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MEDICARE REFORM AND COMPETITION AMONG HEALTH PLANS

Reforms to Medicare suggested in recent years range from relatively small, incremental steps to a more sweeping reconfiguration of the program. The proposals vary in their comprehensiveness, in the complexity of the program restructuring they would require, and, most important, in their potential effect on the ways in which current and future Medicare beneficiaries will obtain and pay for health care services.

Increasing the Medicare program's reliance on competition among private health plans is an element common to the two major, competing legislative proposals for Medicare reform, which will be discussed in Chapter 3. The degree and manner of the proposed reliance on private plans also is the major distinction between the two approaches.

In order best to understand these issues, this chapter outlines several approaches to health plan competition that have helped to shape the current debate. These are the theoretical approaches known as "managed competition" and "defined contribution" and the existing models of plan competition found in the Federal Employees Health Benefits Program and in Medicare+Choice (see "Competition and Medicare," page 138).

MANAGED COMPETITION AS THE BASIS FOR REFORM

COMPETITION AND MEDICARE: A GLOSSARY OF TERMS

Defined Benefit	Individuals are entitled to benefits defined as coverage for specific health care services. Benefits are not tied to the cost of services to the plan sponsor over time. Medicare is a defined benefit health insurance program.
Defined Contribution	Individuals are entitled to benefits defined as a fixed dollar subsidy for the purchase of health insurance coverage. It is an alternative to the defined benefit structure. The defined contribution dollar amount may be determined in a variety of ways and need not be directly related to the price of health insurance.
Managed Competition	A system of structuring the market for health insurance under which, according to a set of rules, health plans compete for enrollees based on the price and quality of services provided.
Premium Support	A variation of the defined contribution approach under which the dollar subsidy is related to the price of health insurance coverage, and the dollar amount is computed to ensure that it is sufficient to purchase a specific set of benefits.

Many proposals for health financing reform, both systemwide and Medicare-specific, rely in some fashion on the managed competition concept initially described by Alain Enthoven and others.[1] For example, managed competition principles formed the basis of the 1994 Clinton administration health care reform proposal, under which individuals would have purchased health insurance through health alliances responsible for administering competition among health plans.

While the managed competition approach does not promote a totally deregulated health care system (hence the "managed"), it relies on markets and financial incentives to establish prices and benefits. This places it in contrast to approaches under which pricing and benefits are determined by the government, as is generally the case with the current Medicare program.

Under managed competition, private health plans would compete for enrollees within a set of rules established and overseen by the purchaser. The competition is intended to be based on both price and quality of health care delivery, as well as to a limited degree on benefit design, with the goal of obtaining "maximum value for money for the purchaser and consumer." The rules of participation by plans (management of the competition) stipulated by the

purchaser are intended to ensure that plans do not compete by selecting risk: attracting the healthiest, lowest-cost enrollees while avoiding the sickest, highest-cost enrollees. Without attention to this concern, all plans would work to attract healthy enrollees and avoid unhealthy ones; plans with higher-risk enrollees would be at a competitive disadvantage and might fail financially. All plans would offer the same minimum set of benefits to permit comparisons across plans and to minimize risk selection on the basis of benefit design. The premium paid by plan sponsors (employers or perhaps Medicare) would be set to ensure that enrollees have financial incentives to choose low-cost health plans. For example, a sponsor might elect to pay an amount equal to the premium of the lowest-priced plan. Enrollees choosing that plan would pay nothing; those choosing another, more expensive plan would pay the excess amount.

One of the biggest challenges in a managed competition approach is correcting for the unequal distribution of healthy and unhealthy enrollees across plans by a "risk adjustment" mechanism. Even with standardized benefits and other oversight efforts to prevent plans from actively seeking healthier enrollees, some plans still may have healthier enrollees and therefore look more efficient than others even when they are not. Risk adjustments modify payments to plans to correct such inequities and ensure that plan prices reflect differences in the efficiency and quality of the plan's health care delivery system and not in the characteristics of enrollees. With risk adjustments in effect, plans with less risky enrollees are paid less than those with higher-risk enrollees.

As a technical matter, identifying and measuring what distinguishes high-risk patients from others has proved difficult. Demographic characteristics such as age and gender are relatively easy to obtain but explain very little of the variation in health care use. More detailed information on the health status of individual enrollees permits better adjustments; nonetheless, the development of appropriate risk adjustment techniques is considered to be in its early stages.[2]

Defined Contribution and Premium Support Approaches to Reform

The "defined contribution" approach to Medicare reform builds on

managed competition principles. In general, Medicare beneficiaries would be given a subsidy to purchase coverage among competing plans. Converting Medicare from a "defined benefit" health plan to a "defined contribution" structure would make a profound and fundamental change in the nature of the program.

Because the defined contribution concept has influenced the development—and criticism—of recent legislative proposals, it therefore bears review before turning to the specifics of these proposals.

The terms "defined benefit" and "defined contribution" come from the realm of employer pension benefits, within which defined contribution plans have become more popular over the past twenty-five years. In the more traditional defined benefit pension program, benefits are computed according to a formula, perhaps based on years of service and percentage of pay, and are generally paid out as an annuity to provide guaranteed income in retirement. In contrast, defined contribution plans are employee benefit programs that are often designed more as savings vehicles than retirement plans. Employers pay predetermined amounts, typically a percentage of compensation, into individual accounts. While both plans have advantages and disadvantages, the defined contribution approach is generally thought to provide less security of retirement income because employee contributions or investment growth may be inadequate.[3]

Under the basic version of a defined contribution approach for Medicare, the federal government would provide Medicare beneficiaries with a subsidy, or voucher, toward the purchase of private health insurance rather than guaranteeing payment for specific health care benefits.[4] The voucher would not necessarily be given directly to beneficiaries for the purpose of purchasing insurance. Instead, the government could send the subsidy payment to the beneficiary's private health insurance plan of choice, with the beneficiary responsible for paying any premium amount charged above the value of the subsidy. Critical details of such an approach include how much the government subsidy would be worth, at what rate the subsidy would grow over time, the extent to which benefits could vary among competing plans, and what other rules, if any, would cover the private health insurance plans available for purchase with the subsidy.[5]

An important issue to be addressed in considering the conversion of Medicare into a defined contribution plan is the treatment of the original fee-for-service Medicare program (defined under the Social Security Act as "original Medicare"). While more than 6 million

beneficiaries are currently participating in Medicare through health maintenance organizations (HMOs) and other private plans, about 85 percent of the program's beneficiaries receive their services through original Medicare. (Beneficiaries in original Medicare are free to choose their health care provider, and the provider is generally paid a fee established by the Medicare program for each service provided. Beneficiaries who are enrolled in HMOs are generally restricted to providers who are employed by or under contract to the HMO. Rather than being paid separately for each specific service, HMOs sometimes pay providers a monthly, per enrollee fee.)

In theory, under the purest form of a defined contribution approach for Medicare, competition would attract the participation of private plans, making them available everywhere. Thus, the traditional government-run plan could be scrapped, with beneficiaries enrolled in the private plan of their choice. Alternatively, original Medicare could be continued only in those areas that have no private plans available (for example, rural areas), it could be maintained as a competing plan option in all areas, or it could be retained for current beneficiaries, ultimately to be phased out as an option.

From the perspective of the federal budget, a defined contribution approach to Medicare has obvious benefits. For the first time, Medicare spending would be easily controllable and predictable for budgeting purposes. An annual aggregate Medicare budget could be easily converted into a per beneficiary subsidy amount. Or the value of the per beneficiary Medicare subsidy could be determined in a number of other ways intended to link it to the cost of the health insurance it is meant to subsidize.

Proponents of the defined contribution approach believe that it would lower the cost of providing Medicare benefits by creating a competitive insurance market. Beneficiaries would choose among a number of plans, which would compete for enrollees on the basis of premiums, benefits, and the quality of the health services they finance. Because the government contribution would be fixed, beneficiaries would have a financial incentive to choose the lowest-cost plan that met their health care needs. In such a market, plans would become more efficient in order to attract enrollees, and this in turn would lower the overall cost of the Medicare program. In addition, this view holds that the systemic savings achieved through private plan competition would outweigh the new costs to Medicare associated with competition, such as duplicative marketing campaigns

and other administrative expenses borne by individual plans.

Underlying the argument that competition will improve the overall efficiency of Medicare is a belief that private plans, particularly managed care plans, will be more cost-effective than the original fee-for-service Medicare program. Managed care's emphasis on preventive care, discounting achieved through selective contracting, and utilization controls (for example, shortening hospital stays) are seen as efficiency advantages over fee-for-service systems. Included in this line of thinking is the notion that, in a reformed Medicare program, beneficiaries should only be allowed to participate in what is viewed as the relatively inefficient fee-for-service program if they are willing to pay more to do so, or if changes are made to original Medicare to make it more efficient and competitive with private managed care plans. The major concern with the defined contribution approach is the danger that it could "solve" Medicare's long-term financing problem simply by shifting costs onto Medicare beneficiaries, who then might not be able to afford the health care they need. Of course, the specific impact of a defined contribution approach would depend greatly on the details, particularly the generosity of the government contribution. But because enrollees would no longer be guaranteed any particular health care benefits, there would always be a risk that the subsidy would be insufficient to purchase comprehensive health insurance, causing some beneficiaries to forgo needed care. Even subsidies adequate to cover premiums for the lowest-cost-available plan might force those beneficiaries who cannot afford to pay more into a plan with benefits or quality of care that is not adequate to meet their health care needs or that would disrupt their existing care arrangements. If, as proponents argue, many plan options were made available across the country and appropriate attention was paid to quality standards for plans as well as to price competition, these concerns could be mitigated.

Furthermore, even if the level of the government subsidy was always sufficient to enable all beneficiaries to afford adequate coverage, a defined contribution plan would significantly change the relationship between beneficiaries and the Medicare program. In order for any competitive system to work, all beneficiaries would have to keep themselves informed about the health plans available to them and would have to learn how to evaluate their choices. Such a process would be new and confusing for many beneficiaries, and an aggressive program of beneficiary education would be essential. Language barriers and variation in literacy skills would need to be taken into account.

Furthermore, unique aspects of dealing with the Medicare population need to be considered. Some elderly and disabled individuals have physical or cognitive limitations that would make it difficult if not impossible for them to participate as active and savvy consumers in the way envisioned under the defined contribution approach. Indeed, nearly one-quarter of Medicare beneficiaries have cognitive impairments.[6]

These issues surface in the Medicare program already since alternative plans are available to many beneficiaries, but they would become critical under a defined contribution approach. The worst-case scenario currently for beneficiaries who stay in original Medicare because they are unaware of or confused by the availability of other choices is that they pass up possible savings on additional benefits. Under the defined contribution approach, beneficiaries who did not understand the implications of various plan options could pay much more than they do currently for basic Medicare benefits or could be locked into a network of providers inadequate to their needs.

Beyond the issues of financing, shifting the locus of decision-making about health care coverage and payment is another aspect of a defined contribution approach that appears to be attractive to some policymakers. Under a subsidy program, many difficult decisions about coverage of new technologies as well as about how to constrain payments to health care providers or limit benefits to keep within available resources could be left to private health plans rather than to the government. The government could modify the formula under which its Medicare contribution is determined, but many other changes would be made by individual plans. Plans may raise premiums, modify benefits, or reduce payments to health care providers. Plans will make these decisions taking into account calculations such as the likely behavior of competing plans, how changes would affect provider participation in the plan, the likely effect on beneficiary enrollment decisions, and other market conditions. Like private plans, those responsible for operating the fee-for-service Medicare program would have to consider these elements in order to ensure its financial survival.

Concern about micromanagement of the Medicare program by both Congress and the Health Care Financing Administration (HCFA) is often raised by supporters of reform and seems to underlie the desire to shift the locus of decisionmaking away from the government to private plans.[7] This concern has been highlighted in recent

years as efforts to slow growth in Medicare spending have produced complex policy decisions involving the creation and modification of fee schedules and other payment systems. All of these decisions are made within the context of the legislative and regulatory process, with the interests of beneficiaries, providers, and taxpayers in the balance, and they often have been the subject of intense congressional debate. At the same time that some policymakers may welcome relief from these hard choices, however, the push for increased regulation of managed care plans in most states and in Washington suggests that the public is not entirely comfortable granting private organizations sweeping authority to make decisions affecting access to health care services. At a more fundamental level than the popular desire for some government oversight of private health plans, policymakers will always be held accountable for how well the Medicare program serves beneficiaries because public dollars are involved.

As discussions about Medicare reform have evolved in Congress and policy circles, proposals for a defined contribution approach appear to have been set aside in favor of "premium support." The basic scheme of competing plans and providing beneficiaries with financial incentives to choose lower-cost plans is the same under both constructs. In at least one view, however, that of Robert Reischauer, "defined contribution" describes a system under which the amount the government pays toward private health plan premiums is calculated by formula and unrelated to the cost of health care benefits. For example, the government contribution could be computed simply to meet federal budgetary goals. In contrast, under a premium support approach, the dollar amount of the government contribution is linked in some way to the cost of a core set of benefits. This could be accomplished by basing contributions on the prices bid by competing plans for a basic set of benefits, for example.[8] With this distinction, premium support can be seen as a variation of a defined contribution approach that responds to the strongest criticisms about how a pure defined contribution approach would affect the ability of Medicare beneficiaries to pay for the health care services they need.

Plan Competition in Practice: The Federal Employees Health Benefits Program and Medicare+Choice

The Federal Employees Health Benefits Plan (FEHBP), through which federal employees receive their health insurance coverage, and Medicare+Choice, the part of Medicare that permits beneficiaries to receive coverage through private plans, each have been cited as models for reforming Medicare using competition among private plans. Experience with these programs is useful in identifying issues that must be confronted when considering approaches to increase Medicare's reliance on plan competition.

The Federal Employees Health Benefits Program as a Model for Medicare

FEHBP is often suggested as a model for a reformed Medicare program. (Indeed, FEHBP has been offered as the basis for health care reform proposals involving the non-Medicare population as well.) Beyond the obvious political appeal of advocating that other Americans should have the same health insurance as members of Congress and federal employees, FEHBP is cited, with some overstatement, as a working model of the premium support approach to providing health insurance.

FEHBP does feature some elements of a premium support approach. Federal employees and retirees are provided an annual choice of private health plans, including a national Blue Cross/Blue Shield plan, several other national plans offered by federal employee associations, and a varying number of local HMOs.[9] The Office of Personnel Management, which contracts with plans, provides participants with comparative information on plan benefits, premiums, and quality measures.

The financing of FEHBP is somewhat reflective of premium support principles. The government contribution toward employee coverage provides some incentive for employees to choose lower-cost plans, consistent with the defined contribution and premium support approaches.[10] But under FEHBP, benefits vary across plans, and the government contribution is not linked to any specific set of guaranteed benefits. As described earlier, the emerging premium support model would have the government payment ensure that at least one plan offering a particular set of benefits would always be available for the minimum enrollee contribution.

One area in which FEHBP has not been a model for the man-

aged competition or premium support approaches is in avoiding biased selection of plans. The program has had no mechanism for adjusting premiums among plans to reflect the relative risk of enrollees. The result is a wide variation in plan premiums, even within geographic areas, largely owing to differences in the characteristics of enrollees. This means that the government is most likely compensating excessively those plans that have enrolled relatively healthy enrollees and therefore overpaying for health benefits overall. For example, one analysis of the Washington, D.C., area found that while the estimated benefit value of plans varied by 31 percent, premiums varied by 159 percent, with the geographic basis on which premiums are computed and overall plan efficiency explaining little of the variation.[11]

A history of relatively low premium growth has been suggested as an advantage of the FEHBP approach, but, like private sector health costs generally, the trend more recently has gone in reverse. Spending per FEHBP enrollee grew at an annual rate of 7.1 percent over the 1987–97 period, compared with 8.1 percent growth in per capita spending under Medicare. While annual FEHBP spending growth was below this average in the mid-1990s, the past two years have seen sharper increases—premiums increased by an average of 7.2 percent in 1998, 9.5 percent in 1999, and 9.3 percent in 2000.[12] In contrast, Medicare spending growth has been much slower than average in the past few years, with an unprecedented decrease in 1999.

The important question is to what extent the structure of FEHBP demonstrates cost-containment success that could be replicated in Medicare. Proponents argue that the Office of Personnel Management (OPM)can use its administrative flexibility and bargaining power to negotiate favorable terms with plans. Other students of the FEHBP believe, however, that the OPM has been less active as a premium negotiator than is often suggested.[13] In addition, like any employer, the federal government is constrained in managing its health benefits program by having to take into account labor market conditions and likely employee reaction when considering any decision that might reduce benefits or require employees to leave a popular plan. Unlike for private sector employers, there is a political element as well, as unions and employee associations have recourse to Congress if they are unhappy with OPM decisions. These constraints are cited by analysts as making it difficult for OPM to avoid, for example, recent dou-

ble-digit increases in the Blue Cross/Blue Shield premium, the most popular plan.[14]

How the virtues of this process could be applied to the Medicare program is uncertain. If the FEHBP model were directly adopted by Medicare, private plans would have freedom to propose benefits and premiums. But how much of a "free market" would be created is arguable given that the government, possessing new flexibility in entering into agreements with plans, would have a great deal of negotiating strength in representing the single largest pool of potential plan enrollees. On the other hand, the negotiating balance could shift if the FEHBP model were applied in its entirety and Medicare no longer operated its own health insurance program. Under that circumstance, the government would be responsible for arranging affordable private coverage options for millions of Medicare beneficiaries around the country without a safety net.

MEDICARE+CHOICE AS A PLATFORM FOR MEDICARE REFORM

The changing nature of HMOs and their role in the American health care system have been reflected in Medicare policies over the years. Only a small number of HMOs existed when the Medicare program began in the 1960s. Since these organizations were not set up to bill on a fee-for-service basis as Medicare generally requires, special policies were created to pay HMOs for services provided to Medicare beneficiaries. As managed care began to expand in the 1980s, a mechanism was established under which managed care plans could contract to provide Medicare benefits for a monthly, per enrollee (capitation) payment.

More recently, influenced by the managed competition model, major changes were made to the Medicare managed care program in 1997, with the creation of Medicare+Choice under the Balanced Budget Act of 1997 (BBA). More plan choices were encouraged, as private plans other than HMOs, such as provider-sponsored organizations, preferred provider organizations, and private fee-for-service plans, were enabled to participate in Medicare. An annual open enrollment process was established, consistent with the managed competition model, under which beneficiaries would ultimately be locked in yearly to their plan choices.

The most significant changes made under the BBA, however,

were those regarding how plans are paid, and issues surrounding payments to Medicare+Choice plans are relevant to reform proposals based on increasing plan competition. They include the overall level of payments to plans, the related issue of risk adjustment methodology, and geographic variation in plan payments leading to differences in benefits.

Overall level of plan payments. Under pre-BBA policies, aggregate Medicare payments to HMOs were known to be excessive. Medicare had generally paid HMOs capitation rates based on the cost experience of fee-for-service Medicare in their local area, less 5 percent, a discount intended to recognize managed care efficiencies. For years, analysts have concluded that, despite this discount, plans are overpaid because beneficiaries choosing HMOs are relatively healthy compared with those enrolled in original Medicare.[15] While payments were adjusted to reflect cost differences attributable to demographic characteristics, such as age, sex, and institutionalization status, these adjustments were insufficient to correct for the relatively healthy condition of the Medicare HMO population. In response, the BBA lessened increases in average plan payments for several years and required adoption of a new risk adjustment system, although subsequent legislation reversed these to some extent.

Risk adjustment. Because risk adjustment is critical to the success of any plan competition approach, the associated operational difficulties are important to note. The new risk adjustment system resulting from the BBA requirements will be based on actual use of services by individual enrollees, initially using inpatient hospital data.[16] Plans will be paid more for enrollees who have in the past been hospitalized with certain diagnoses than they will for those enrollees who have not had such a hospital stay. The new system is controversial, in part because it will result in a reduction in total payments to Medicare+Choice plans. More important, since it reflects exclusively inpatient hospital data, it is considered only a first-generation risk adjustment system, one that may inadvertently encourage greater use of those services that trigger higher payment. HCFA has indicated that it plans to move to a more comprehensive risk adjustment system by 2004, but many technical obstacles must be overcome before then. In particular, plans must develop information-gathering procedures that enable them to furnish the accurate health

status data necessary for such a system to work.

Geographic variations in payments and benefits. The BBA also made changes in payments to reduce geographic disparities among Medicare payments to managed care plans—a particularly complex issue because it has implications for the scope of benefit packages available to Medicare beneficiaries through Medicare+Choice plans. As will be seen in Chapter 3, all Medicare reform proposals will confront difficult choices involving geographic variation.

Specifically, in some high-cost areas, Medicare payments to Medicare+Choice plans have permitted HMOs to offer Medicare enrollees additional benefits, such as prescription drug coverage, for no additional premium. In other areas, payments to plans have not permitted as much additional coverage, or no private plan options were available at all. The opportunity that some Medicare beneficiaries have had to receive federally subsidized supplemental benefits might not seem to be a problem; in fact, it is arguably a good incentive to encourage beneficiaries to enroll in managed care plans, if that is seen as desirable.

But free additional coverage has not been uniformly on offer. Its availability depends on how much Medicare pays plans in an area, including overpayments resulting from favorable risk selection, rather than on the efficiency of the local HMOs. By modifying payments to plans (for example, increasing payments in rural areas and blending payment rates in high-cost areas with national average rates), the BBA policies intended to encourage HMOs to offer policies in previously unserved areas while attaining savings in places where overpayment has been a concern.

Medicare+Choice experience and lessons for Medicare reform. While both the number and proportion of beneficiaries opting to receive Medicare benefits through a Medicare+Choice plan have grown since the program began, expansion in Medicare+Choice enrollment has been less than expected, and the curve flattened in 2000. In January 1998, the Congressional Budget Office projected that, with the enactment of Medicare+Choice, enrollment in managed care plans would grow by about 20 percent a year—reaching 7.8 million in 2000 (about 20 percent of enrollees) and more than doubling to 16.8 million, or 38 percent of enrollees, by 2008.[17] As of July 2000, however, 6.2 million Medicare beneficiaries were en-

rolled in private plans (about 16 percent of beneficiaries). While this is significantly higher than the figures prior to implementation of Medicare+Choice (5.2 million enrollees for December 1997), plan enrollment fell during 2000—having peaked at 6.4 million in December 1999.[18]

In the past few years, Medicare+Choice plans have reduced the extra benefits that are a major attraction to enrollees. More plans are charging a premium for such benefits, and prescription drug coverage is being significantly reduced by caps and copayments.[19] The average premium for the basic benefit package for continuing plans rose from $5 a month in 1999 to $16 a month in 2000.[20] Plan withdrawals from the program also have been a concern, disrupting coverage for thousands of beneficiaries.[21] Even more plans intend to reduce benefits or withdraw from program participation in 2001.[22]

These changes have occurred despite continual findings that Medicare+Choice plans are overpaid for basic benefits, adding to the cost of the Medicare program. Unusually small increases in payments to plans over the past few years have been applied, indirectly reflecting savings achieved in the original Medicare program as well as changes in Medicare+Choice compensation policies. Coupled with the rising costs of prescription drug coverage, the amounts awarded apparently have not been sufficient for many plans to maintain the level of benefits that draw enrollees or for making Medicare+Choice participation an attractive line of business for plans. Thus, the Medicare+Choice program may inadvertently have achieved greater beneficiary equity by taking away the additional coverage provided to beneficiaries in some areas rather than by making those benefits more available to others, as intended. The 106th Congress enacted legislation to increase Medicare+Choice payments to plans in an attempt to reverse these trends.

This recent experience with Medicare+Choice sets the stage for the larger debate over the long-term role of private plans in Medicare. In the view of some analysts, difficulties with Medicare+Choice reveal the advantages of a premium support approach under which plans could bid premiums reflecting local market conditions rather than being forced to accept or reject a government-determined payment level. To others, however, the Medicare+Choice experience raises questions about the feasibility of increasing the role of private plans in Medicare. If a major goal of reform is to make Medicare more

affordable to taxpayers in the long run, private plans must be able to provide Medicare benefits at a significantly lower cost than the original program, especially given the costs and burdens associated with managing an expanded competitive market (for example, risk adjustment and beneficiary education).

Thus, issues emerging from experience with the Federal Employees Health Benefits Program and Medicare+Choice, such as the effectiveness of plan competition as a cost-containment tool, the importance of risk adjustment, and geographic variation in benefits, will figure prominently in the discussion about reliance on private plans in Medicare. Chapter 3 examines how the two leading proposals for Medicare reform suggest handling these and other issues.