

Why Press Medicare and Not the Insurers?

Commentary

Marilyn Moon

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What a difference a year makes. In 1997, the Republican-led Congress was celebrating passage of legislation to expand options for private plans to participate in the Medicare program. The goal was to have elderly and disabled beneficiaries increasingly choose to enroll in private plans instead of the traditional fee-for-service part of the program.

Using health maintenance organizations (HMOs), which now participate in Medicare, and other new types of insurance, supporters expected that efficient private plans competing with each other would be able to lower growth in Medicare spending.

Fast forward to today. Few new non-HMO plans have signaled any interest in participating. And although a number of new HMOs are enrolling Medicare beneficiaries, the changes capturing headlines are the withdrawals of HMOs from the program.

While it is premature to pronounce a trend, tens of thousands of beneficiaries will have to change HMOs or return to traditional Medicare. Moreover, the major trade association representing HMOs is calling for permission to raise premiums or cut benefits - or else. What does this all mean?

Most of all, it raises some red flags about easy solutions to Medicare's financing problem. There is nothing magic about private plans or even managed care. To control health-care cost growth, you either must pay less to doctors, hospitals and other providers of care; find ways to reduce the use of health-care services or change use to less expensive forms of care. In the 1990s, many HMOs for the under-65 population have been successful in getting big discounts from doctors and hospitals in return for a steady stream of patients. And HMOs have been pretty successful at reducing hospital stays and discouraging use of specialists and the extra tests that specialists often prescribe.

But HMOs face a bigger challenge in treating Medicare patients, and one that many HMOs may not have appreciated when they got into the Medicare business.

In the 1980s, Medicare was a leader in obtaining lower payments from doctors and hospitals; even today, Medicare's payment rates are below those of most insurers. And Medicare shortened hospital stays through its reforms in the 1980s.

Thus, when an HMO signs up a Medicare patient, the payment the HMO receives already captures many savings that HMOs traditionally have used to cut costs. Thus, it is hard to be more efficient than Medicare (as compared to when HMOs were negotiating lower premiums for employers that had been funding generous health-care plans).

Moreover, to attract Medicare beneficiaries, plans are correct when they argue that they have to offer extra benefits or low premiums in exchange for the restrictions that they place on the choices of providers of services. Traditional Medicare offers a more limited package of benefits but places almost no restrictions on what doctors you can see or what hospital you can use.

Plans are also correct when they point out that Medicare payments are rising more slowly than in the past. Last year's Balanced Budget Act was primarily legislation aimed at cutting government spending, and Medicare was no exception. That legislation set limits on the growth in payments that HMOs would receive for each participant.

This was not just an arbitrary cost-cutting exercise, however. Most credible studies of Medicare's HMOs have indicated that Medicare loses money on these plans because the payments have been too high. This is because those who signed up for HMOs have, on average, been healthier than those who stayed in traditional

fee-for-service. However, the payments to HMOs are based on the average costs of care, which include those with various, and sometimes expensive, medical problems.

Thus, it was reasonable for the government to slow its payment growth to HMOs. Private plans cannot save Medicare money if they are paid more than it would cost to treat the same person in the traditional part of the program. Nonetheless, plans have not been happy to live with increases of 2 percent a year after years of 8 percent or 10 percent payment growth, and beneficiaries will suffer if plans withdraw from the program or, over time, cut the benefits that lured people to enroll in the first place.

Caving in to plans and paying them more implies that they deserve some special treatment. But should we bail them out and help their relatively healthier beneficiaries while holding the line on traditional Medicare, which serves the sickest and frailest beneficiaries?

This is the unpleasant dilemma that Medicare faces.

So what should be done? With some exceptions, Congress should resist increasing payments to private plans that operate under Medicare. Instead, we should expect managed-care plans to make good on their claim of providing a more efficient way of delivering quality health care.

If they cannot do better than the traditional program, we need to re-evaluate the role they can play in Medicare and certainly should not take further steps to turn Medicare into a system of private insurance plans.

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