnerable Populations

Coverage for low-income beneficiaries would be provided through high-option plans. The federal government would pay 100 percent of the premiums for those high-option plans at or below 85 percent of the national weighted average premium of all high-option plans for those eligible individuals up to 135 percent of the federal poverty level (FPL) ($10,568 for an individual and $13,334 for a couple). In areas where all high-option plans cost more than this threshold, the percentage would be determined locally to ensure that all low-income beneficiaries had access to high-option plans.

States would maintain their current level of effort, but the federal government would pay 100 percent of the costs of covering individuals not already on Medicaid. In other words, if state Medicaid dollars were currently paying Medicare cost-sharing and premiums as well as any Medicaid benefits (such as prescription drug coverage) for these individuals, such funding would be expected to be continued. Newly covered beneficiaries would be funded entirely out of federal funds. How this would work over time is not specified.

Areas of Limited Competition

In areas of no competition (presumably meaning the absence of any private plan), beneficiaries’ obligations would be no greater than 12 percent of the premium for traditional Medicare or the national weighted average, whichever was lower. Presumably, if a private plan entered the local market, the normal beneficiary contribution requirements would
apply. The Board would periodically review the situation to ensure that premiums are not anticompetitive.

**Discussion**

**Setting the Government Contribution**

The Breaux-Thomas proposal is designed to provide strong incentives for the beneficiary to elect plans with premiums at or below 85 percent of the national weighted average. As shown in the table, beneficiary liability would rise as plan premiums exceeded the 85 percent threshold. The extent to which beneficiaries would have a choice of plans with zero premiums or low-cost premiums would depend on the operation of the payment adjusters for risk and geography. For example, and depending on how the geographic adjustment worked, a plan of average efficiency in a high-cost area might find it possible to bid a premium at 85 percent of the national weighted average price because it would know that its geographic-adjusted government contribution would be adjusted upward to reflect local costs. In contrast, a plan of average efficiency in a low-cost area might not be able to bid such a premium because the geographic adjustment would result in payments below those needed to meet its costs. It is also important to note that the cost of traditional Medicare is likely to be above the weighted average premium. If that occurs, beneficiaries wishing to select that option will have to pay more than 12 percent of the premium.

**Vulnerable Populations**

As noted above, the government would be paying the full cost of the premium for eligible beneficiaries for high-option plans costing up to 85 percent of the national weighted average premium for high-option plans. If a plan was not available at or below that price, the proposal says that an amount would be calculated locally to guarantee that whatever high-option private plans were available in the area, qualified beneficiaries would have access to those plans. No further elaboration is provided on this point, but presumably it means that the government would pay 100 percent of whatever was the lowest-cost qualified high-option plan in the area, which may or may not be traditional Medicare. Accordingly, low-income beneficiaries could find their plan options restricted.
To obtain the federal subsidy for high-option plans, beneficiaries would have to qualify through their state Medicaid programs. The Commission staff estimated that 60 percent of those eligible would actually become qualified. The “take-up rate” is hard to predict. Under current law, a smaller fraction of beneficiaries who are eligible for the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and Qualified Individuals (QI) programs actually sign up. Studies have shown that this results in part because many low-income beneficiaries are unaware of the program. It also may be due to the resistance by individuals to the welfare stigma associated with Medicaid. Under the Breaux-Thomas proposal, however, states may have a greater financial incentive to sign up beneficiaries. In any event, the Commission staff estimated that the proposal would help an estimated 3 million low-income beneficiaries obtain prescription drug coverage. What is not clear from the proposal, however, is the extent to which such beneficiaries would have to pay out-of-pocket for any cost-sharing charged by the plan for drug coverage or other services.

*Treatment of Areas of Limited Competition*

As stated in the proposal, beneficiaries living in areas in which there are no private-plan options would always be able to buy traditional Medicare, paying out-of-pocket the lesser of 12 percent of the traditional Medicare premium or 12 percent of the weighted average premium. This should provide reasonable financial protection to beneficiaries over the short term. Over the long term, however, the proposal sets up the possibility that beneficiaries could experience significant “rate shock“ with the entry into their area of one or more private-plan options.

**MEDICARE’S OTHER MISSIONS**

As noted above, the Breaux-Thomas proposal states that the costs of Graduate Medical Education (GME), Disproportionate Share Hospital (DSH), and rural health subsidies would be taken out of the calculation of the premium for traditional Medicare. It leaves for future consideration how such missions should be treated under Medicare reform. The decision to remove these costs from the premium for traditional Medicare would bring down its cost and place it on a more level playing field with private plans.
FINANCING AND FISCAL VIABILITY

The Breaux-Thomas proposal would improve Medicare’s financial picture through a variety of methods, but the long-term fiscal viability of the program is left uncertain. The paper describing the final version of the proposal states that even if the premium support plan achieves the significant slow-down in Medicare spending growth envisioned by the proposal’s authors, additional revenue will be needed to pay for the Medicare program. The source of that revenue is left unspecified in the proposal.

The HCFA actuaries scored earlier versions of the Breaux-Thomas proposal in which long-term Medicare spending (through 2030) would be reduced by about 10 percent. Under the actuaries’ estimates, the greatest savings (a reduction of 3.1 percent) would come from income-relating Medicare premiums, a feature that was dropped in the final proposal. Premium support was estimated to reduce spending by 2–3 percent, about the same amount as extending the BBA cost-containment provisions and “modernizing” cost containment for traditional Medicare. Increasing the age of eligibility was another significant savings provision (1.7 percent). Removing direct medical education expenditures was estimated to reduce spending by 0.9 percent, and the spending reduction from changes in cost-sharing and Medigap (prohibiting coverage of the deductible) was estimated to be about 0.3 percent (Commission 1999b). The Medigap provision was dropped in the final version of the proposal. It now states that the new single Medicare deductible and coinsurance would be insurable in part or in whole.

The proposal would establish a new mechanism for assessing the financial status of the Medicare program that would look beyond the solvency of the Hospital Insurance Trust Fund. Under this approach, the Part A and Part B trust funds would be combined, and the actuaries would report each year on the proportion of the total program’s funding supported by general revenue rather than payroll taxes and premiums. While not stated explicitly in the final paper, the proposal implies that the combined trust fund would be financed by current-law payroll taxes and premiums, and like the Part B trust fund, general revenue would automatically be transferred to the newly combined trust fund to keep the program solvent.

Under the proposed mechanism, however, general revenue contributions in excess of 40 percent of total program funding would not be auto-
matic—Congress would have to approve such additional general revenue support. The proposal envisions that when this cap was expected to be breached, the actuaries’ report would trigger a congressional debate about the appropriate source of additional financing. Under the Commission staff scoring of the Breaux-Thomas proposal, the 40 percent threshold would be reached by 2005.⁹

**Discussion**

The proposed financial status test, or “programmatic solvency,” is intended to move away from a focus on Hospital Insurance Trust Fund solvency to an overall picture of how Medicare is financed. As noted earlier, general revenue support for Medicare Part B is expected to increase under current law. As the proportion of Americans paying payroll taxes declines as a result of coming demographic trends, this shift toward greater general revenue support will continue to be true under any future scenario.

By capping general revenue funding, the Commission approach would establish an emergency decisionmaking process under which future Congresses would be forced to decide how to fund Medicare. Is such a process really needed? If instead of a cap, general revenue financing were continued as the default method of funding the combined Medicare trust fund, wouldn’t the draw on general revenue eventually get the attention of Congress as it tried to fund other priorities? Would forcing Congress to act in a particular year invite political brinkmanship and “shutting down Medicare” scenarios that might not produce the best public policy?

**TRANSITION ISSUES**

Transition provisions are generally not specified in the Commission’s proposal. It does state that the proposed changes to the current program, such as combining Part A and Part B into a single Medicare trust fund and modernizing the benefit package, would be implemented immediately. The federal subsidy to help low-income beneficiaries up to 135 percent of the FPL purchase outpatient prescription drug coverage is also assumed to begin immediately, but the mechanics are not specified. The changes in Medigap policies could be made relatively quickly. But how Medicare would move from current law to the premium support system is not discussed.
NOTES

1. Unless otherwise indicated, all references to the Breaux-Thomas proposal are based on the Commission (1999a).

2. Unspecified, for example, is the level of stop-loss coverage. How much out-of-pocket spending would have to be incurred by the beneficiary before the stop-loss coverage is triggered? What cost-sharing would be applied toward the calculation of that threshold? Would cost-sharing for prescription drugs be included?

3. See, for example, O’Sullivan (1998).

4. In one section of the staff memorandum accompanying the March 16 proposal description, it states that HCFA would be allowed to contract with or enter into joint marketing arrangements with private insurers offering prescription drug benefits. This would “allow a public/private high option plan or plans, with HCFA providing coverage for Medicare covered services and its private partner(s) providing coverage for drugs. . . . In the long run, HCFA would be allowed to transition the government-run fee-for-service plan to a more private-managed basis overall, possibly with different alternatives available regionally.” It may be that the sponsors are thinking of regional pharmacy benefit managers (PBMs), which would contract to administer the drug benefit for traditional Medicare.

5. This includes reviewing benefits and premiums of high-option plans.

6. This amount is calculated to reflect the current portion of the government’s share for Medicare.

7. This scenario is similar to what happens in the Medicare+Choice program. A plan in a high-cost area like Miami, Florida, can offer additional benefits for no additional premium (beyond the Part B premium) because its geographic-adjusted Medicare capitation payments are greater than the plan’s cost of providing Medicare’s basic benefit package. The opposite is true for plans in low-cost areas.
8. Whether low-income beneficiaries would be allowed to elect a higher-priced plan and pay the difference out-of-pocket between the government’s contribution and the plan’s premium needs to be clarified.

9. It is not clear if the “combined” trust fund would continue to track Part A and Part B expenditures. Even though the 40 percent might be reached in 2005, funds would still be in the trust fund to pay claims.
Introduction


Part I: A Framework for Comparing Incremental and Premium Support Approaches


CBO. See U.S. Congressional Budget Office.


GAO. See U.S. General Accounting Office.

HCFA. See U.S. Department of Health and Human Services, Health Care Financing Administration.

House. See U.S. House of Representatives.


MedPAC. See Medicare Payment Advisory Commission.


NASI. See National Academy of Social Insurance.


PPRC. See Physician Payment Review Commission.


**Part II: Perspectives on Premium Support**

**Administration of a Medicare Premium Support Program**


GAO. See U.S. General Accounting Office.


Comprehensive Pricing by Medicare’s Private Health Plans: Be Careful What You Wish For


**Risk Adjustment in a Competitive Medicare System with Premium Support**


HCFA. See Health Care Financing Administration.


ProPAC. See Prospective Payment Assessment Commission.


Price Sensitivity of Medicare Beneficiaries in a Premium Support Setting


**Appendix**


About the Editor

Marilyn Moon is a senior fellow at the Urban Institute, where she conducts research and policy analysis in health policy. Recent publications include “Will the Care Be There? Vulnerable Beneficiaries and Medicare Reform” and “Managed Care in Medicare: A Threat or a Promise?” Since October 1993, she has been writing a periodic column for the Health section of the Washington Post on health reform and health coverage issues. She also serves as a public trustee for the Social Security and Medicare trust funds.
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Len M. Nichols is an economist and principal research associate at the Urban Institute who studies private health insurance markets and how they work in response to decisions by employers, individuals, regulators, and public insurance programs. He has written extensively on these and other issues under the general rubric of health reform. Mr. Nichols is currently a member of the Competitive Pricing Advisory Commission (CPAC) for the U.S. Medicare program and was the senior advisor for health policy at the Office of Management and Budget (OMB) during 1993–94. Prior to
OMB, he was a visiting public health service fellow at the Agency for Health Care Policy and Research; prior to that, he was an associate professor and economics department chair at Wellesley College.

Lisa Potetz is a health consultant and serves as director of public policy research at the March of Dimes. She has many years of experience as an analyst of Medicare and other health care issues and has held staff positions with the House Ways and Means and Senate Finance Committees, the Prospective Payment Assessment Commission, and the Congressional Budget Office. She has a master’s degree from the University of Michigan School of Public Policy and a B.A. in economics and political science from Boston College.