Restructuring Medicare

Testimony before the the Senate Committee on Finance, Subcommittee on Health Care

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Hearing to Examine the Magnitude of the Financial Crisis in Medicare

My name is Len Nichols and I am a Principal Research Associate at the Urban Institute. The views I will express today are my own and not those of the Urban Institute, its sponsors, or its trustees.

Medicare is our most sacred social contract precisely because it binds generations of Americans together. It has achieved much success, helping to lengthen and to improve the quality of life for our senior citizens since 1965, when it was implemented over the objections of some of the program's most vocal supporters today. While accomplishing these impressive feats, Medicare has become both our most popular public program and a program that is in need of serious structural repair. Without this repair, it cannot continue to serve us well in the 21st century. I am pleased to come before you today to offer some thoughts on how we might perform the repair without reducing our fundamental commitment to quality health care for *all* our seniors, a commitment that I know we all share.

The discussion of "Restructuring Medicare" is really a question about how to make the market work well for Medicare beneficiaries and for taxpayers. Sadly, it is not as simple as setting the market absolutely free, for completely unregulated health insurance markets have not performed well for the elderly in the past and there are good reasons to believe they will need some structure in the future. At the same time, the tremendous power of a well-structured market needs to be harnessed for the good of Medicare beneficiaries, for this is the only way to accomplish our long run goals of quality, choice, and an affordable price tag. Happily, it is my belief that a reasonable and mutually beneficial set of market rules and profitable incentives can be implemented in time to head off the coming financial challenges. When coupled with reasonable financing and program flexibility over time, I am confident that Medicare can continue to be a bedrock commitment upon which all Americans depend.

LONG RUN PROBLEMS AND RECENT PERFORMANCE

By now, at least to this audience, Medicare's two long run problems are well known: (1) the cost per beneficiary is growing at an unsustainable rate; and (2) the number of beneficiaries per worker will increase precipitously as the baby boomers begin to retire after 2010. The baby boomer problem cannot be properly addressed until the cost growth problem is solved. All palatable solutions to Medicare reform require reductions in the real rate of growth of cost per beneficiary.

The feasibility of cohort-based financing, for example, the proposal advanced by Profs. Saving and Rettenmaier in their testimony today, depends vitally on reducing the real rate of growth of cost per beneficiary down to 1% per annum. Now their proposal has much to recommend it, in my view. I like the emphasis on having relatively more responsibility placed on beneficiaries to pay for themselves, and I like the fact that that responsibility is applied in a straightforward and fair way. As I understand it, there would be one payroll tax rate for all in a cohort, and thus the highest earning members of a cohort would pay for more than the cost of their care, while the lower earning members of a cohort would get their Medicare coverage subsidized. These are principles which I would welcome as cornerstones of a restructured Medicare program.

However, adopting cohort-based financing in its entirety is not the path that I would recommend. The risks of the assumptions not working out as calculated are just too great for any one cohort to bear alone. For example, Figure 1 shows the tradeoff between Medicare cost growth per beneficiary and the number of years that cohort-based financing could support the expected Medicare needs of today's 22 year olds. At a 1% real rate of growth of cost per beneficiary, as the cohort-based financing model assumes, a 4.22% overall tax rate will pay for 18 years of today's Medicare benefit package for all of today's 22 years olds who will retire in 2041. This would be enough to fully fund the proposal.[1] However, if the growth in cost per beneficiary turns out to be 3% in real terms, the same tax rate will pay for only 6 years of Medicare. And if the real growth in cost per beneficiary remains lodged near its 20 year average of 5% per year, that same tax rate will buy

fewer than 3 years of Medicare coverage.

There are different ways to compensate for higher cost growth, but no single one is likely to be feasible. Figure 2 shows that if the real rate of return on savings turns out to be 6% for the next 70 years, then this cohort could afford 3% annual growth in cost per beneficiary between now and their retirement. That kind of investment performance can hardly be guaranteed over the long haul, however. Figure 3 shows that the generosity of the Medicare benefit package could be reduced to compensate for faster cost growth, but even a growth rate as low as 2% would require a 40% reduction in Medicare's generosity for the younger generation. Finally, Figure 4 presents payroll tax rate tradeoffs. It shows that a real growth rate of cost per beneficiary of 3% would require a medicare payroll tax rate of over 12% throughout their working lifetime to finance today's Medicare benefit package for the length of time expected to be necessary for today's 22 year olds.

Obviously, if real growth in cost per beneficiary is actually higher than 1%, a combination of all the policy options mentioned above will likely prove necessary. But ultimately, under the cohort-based financing proposal, the risk of faster than anticipated cost growth, i.e., the risk of erroneous projections, is borne completely by each cohort alone. This is the one great disadvantage of cohort-based financing, in my view. If optimistic assumptions turn out not to hold, then each cohort will face the abyss alone. The 22-year old cohort's payroll tax rate, for example, as shown in Figure 4, would have to increase almost threefold throughout their working lifetime to accommodate 2% higher real growth in cost per beneficiary. Intergenerational funding, by contrast, lowers the severity of the required reaction to unanticipated cost growth experience because the funding base is so much larger and more elastic. For example, in the Medicare Trustees Report, the "High Cost" scenario is that costs increase 2% faster in real terms than in the baseline. This 2% increase in cost growth would raise the required payroll tax rate to fully fund all of Medicare in 2020 by about 50%.[2]

But more importantly, erasing the explicitly intergenerational nature of the Medicare program would sever our social contract and loosen the bonds between generations. We Americans require individuals to take a great deal of personal responsibility to fully enjoy the fruits of our society, but we also take care of our elders. We do not forget those who end up unlucky or the victims of the inexactitudes of actuarial, economic, or medical science. The strongest and most prudent safety net is the promise of unconditional acceptance in a larger community. We abandon such a promise at our individual and collective peril.

Still, as the Professors' and my discussion of cohort-based financing's financing tradeoffs have made clear, the future rate of growth of Medicare's cost per beneficiary is a key variable. While we focus on cost, however, it is useful to keep Medicare's cost growth problem in perspective. Private health plans that serve the under-65 working population have done better lately, but Medicare actually outperformed the private sector for most of the last 25 years. From 1969 to 1994, Medicare cost per beneficiary grew slower than the private sector analogue each year (slightly less than 11% compared to just over 12% per year). This is not to say that either's performance was good, just that Medicare has not lagged the private sector, on average, very long. In the last two years, the private sector has done very well, and it is important to understand why and to draw the proper lessons about what this does and does not imply for restructuring Medicare.

First, private prices relative to Medicare prices have fallen largely as the result of hard bargaining from employers and managed care health plans in the face of substantial excess capacity in hospital beds and specialist physicians. This excess capacity has manifested itself rather suddenly as a result of a veritable revolution in health care delivery patterns, epitomized by the rise in outpatient surgery, reductions in hospital admissions and shorter lengths of stay for many conditions and treatments. (This revolution in delivery patterns, by the way, was jump-started by the Medicare hospital payment reforms (PPS) in 1983.) Relative private prices have fallen so far lately because they were much higher than Medicare prices to start with, and because Medicare's current pricing formulae are insufficiently flexible to take advantage of competitive market fluidity. This "one-time adjustment" of private health service prices to new competitive realities has proceeded at different speeds across the country, and thus could continue to exert downward pressure on prices, on average, for a while. Still, there are limits to this source of cost reduction, namely, when the excess hospital and physician capacity is finally squeezed out of the system. This will happen, though perhaps not as quickly as in other markets which have experienced excess supply throughout our nation's history.

In addition, the frequently cited statistics on lower growth in private employer health insurance costs (per employee), which have looked promising lately in both Foster Higgins' and KPMG Peat Marwick's surveys, are also largely due to one time, and not structural, factors. The major explanation here is that much of the country is shifting to lower priced managed care plans from higher priced indemnity or fee-for-service arrangements. Employee switching to plans with lower premiums can lower the average cost per employee of health insurance, even if no underlying inflation rate has been affected at all. The example in Table 1 shows how this can happen. The premium for each hypothetical health plan increased by 10%, but enough employees switched from the high priced plan to the low priced plan that the ***average*** health insurance cost per employee increased by only 3.2%. This is partly why, in their latest report, Foster Higgins analysts predicted a rekindling of health insurance inflation in the next few years, despite the recent good news on this front. Eventually, most employees will be in the lowest priced plans available, but unless the underlying causes of health care cost inflation have been cured, i.e., our apparent taste for ever more expensive health technology, we'll be right back on a path toward higher and higher health insurance costs soon enough. This upward path will steepen as the excess capacity in hospitals and specialists begins to disappear.

In summary, the private sector has done better than Medicare lately by using market forces and excess capacity to negotiate lower prices. The private sector has found a way to make first generation managed care

work for it, at least in the short run. Of course, as you know, first generation managed care does not work all that well for Medicare taxpayers at the moment, since Medicare's payment formula overpays HMOs 5-7%, on average, for the actual cost of care received by beneficiaries who choose managed care. That is why HMOs can afford to offer benefits more generous than the basic Medicare benefits package. This could possibly be fixed with adjustments to the formulae now, but this is a somewhat technical matter for another time.

MAKING 21ST CENTURY MARKET COMPETITION WORK FOR MEDICARE

The real goal of long term structural reform of Medicare is to make next generation managed care and health insurance plan competition work well. By "next generation managed care" I mean managed care that provides proof of high quality outcomes to beneficiaries who use that information to make informed choices about health plan and health provider arrangements. By "health insurance plan competition" I mean market competition among a variety of arrangements, including indemnity plans and preferred provider organizations. By "work well" I mean provide high quality care for all beneficiaries, a reasonable choice of plans and providers, and do so at acceptable social resource cost. Aligning Medicare with market forces is absolutely essential for all this to occur. But at the same time, abandoning Medicare enrollees with a dollar voucher in an unfettered market is unlikely to be judged a success in the short or long term.

The key to making any market work is accountability. Buyers need to be able to evaluate what they're getting, and sellers need to be forced by competition to produce quality products efficiently and to provide enough information to evaluate the product itself. Some, but not many, health insurance markets are working this way today. All the successful ones I know of, across both the private and the public sectors, are practicing rather similar variants of the principles of managed competition to demand and get health plan accountability. A major problem with health plan innovation in Medicare today is that plans and provider groups are not held accountable and forced to provide adequate information for HCFA to evaluate how its beneficiaries and its payment rates are doing.

Successful principles for health insurance purchasing systems today are being practiced by groups as diverse as the San Francisco-based Pacific Business Group on Health, the Minnesota Buyers Health Care Action Group, the Colorado Health Care Purchasing Alliance in Denver, The Employer Health Care Alliance Cooperative of Madison, Wisconsin, the California Health Insurance Purchasing Cooperative, and the Washington (state) Health Care Authority, to name a few. Over 100 business coalitions for purchasing health insurance have sprung up in recent years. "Value based purchasing" is more than a new buzzword. It means getting the most out of what you pay for. In my judgment, the real world experience of employers and state governments suggest seven important steps to value based purchasing.

Define benefit packages. Standard benefit packages help consumers comparison shop among plans, allow purchasers (employers and governments) to evaluate exactly what they're getting for their money, and help reduce risk selection by benefit design. There can and should be different cost-sharing options and perhaps different add-ons (like dental or vision), but they, too, need to be defined to focus competition on the twin dimensions of price ***and*** quality.

Medicare beneficiaries' experience with Medigap regulations should be enough to demonstrate the merits of defined benefit packages. The Baucus Amendments of 1980 called for voluntary industry standards, but seniors still found literally hundreds of Medigap policy configurations and found it quite difficult to compare the plans. There is little doubt that some insurers used seniors' confusion over all this to select good risks and to sell seniors duplicate coverages. OBRA 1990 addressed this shortcoming of the Baucus legislation by specifying 10 different types of Medigap policies. A recent study published in the Health Care Financing Review by Fox, et al found that the vast majority of market participants think the medigap market is now functioning much better than it did before the benefit standardization reforms. [3] States, by the way, administer these medigap regulations under broad HCFA guidelines and oversight.

We should always be mindful that the Medicare population is not just a sightly older version of the under-65 population that is largely insured through employer-sponsored health plans. Many elderly have severe and chronic health care needs, and thus the standard set of services guaranteed for Medicare beneficiaries must differ substantially from the typical insurance policy sold to thirty-something with two young children. Medicare must, e.g., include skilled nursing facility and home health care benefits, as well as age-appropriate preventive services. Fee-for-service medicine may very well be the only way to provide some of these services in the foreseeable future in some parts of the country, and thus that option must be preserved and integrated into the new competitive framework.

Define enrollment and marketing rules. Within business coalitions, this is simply an annual open enrollment process. In Medicare's case, this would entail open enrollment as Medicare risk contractors must provide today, as well as oversight over marketing materials and recruitment techniques. This oversight need not be heavy handed, at least no more heavy than many employers and employers' coalitions exercise on behalf of their workers today, but it does need to be effective so that all health plans are truly open to all Medicare beneficiaries.

Specify plan reporting requirements. Health plan reporting is a prerequisite for the evaluation of quality outcomes, a key component to next generation managed care and all health delivery systems of the 21st century. Without laying the foundation for quality reporting and assessment, no market-based purchasing strategy can ever succeed in delivering outstanding performance. Definitive case-mix adjusted outcomes measures, especially for ambulatory care, will likely never be perfect, so all participants should exercise due diligence and caution in making clinical judgments based upon the ones we have available today. Still, enough progress has been made in developing process measures that are likely to be correlated with true

outcome quality that the case for "waiting" until better measures come along is getting weaker every day. At a minimum basic utilization statistics should be institutionalized as reportable as soon as possible, as many organized health care purchasers have learned recently.

Negotiate competitive bids with plans. Business coalitions have found they need about a 15% market share to exercise enough purchasing clout to get providers' attention and to demand accountability from their local health care systems. Medicare starts the game with easily enough clout to get everyone's attention in virtually every market in the country. HCFA is now starting a competitive bidding demonstration in Denver, after a false start in Baltimore. I think for the first time HCFA now wants to move to competitive bidding more than do Medicare vendors. That says good things about the learning curve at HCFA and not so good things about the current formulaic overpayment to risk contract HMOs. In any event, competitive bidding is a vastly superior way to contract for the guaranteed Medicare benefit package than any formulaic or fixed growth approach, for it allows the program to react to market trends, favorable and unfavorable, as time passes and our health delivery system evolves.

Give consumers incentives to choose efficient plans. This has proven to be particularly effective in state plans in Minnesota, Washington, California, and in various universities. Contrary to long held myth, if faced with price incentives, people will switch to lower cost plans, voting with their feet, which will force those plans that have more costly delivery styles to demonstrate their extra value or lose market share and ultimately disappear. While this is essential to letting consumer preference drive the market in the long run, Medicare must be careful not to rush through incentives into a two-tiered system with low income beneficiaries congregating in lower priced and ultimately lower quality health plans (in the very long run). Senator Gregg's Medicare reform proposal, I believe, deals with this issue adroitly by letting seniors share in the savings from choosing lower priced plans, but does not require higher payments from seniors for choosing any plan that Medicare sponsors. Medicare does not have to sponsor every health plan in the world, but it must allow all Medicare beneficiaries equal access to the plans it does sponsor to preserve our traditional commitment to one-tier medicine for seniors. This can be done in a manner consistent with new incentives for efficiency.

Publish enough information to inform enrollees about quality measures and to facilitate plan switching. Effective consumer choice requires that objective information be readily available. Health care is a very complex commodity, and health insurance arrangements are not simple either. Still, organized buyers can generate sufficient high quality information that not every consumer need know every detail, for plans will try to attract knowledgeable consumers who are likely to drive the switching behavior in any market. Thus, good knowledge for some protects all consumers/patients. Employers often act in employees' behalf, as do state governments. There is a crucial role for HCFA to play here as the ultimate agent on behalf of seniors and their families, especially for older and more infirm beneficiaries.

Risk adjust plan payments. To engender true price-quality competition and avoid selection effects, good risk adjustment is necessary. This will ensure that premium dollars flow to plans that do a better job delivering high quality cost-effective health care and not just to those who do a good job of selecting healthy enrollees. Risk adjustment is being practiced by a few public or publicly organized purchasing coalitions, but no private business coalition to date is using this complex and as yet imperfect methodology. Medicare would have to, however, since its experience with the Medicare risk program indicates that selection effects are very likely. This is particularly important if we decide to permit MSAs as an option for Medicare beneficiaries, for it is possible that selection effects for MSAs would be extreme.

But the proof of all these experience-honed insurance market rules is in the pudding, as they say. For a study that my Urban Institute colleague Linda Blumberg and I are doing of purchasing cooperatives in four states, I have been granted access to (unidentified) plan specific pricing data by one of the purchasing cooperatives listed above. Table 2 shows the effects of their application of these market structuring principles over the last three years. Unlike Table 1, where hypothetical plan switching was used to explain the reported result that health insurance costs per enrollee has grown slowly in recent years, these premium inflation rates apply to specific types of plans with an unchanged benefit package (a package substantially richer than Medicare's, by the way). These inflation rates are not enrollment-weighted, to permit evaluation of the plans' performance independent of employee switching. The plan types are ordered from tightest to loosest forms of managed care and by generosity.

The salient lesson I draw from the table is that when consumers can compare apples to apples and weigh the benefits of more choice or lower copays vs. the demonstrable cost, many opt for lower priced alternatives. Competition thereby imparts greater pressure for all health plans to deliver even more value for dollar the next year. Enrollment in plan types 3 and 4 has fallen to less than 2% of the total over these three years, and yet intra-plan type competition is clearly keeping the performance of the most successful plan types well beyond that observed in less competitive markets. Structured competition works for enrollees and for payors, and for successful and effective providers and health plans as well.

Although these business coalition experiments are fairly new and all data are preliminary, I believe that organized purchasing experiences to date strongly suggest that defined benefit packages, reporting requirements, competitive bidding, and marketing rules all force accountability on health plans and can MAKE HEALTH INSURANCE MARKET COMPETITION WORK! This is exactly what Medicare needs for the 21st century.

A BALANCED APPROACH TO THE FUTURE

Would effective market competition of this type guarantee the 1% real rate of cost growth per beneficiary that so many "save Medicare" plans depend upon? Probably not, for there are no guarantees in the real world. I am not a fan of the silver bullet theory, that there is one magic solution to Medicare's financing problem that

we just haven't been smart enough to discover yet. Any serious Medicare restructuring effort, as Senator Dole wrote the other day in the *Washington Post*, will require a little bit of sacrifice and change from all parts of the program and from all parts of our society. This entails some version of the usual list of suspects to address the short run Part A trust fund shortfall, and it probably entails some tax increases down the road in the longer run. But with competitive bidding and a defined benefit package, we could decide collectively exactly what we are willing to pay for as promised medical value and current opportunity cost are weighed right here in Congress each year into the future, as it should be.

Though we may end up with tax increases if we decide collectively we would actually like to pay for more health technology as it becomes available, we need not start there. Where we should start is with a serious effort at restructuring Medicare along workable market lines, not ideologically pure free market lines, but structured market lines. A competitive health plan market can be the Medicare program's best long run friend, but only if we structure the relationship carefully. This structured relationship would be stronger, I believe, if the overall program remains integenerational. Those are our elders out there looking for medical care after a lifetime of work and sacrifice. They are us.

Notes

1. I am grateful to Tim Waidman for making the life expectancy calculation using Center for Disease Control's death rate projections for 65 year olds in 2039. The complete estimate in the text assumes a 3% real rate of return on savings during the cohort's working lifetime, 1% real wage productivity growth and returns to experience over a working lifetime similar to those that are observed today. 4.22% is the 1993 (the last year that Social Security Administration payroll data are publicly available) payroll tax rate required to fully fund Medicare, the ratio of Medicare expenditures to worker plus self-employed earnings.

2. From 12.7% in the baseline to 18.8%. These rates take into account the HI cost ratio and the estimated ratio of SMI to HI outgo in 2020, taken from the Trustee's report.

3. cite. This is not to say the medigap market is functioning perfectly, but that too is a topic for another day.

*This statement represents the views of the author alone and not of the Urban Institute, its sponsors or its trustees. Adam Badawi and Laurie Pounder of the Urban Institute provided outstanding research assistance for this testimony, and I am grateful for helpful comments from my colleagues Marilyn Moon and Tim Waidman. I would also like to thank Andy Rettenmaier of Texas A&M University for explaining the details of the model used to estimate the cohort-based Medicare funding proposal on the phone.

Figures, Charts & Graphs

Figure 1

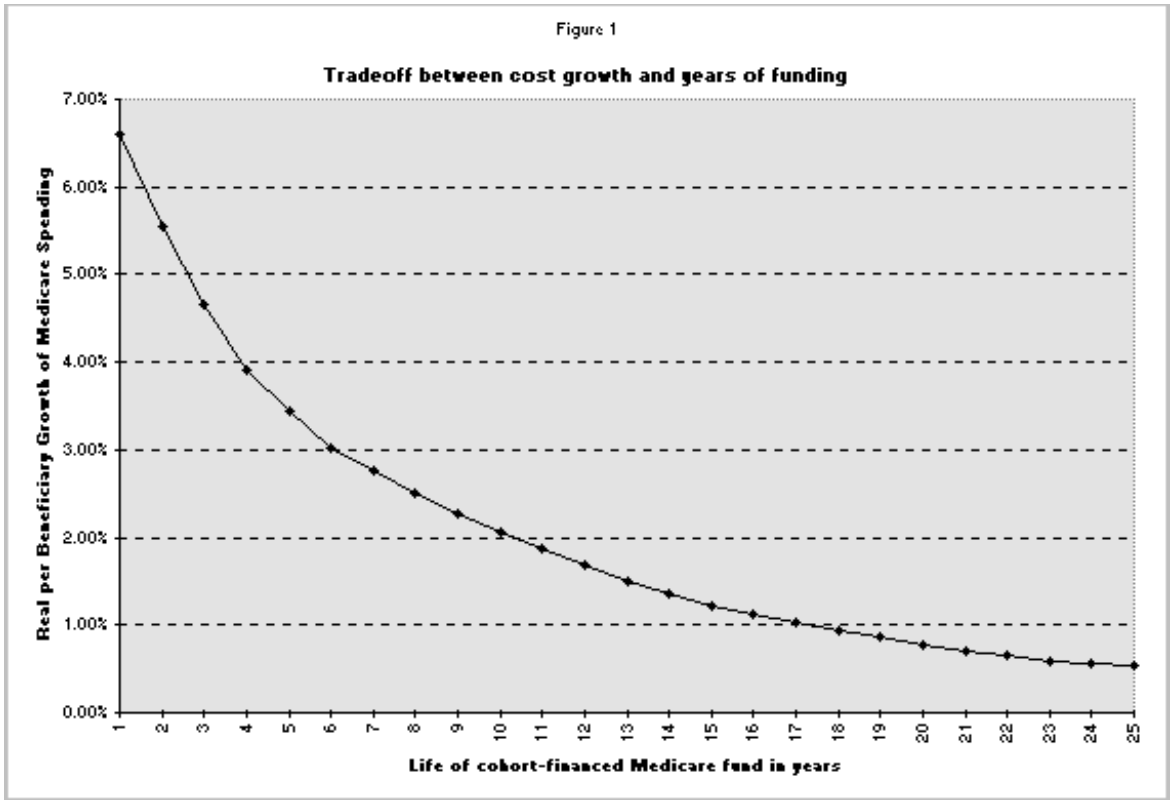

Figure 2

Figure 2

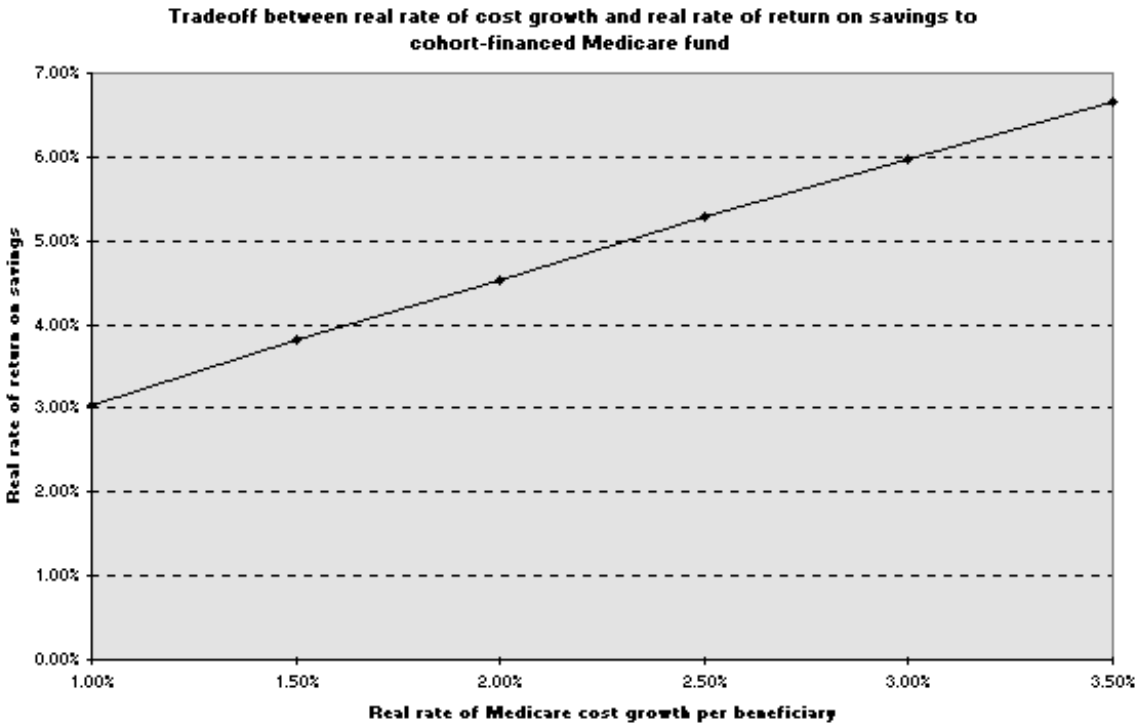

Figure 3

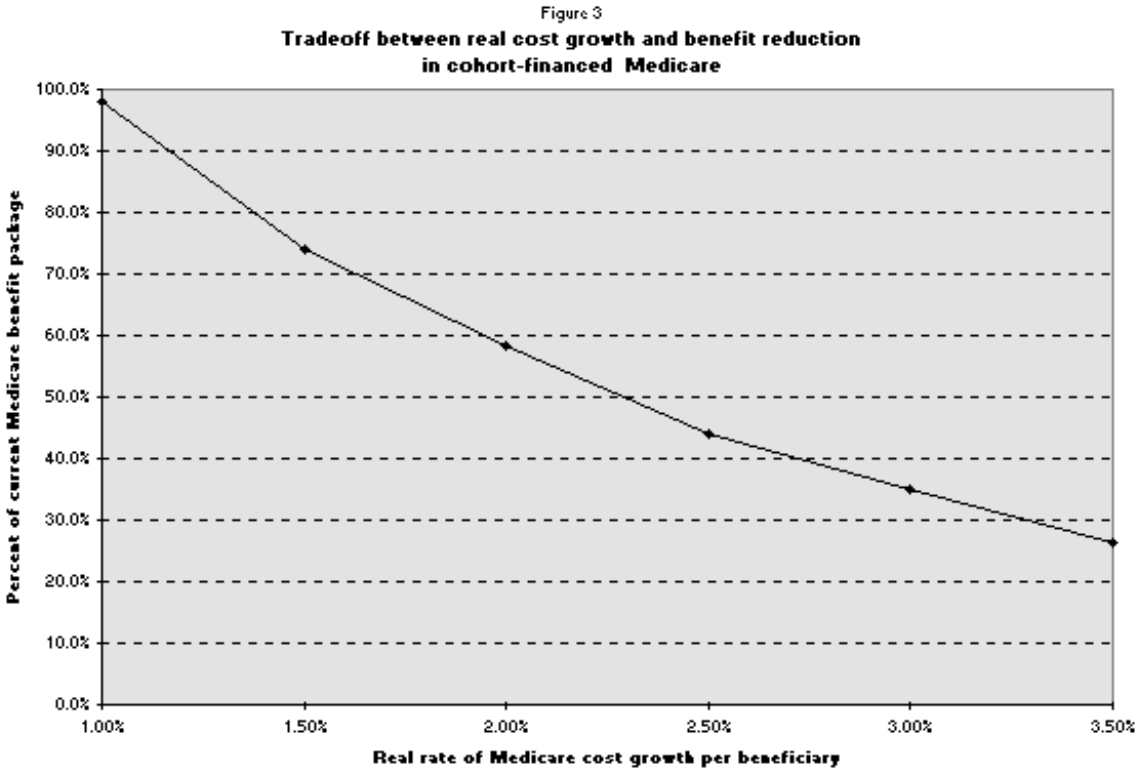

Figure 4

Figure 4

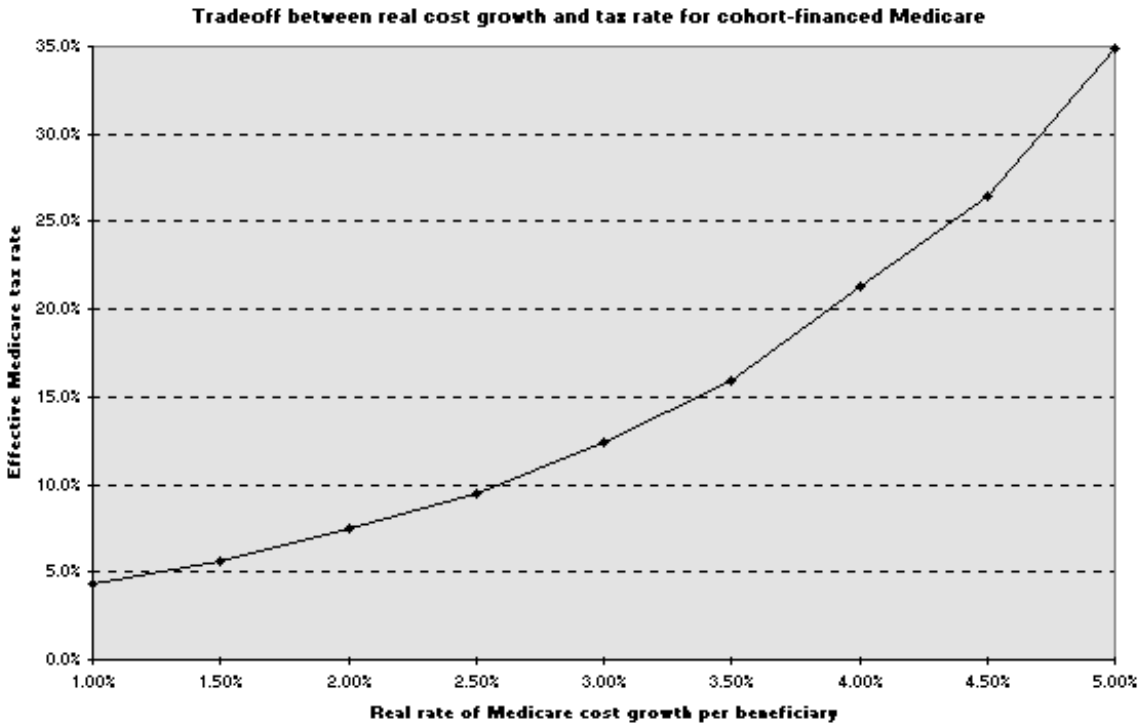

Table 1

How Switching Among Health Plans Can Lower the "Growth" in Health Insurance Cost Per Worker

	1995	1996	growth
Indemnity			
premium	$ 400	$ 440	10%
enrollment	200	100	-50%
HMO			
premium	$ 330	$ 363	10%
enrollment	100	200	100%
Total Employees	300	300	0
HI cost per worker	$ 376.67	$ 388.67	3.20%

Source: Author's example.

Table 2

Table 2.

Growth rates in premiums of specific health plan types
rates of change in a family policy bought by a 45 year old employee

	1994-95	1995-96	1996-97	cumulative
plan type 1	-7.00%	-7.90%	-3.60%	-17.40%
plan type 2	-6.50%	-7.40%	-1.90%	-15.10%
plan type 3	-4.30%	5.60%	16.20%	17.40%
plan type 4	-4.40%	7.40%	16.90%	20.00%

Source: Confidential data from an actual purchasing coalition.
Plan types are ordered from tightest to loosest form of managed care and by generosity.

Other Publications by the Authors

- Len Nichols