

April 1996

Medicare Reform: A Model for National Healthcare Reform?

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Prepared with support from the Robert Wood Johnson Foundation

Summary: Among the factors that have stalled enactment of national healthcare reform have been ideological divisions between those who favor a government-run social insurance program and those who favor private health insurance plans and market solutions. These differences have deep roots in the political philosophies of the two major political parties and their core supporters. Nevertheless, with nearly 45 million individuals uninsured and with that number growing by 1 million per year, our society needs a political compromise that will end the gridlock.

Is there a political formula that could serve as a starting point for enacting bipartisan healthcare reform, with universal coverage, next year? The possibility explored in this paper is that the Medicare reforms passed by Congress in this legislative session may provide such a model. These reforms offer a broad framework for dealing with issues of social insurance versus private health insurance as well as with market reforms, quality assurance, benefits, cost control, and financing for 37 million individuals. The basic elements in this Republican-drafted legislation were also included in President Clinton's proposals, and they incorporate ideas with sponsors from each political party and from key constituency groups.

If national reforms were based on this model, individuals with employer-offered coverage would be able to choose enrollment in private plans or Medicare, with equal employer contributions, at their workplace; other individuals could also sign up for private plans or Medicare. All health insurance coverage would be guaranteed-issue, renewable, and without preexisting condition limits, and individuals would be able to make informed enrollment choices based on quality report cards and other performance measures. Quality standards would be established for managed care plans, and provider-sponsored networks would be encouraged. The Medicare program's costs would be controlled by a preset per capita budget, enforced (if necessary) by adjustment of its provider payment rates; private health plan premiums would be set by market competition. Affordable coverage would be more available because of Medicare's low administrative expenses, price discounts, basic benefits package, and predetermined cost increases and as a result of

market competition between Medicare and private health plans. To provide new financing for the uninsured, federal tax subsidies for private health insurance would be phased out over the same income range as the proposed phaseout of Medicare general revenue subsidies for the Supplementary Medical Insurance (Part B) premium. The potential attractions of the Medicare model as a starting point for national healthcare reform, with universal coverage, and some of the major unresolved issues for its broader application are discussed in this paper.

The Medicare reform model in the Balanced Budget Act of 1995 deals with most of the major issues that arise in designing comprehensive healthcare reforms. In resolving these issues, the legislation proposes a grand compromise in which visions of competing private health plans and a social insurance program coexist, without government forcing acceptance of either approach. Rather, both social insurance (Medicare) and competing health plans are offered, allowing each individual to choose the financing-delivery system package that best meets his or her needs. The legislation also reflects astute balancing of many interests among providers, insurers, the elderly, and other groups. The unresolved issues between this legislation and the Clinton administration's proposals mostly involve creating a level playing field between the Medicare program and private health plans, so that the public could choose between the best that the government and the private sector can offer.

How well would these Medicare proposals work as a model for national healthcare reform? In this paper, the reader is invited to consider this question with an open mind. This model will not be the first choice for many of the individuals and interests involved in healthcare reform legislation; it would be a compromise formula, as it is for Medicare reform. Nevertheless, national healthcare reforms based on this model, particularly if a final agreement included universal coverage,

would be a “win-win” proposition for both market-competition and social insurance advocates, providing both a better-functioning private health insurance market and a social insurance option on a nationwide basis. This model does not try to resolve, through the application of political power, the victory (or demise) of either party’s political ideology or to determine the health system’s future; it accords the decision power to individuals, through choices in a competitive marketplace.

The following sections take up each of the major elements of the Medicare legislation and their potential application to national reform:

- social insurance and private health plans;
- market structure, health plans, and quality assurance;
- benefits;
- cost control; and
- financing for universal health insurance coverage.

SOCIAL INSURANCE AND PRIVATE HEALTH PLANS

The “public versus private” debate has been a central philosophical issue in national health insurance debates over the past century. Those who favor government health insurance and price regulation, e.g., a Canadian model, have emphasized the economies of this approach and the shortcomings of private health insurance. Those who favor private health insurance have emphasized the dangers of government-run health systems and the virtues of private market solutions. The inability to resolve such differences through deciding politically on a single national model reflecting one philosophy or the other was a key factor in the political failures of past national healthcare reforms.

The lack of national consensus in favor of one or the other of these approaches is also reflected in public opinion polling. During the recent political debates on comprehensive reforms, no approach was able to garner more

than about one-third of the public’s support as a first-choice solution, and each approach had significant opposition, particularly from those who wanted a different solution. Not surprisingly, core Democratic constituencies tend to favor social insurance and government regulation, while core Republican constituencies tend to favor private insurance and market solutions. These differences seem unlikely to disappear in the immediate future.

In the Medicare reform legislation, the Congress proposes a “two-track” compromise formula that includes both a social insurance program, with government price controls (Medicare) *and* private health plans with market-set premiums, benefits, and other features. The two systems would compete, in this real-world test, to determine which approach can best serve the public. Individuals who preferred the Medicare program would be able to elect that choice; individuals who preferred private plans would be able to elect their preferred option, and no one would be required to enroll in a plan he or she did not want.

How would this new Medicare model work if it were adopted as national reform legislation? A comparable choice system might have the following elements:

- Individuals with employer-sponsored health insurance plans would be able to choose between enrollment in these private plans or (with equal employer contribution) in the Medicare program.
- Individuals without employer-sponsored health insurance or other coverage would also be able to enroll in either Medicare or private health plans, e.g., through an insurance broker, by mail, or in a number of other ways.

How might individuals, employers, insurers, and providers see this broader menu of choices?

- Individuals might respond well to a broader choice of health plans, particularly the assurance of a cost-controlled fee-for-service insurance plan. Over the past

several years, employers have moved most workers into managed care plans, with limited choice of options. The percentage of insured workers in managed care rose from 29% in 1988 to 70% in 1995.¹ The most usual arrangement for private sector employees (48%) is to have only a single plan—no choice. An additional 23% of workers can choose only between two health plans. Some 83% of workers can choose among three or fewer health plans, and only 17% can choose among four or more offerings.² Public opinion polls show dissatisfactions with managed care, quality assurance in many managed care plans is well short of what is needed, and there are strong reasons for worry about how well chronic care and high-expense populations, on whom managed care companies predictably lose money, will fare in the future.

- Employers might also welcome the opportunity to offer a Medicare option as a cost-controlled fee-for-service plan. Employers have dropped traditional fee-for-service insurance because private plans could not control costs, but managed care plans and limits on provider choice are far from universally popular with workers. A Medicare option, with the government responsible for cost control, would offer a way for employers to include a fee-for-service, open-choice option without financial risk. The option would also be a “safety valve” for employees who do not like or are not well-served by managed care choices. If an employer were required only to make a contribution to Medicare that was equivalent to that for a private health plan, this arrangement would seem to assure more satisfied employees without additional employer costs.

The Medicare option might prove particularly attractive for smaller employers and in areas of the country without well-developed managed care plans. Smaller employers, facing high insurer administrative expenses (15% to 40% of premiums)

and less able than larger companies to take advantage of purchasing power, could find a Medicare option to be quite price-competitive. Employers in areas where many managed care companies are only “discount” networks with little real management capacity might also find that a Medicare price-controlled program offered a tough (and useful) competitive “benchmark” for private health plans.

- For private health insurers, although the new arrangements provide additional competition, they would also help to assure that individuals who dislike managed care or whose conditions are not well taken care of in such arrangements would not be forced to join or remain in such plans. This safety valve might help to lessen public pressures for comprehensive regulation of the managed care industry. Preservation of a viable fee-for-service program, which protected providers from being forced into managed care plans, might also serve as a safety valve that lessened provider pressures for anti-managed care legislation. Those insurers who believe that the private sector would unquestionably be able to do a better job than a government-run insurance program should not be dissuaded by having to compete with a Medicare option.
- Many providers, with the rapid demise of private fee-for-service insurance, face a future of working for insurance companies that tell them how to practice medicine, cut their incomes, and extract a 15% to 25% management fee and profit margin from the premium dollar. Broader Medicare availability would preserve a national fee-for-service option and, leaving out the insurance company middleman, would foster development of the “direct contracting” initiatives that Medicare has started with healthcare providers. If a final agreement included universal health insurance coverage, providers would also see a substantial reduction in bad debts and charity care, and their patients would have fewer financial barriers to needed medical care.

MARKET STRUCTURE, HEALTH PLANS, AND QUALITY ASSURANCE

Healthcare reform debates have moved far toward agreement about how to redesign the private health insurance market so that it works better for consumers. Many leading reform proposals have included requirements that health insurance plans be available on a guaranteed-issue and guaranteed-renewable basis, that they include no exclusion of preexisting conditions for continuously insured individuals, and that individual health status not be used in premium setting. New quality assurance standards for managed care plans and "report cards" for quality assurance are other features of many market reform proposals. The Clinton health plan included large health alliances to manage much of the private health insurance market, but this proved to be one of its most controversial features.

The Medicare reform legislation would structure an individual choice market that included major reforms to improve the health insurance market. Health plans would be required to meet standards for guaranteed issue and renewability and prohibited from excluding preexisting conditions; in addition, they could not vary rates by individual health status. Health plans would be required to meet new quality and accreditation standards, and consumers would have "report cards" that provided them comparative information on health plan performance. New sponsors of managed care, e.g., "provider service networks" would be encouraged. There would be no large health alliances, but, as in the Federal Employees Health Benefits program (FEHBP), individuals could switch plans at an annual open season.

How would such an arrangement be extended from Medicare-only provisions to comprehensive health reform? This extension also might be done in a straightforward manner:

- National reform legislation would set standards requiring health plans to be guaranteed-issue, guaranteed-renewable, without restrictions for preexisting condi-

tions for continuously insured individuals, and to bar individual health status as a factor in premium setting.

- National reform legislation would also establish the same quality and accreditation standards as for Medicare plans and require the same kinds of "report card" information for consumers.
- Provider service networks would be fostered for the under-65 population on the same basis as for the over-65 population;
- Individuals could sign up for Medicare or other health insurance plans with their employer, through insurance brokers or cooperatives, in other locations, and by mail.

These reforms also seem likely to have broad public appeal. In particular, they would solve most of the concerns about portability of benefits and medical underwriting that have kept health insurance reforms high on the nation's political agenda. The option for anyone to select Medicare enrollment, which would be universally available and totally portable, should be particularly reassuring.

BENEFITS

The recent national health insurance reform debates involved much discussion about designing a uniform comprehensive benefit package that would be offered by all health insurance plans. There are arguments for and against benefits standardization. In considering the Clinton health bill, the political process was unable to resolve this issue, and there were many pressures to require benefits that were more expensive than those now being purchased in the market.

The Medicare reform legislation would resolve this issue by (1) requiring that Medicare and all of the competing plans cover at least the basic Medicare benefit package but (2) allowing private health plans to provide additional benefits or lower cost sharing. Most private plans now offer richer benefits than the basic Medicare package. The legislation

also includes a catastrophic health insurance plan and medical savings account option.

If the Medicare model were extended to national health reforms, it could provide that:

- All health plans would have to offer at least the basic Medicare benefit package.
- Health plans could also offer additional benefits and lower cost sharing.

The requirement for health plans to match the current Medicare benefit would not be a difficult one. In the recent national health reform debates, the Medicare program was considered only a "20th percentile" health plan by today's standards. It does not offer benefits that are as comprehensive as most private health plans (particularly drug coverage), nor does it have a limit on out-of-pocket expenses or catastrophic expenses. Its cost sharing is high compared to private sector norms.

Allowing health plans to offer a variety of benefit, cost-sharing, premium, and other options would lessen but would not eliminate effective head-to-head competition among health plans. As has been found in the FEHBP, for example, most plans tend to have similar benefits, reflecting what most individuals seem to want. Only a few plans can really find "niche" markets that are far outliers from the mainstream benefits. In the employer-sponsored market, employers can still standardize the private sector health plans available to their employees.

Some modification of the Medicare benefit package should be considered, however, for providing basic medical care for a population not made up of the elderly and disabled. The most important improvement would be preventive care for expectant mothers and children. A possible tradeoff would be to limit the types of posthospital (home health, rehabilitation facility) benefits that are important for Medicare's elderly and disabled enrollees but are not offered by most private insurance plans for the under-65 population; they have also been difficult expenses for Medicare to control. A national debate on using the

Medicare reform model would likely produce some additional changes, as well, but it seems advisable to start discussions close to the current benefit package, for three reasons:

- The Medicare program's basic benefit package helps to make it affordable and also reduces the costs of expanding coverage for the uninsured.
- The Medicare program's basic benefit package, e.g., its lack of prescription drug coverage, may help protect it from adverse selection in a multiple-choice environment where most of its competitors offer richer benefits.
- A major expansion of the Medicare benefit package for the under-65 would be difficult to justify unless financing also exists to make these benefits available to the over-65 Medicare population.

In its Medicare reform proposals, the Clinton administration has suggested that Medigap policies also be included in the new "open season" market, so that individuals could supplement Medicare economically. Currently, many Medigap products are significantly overpriced, e.g., 38% of Medigap plans failed to even meet minimum national payout standards in 1993.³ Alternatively, the Medicare program itself could be allowed to offer supplements. Either of these approaches would also be candidates for an expansion to the under-65 market.

Whether or not to include medical savings accounts and catastrophic-only coverage for Medicare beneficiaries is an outstanding issue between the Clinton administration and Congress on Medicare reform. It would also be an issue to be resolved in an expansion of the new Medicare model to national health reform.

COST CONTROL

The issue of controlling healthcare costs has been one of the perennial controversies producing a stalemate in national health reform debates. Advocates for private markets have maintained that competing managed care

plans will best be able to achieve economies in healthcare delivery. Advocates for government regulation have argued that it is the only guaranteed-effective means for limiting future spending. The provisions of the Clinton reform plan that budgeted national health spending through limits on private health insurance premiums (with backup price controls on the fees between private health plans and their participating providers) were among its more controversial features.

In the reformed Medicare plan, the Congress has designed a way to let the public sector program and private sector plans achieve cost control in different ways, while holding government costs in line. The traditional Medicare program would be limited to a prebudgeted rate of increase in per capita spending over the next seven years, with fees for providers cut back, as needed, to keep the program within its budget. The government's per capita payments for private health plans would also be preset over the next seven years, but private market competition would determine the plans' actual premiums, benefits, and cost sharing. Unlike the Clinton plan, this plan would have no government-set premium regulation and no price controls on health plan payments to their participating providers. Over time, the government payment to health plans would also be adjusted to provide fairer payment differentials between low-expenditure and high-expenditure areas.

In this design, the budgeted limit on the basic Medicare program (and a preset Part B premium) would help to keep health insurance affordable and also serve as a competitive brake on private health plan premiums, since, if the plans became too expensive, individuals could choose to opt out of them to join the Medicare program. The limits on federal premium payments also would mean that consumers would be fully cost-conscious for choosing high-premium plans.

A national reform model based on this "two-track" cost control approach could include the following elements:

- The expanded Medicare program for the under-65 population would also be pre-budgeted with a per capita enrollment budget and it would be maintained within these budgets over the next seven years by fee cutbacks to providers (if necessary).
- Private health plan premiums would be determined by market competition.
- The actual per capita costs of the Medicare program for the under-65 population could be used to set caps on the amount of the employer premium contributions that would be exempt from the personal income tax. Thus, these federal (tax) expenditures would also be budgeted (with budget savings), and there would be stronger market incentives against excess inflation.

One of the issues still to be resolved for the Medicare model is the need for new Medicare authorities. Modifications proposed to the congressional reform legislation would give Medicare greater purchasing flexibility to compete with private plans. If Medicare had only its price-control authorities, it would be more competitive than traditional health insurance plans but would lack all of the tools needed to be as good a program as it could be. These types of changes seem essential if Medicare is going to be able to achieve better cost control and compete fairly in the new environment.

A second issue in assuring fair competition between Medicare and private health plans for the under-65 population is the possibility of "cost shifting" if Medicare had to make major cuts in its provider payment rates in order to stay within its legislatively set budget. It is not clear whether such cost-shifting problems would occur. Initially, the opposite would probably occur; there would be large economies for private health plans if a comprehensive reform package made possible coverage for the 45 million uninsured, and providers no longer shifted these costs onto private payers. The ability of providers to form "provider service networks" would be a further check on the Medicare program's ability to impose below-market rates.

For the longer term, such concerns also argue that Medicare would need additional authorities to deal with excessive costs other than through price controls, so that such cost shifting could not occur.

This new Medicare-private insurance competitive design, extended to the entire population, might also need some sort of risk-adjustment mechanism between Medicare and competing plans for the under-65 population. It is not clear that such a mechanism would be needed. Medicare's basic benefits package would be some protection against adverse selection compared to more generous private insurance benefits, and the freedom-of-choice differences between Medicare and traditional HMOs would be lessened by the rapid growth of more "point-of-service" plans. As private sector managed care plans have enrolled most of the under-65 insured population and have continued to grow rapidly, their enrollees have begun to look more representative of the population, and the plans have become less able to be only "niche" competitors. But adverse selection against Medicare is a potential development that would need to be watched and dealt with if it posed a problem under a national reform scenario, particularly if managed care plans underserved the chronically ill and high-expense populations and induced them to move into the Medicare program.

Finally, there would need to be technical work and policy resolution about the insurance rating practices used by Medicare and private health plans. Use of the same rating factors and premium structures would foster fair competition between Medicare and competing plans.

If the Medicare model were extended to national health reforms, cost discipline on the entire health system should improve, because of the explicitly cost-controlled Medicare program, the improved health insurance market, and the competition between private sector plans and Medicare. While market-oriented advocates rightly tout the successes of the managed care industry in cost control, recent research has shown that, for comparable benefits, Medicare and overall private insurance

cost increases are quite similar.⁴ At the same time, the ability of the private plans to respond to the market avoids the arbitrary limitations of the Clinton plan.

FINANCING FOR UNIVERSAL HEALTH INSURANCE COVERAGE

A final set of major issues in healthcare reform have to do with financing. These include (1) how to pay for coverage of the uninsured and (2) how to assure a better health system financing base, among federal and state government, employers, and individuals. In past reform debates, these have been difficult issues to resolve. But they may prove much easier to deal with if there is a bipartisan consensus on the other major aspects of national healthcare reform. Certainly, in a \$6 trillion economy, technical options exist for raising the funds. Here again, the Medicare reform proposals may provide a useful starting point and a model for a comprehensive financing package.

The major new element of Medicare financing is the legislative reform provision to phase out the Medicare Part B premium subsidy (now 75%) over an income range of \$60,000 to \$110,000 for individuals and \$90,000 to \$150,000 for couples. This would produce an estimated \$8.5 billion of savings over the seven-year period.

In a national reform proposal, this same policy could be applied to phase out the exclusion of employer-paid health insurance premiums from taxable income over the same range. According to CBO estimates, the revenue loss from the favorable tax treatment of employer contributions was \$74 billion in 1994; comparable limits could produce \$10 to \$15 billion of government revenues annually, which is a solid start for covering the uninsured. For additional health-related tax revenues, other possibilities include increasing the federal cigarette tax to \$.99 per pack, as proposed by President Clinton. According to CBO estimates, this would raise approximately \$10 billion annually.

Another possible source of financing is a redirection of the overall savings achieved by the Medicare reform proposals. As part of the Balanced Budget Act of 1995, the Medicare provisions would account for some \$200 billion of deficit reduction over the 1996 to 2002 period and would be a major factor in allowing for sizeable tax cuts. Some significant portion of the Medicare savings—or a smaller tax reduction—might be additional sources for financing coverage of the uninsured.

The Medicare reform package, if extended nationally, would also help to assure more affordable health insurance for the uninsured and lower-wage workers because of four additional features: (1) the Medicare fee schedule discounts, which would lower its premium costs by 20% to 35% compared to many private market plans; (2) Medicare's low administrative costs—e.g., 3%, compared to the 15% to 40% administrative costs that now prevail in the small employer and individual coverage markets; (3) Medicare's modest benefits package, which would help make it more affordable than most private insurance; and (4) the preset Medicare spending limits over the next seven years. A fifth source of cost savings, if necessary, could be a reduction of the overall Medicare fee schedules to reflect the additional revenues providers would receive from expanded insurance coverage.

Better transitional coverage provisions would also assist in covering the costs of the uninsured. Surveys indicate that most of the uninsured are without health insurance temporarily as they move between jobs with coverage. President Clinton's budget proposals for a special program to help finance health insurance during unemployment might be a useful element of a final package. The Medicare program could also serve as "bridge" coverage for the unemployed, with financing from the Unemployment Insurance tax, a premium surcharge, or other financing sources.

For additional financing, the current Medicare program has a mixed revenue base that might also be adaptable as a model for national reforms.

- The costs of the Medicare program are split between employer-employee payroll taxes, general revenue taxes, and individual premium payments. (Hospital Insurance [Part A], about 65% of program costs, is financed from 1.45% employer-employee payroll taxes; Supplementary Medical Insurance [Part B], about 35% of program costs, is split 75% general revenues and 25% individual premiums).
- The federal-state Medicaid program provides coverage for the low-income Supplemental Security Income (SSI) population; it also pays the Medicare premium and cost-sharing amounts for individuals between SSI eligibility and the poverty level.

If adapted for a national financing formula, this multiple-revenue source model could have the following elements:

- Employers would be expected to pay at least a minimum share of the costs of worker-only coverage. On average, employer costs for a 50% share of comprehensive benefits would be about \$1,000 per worker (\$.50 per hour); possibly such a mandate could be in lieu of a minimum wage increase.
- Government general revenues would assist lower-income families with the costs of children's coverage. Government assistance for children and families has had a bipartisan history, e.g., mandatory coverage of children in poverty under the Medicaid program. The federal revenues from taxing employer health insurance contributions could be dedicated to this purpose.
- The Medicaid program would be redesigned with basic national eligibility standards and a "bridge" program of paying for Medicare (or private insurance) premiums and cost sharing for individuals between full Medicaid coverage and the poverty line.
- Workers with above-poverty incomes would pay the part of their premium not paid by the employer as well as the premiums for

other nonworking dependents. Administrative costs could be lower if workers were able to pay these health insurance premiums through payroll deductions.

If larger general revenue subsidies were needed, substantial amounts of money could be raised with fairly small tax changes. Perhaps it is unwise to attempt to convince the public that complete national health reform, with universal coverage and all of its other benefits, can also be without cost. The CBO estimates that a 1% to 2% rise in the federal income tax rates (from 15% to 16%, from 28% to 30%, 31% to 33%, etc.) would produce about \$45 billion annually in additional revenues.

CONCLUSION

The Medicare reform model could provide a starting point for national healthcare reform discussions next year. Without such a grand compromise formula as is in this legislation, the political system may recycle narrowly partisan proposals and continue political gridlock while the nation's problems grow steadily worse.

The proposed Medicare reforms, if extended as a model for national healthcare reform, would not resolve all of the important issues with respect to government and private sector roles, market reforms, health plans and quality assurance, benefits, cost control, and financing. Some major work would still be needed, particularly on a financing package and many technical issues. But the elements apparently acceptable to Congress and the Clinton administration, if adopted nationally, would go an extraordinary distance toward producing a better health system and a satisfied public.

The author thanks Stanley Jones, David Smith, and Eli Ginzberg for many health policy discussions.

ENDNOTES

1. KPMG Peat Marwick, *Health Benefits in 1995*, 1995.
2. Preliminary data from the 1993 Robert Wood Johnson Employer Health Insurance Survey, courtesy of Steve Long.
3. General Accounting Office, *Medigap Insurance: Insurers' Compliance with Federal Minimum Loss Ratio Standards 1988-93*, HEHS-95-151, 1995.
4. M. Moon and S. Zuckerman "Are Private Insurers Really Controlling Spending Better Than Medicare?" Report prepared for the Henry J. Kaiser Foundation, July 1995.