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Paradigm Shifts in Medicare Reform

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Summary: Reforms passed by Congress and vetoed by the president during the past year would have accelerated initiatives already transforming Medicare. Operating in a rapidly changing insurance marketplace, Medicare is shifting from a social insurance model toward a private individual insurance model—expanding the number and type of alternative health plans it offers—and growing numbers of beneficiaries are enrolling in these plans. Such reforms, especially if bolstered by legislative reforms that are likely to resurface after the November elections, will rewrite the social contract enacted more than 30 years ago. They require fundamental shifts in ways of thinking about the federal government’s responsibilities; the Medicare program’s management; relations between the Medicare program and doctors, hospitals, and other health care providers; and the role of beneficiaries in the Medicare program.

The likely deferral of further legislative attempts to reform Medicare affords an opportunity to step back and consider these ongoing changes. It is not easy to describe paradigm shifts accurately, but there are advantages to trying.

First, conceptual comparisons can allow public discussion to go beyond budget scorekeeping and media soundbites to consider how different the Medicare program will be if it evolves in the new ways being proposed. Second, a conceptual framework can assist health policy analysts to target what to watch for in tracking changes, to assess the tradeoffs involved, and to advise about the needs for refining legislation. This paper includes examples of what to watch for in tracking the implemented changes.

The paradigm shifts are summarized below, then described individually in terms of directions of change along a number of continuums. Note that complete paradigm shifts, from one end of a continuum to the other, are seldom completely realized nor even far advanced. But Medicare’s ongoing reforms, accelerated by legislative proposals, seem likely predecessors of future changes.

For developing this framework, the authors have drawn on the Medicare provisions of the Conference Agreement on the Balanced Budget Act of 1995, the president’s proposals as presented in December 1995, and current and proposed Health Care Financing Administration practices.¹

I. SHIFTS IN GOVERNMENT'S RESPONSIBILITY

From	→	Toward
Government pays for specified benefits	→	Government makes fixed contributions
Government is liable for rising costs	→	Individuals and providers are liable for rising costs
Government is at financial risk	→	Individuals and providers are at financial risk
Social Insurance	→	Private individual insurance
Government sets coverage and premiums	→	Market sets coverage and premiums
Premiums costs are shared collectively	→	Premium costs vary by individual and area

II. SHIFTS IN MEDICARE PROGRAM MANAGEMENT

From	→	Toward
Medicare is a universal insurance pool	→	Medicare is a residual insurance pool
Medicare for all	→	Medicare for disabled and chronically ill
Medicare is a health plan manager	→	Medicare is a multiple-choice administrator
One insurance program	→	Many insurance plans
Government is responsible for costs and quality	→	Health plans are responsible for costs and quality

III. SHIFTS IN THE ROLES OF DOCTORS, HOSPITALS, AND OTHER PROVIDERS

From	→	Toward
Appropriate patient care is determined by independent physician	→	Appropriate patient care is determined by plan-physician partnership
Physician is clinical manager		Physician is clinical and cost manager
Provider is paid by Medicare	→	Provider is paid by health plan
Provider is paid fee-for-service	→	Provider is paid by capitation, risk-sharing
Provider profits from too many services	→	Provider profits from too few services
Political system sets rates		Market sets rates
Most providers participate in Medicare	→	Most providers avoid Medicare

IV. SHIFTS IN THE ROLE OF BENEFICIARIES

From	→	Toward
Beneficiary is entitled to coverage	→	Beneficiary is entitled to choice
Standard benefits and premiums	→	Varying benefits, premiums, and other features
Choice of doctors and hospitals	→	Choice of health plans
Beneficiary with rights	→	Subsidized buyer with options
Trusting patient	→	Questioning consumer
Holding government accountable by voting	→	Holding plans accountable by shopping
Individuals wary of politicians	→	Individuals angry at health plans

I. SHIFTS IN GOVERNMENT'S RESPONSIBILITY

Since its enactment more than 30 years ago, the Medicare program has become an essential element of the financial security of the nation's elderly and disabled population, the nation's major payer of health care services, and the federal budget's second largest social insurance program. Medicare's offer of alternative health plans and proposed legislation to expand it embodies new public policies that will radically revise the social contract of the original Medicare legislation with respect to government financial responsibilities and the program's character as a social insurance program.

Government Pays for Specified Benefits → Government Makes Fixed Contributions

The overriding priority of the Medicare program, since its inception, has been to guarantee financing for health services benefits that are specified (or fixed) in statute on behalf of people eligible for Medicare. The federal budget's financial commitment has been open-ended; there has been no specified limit on the total or per capita costs that might be incurred by government. Congress has maintained and expanded Medicare benefits.

The Balanced Budget Act of 1995 would write into law a new overriding priority for Medicare policy: an absolute limit on federal Medicare spending. The reforms would move Medicare toward a fixed contribution, where the government's future liability will be limited to a fixed per capita payment toward alternative health plans chosen by Medicare beneficiaries and to a fixed total benefits budget covering the sum of these per capita payments and the cost of the traditional Medicare program.

The reform legislation would preset these per capita contributions to health plans and the government's total Medicare benefits budget for years 1996 through 2002. These amounts reflect arbitrary rates of increase to achieve federal deficit reduction targets and

tax cuts. They are tied neither to the actual future costs of Parts A and B benefits in either health plans or the traditional Medicare program nor to the future ability to pay of the elderly and disabled populations. The new legislation would “lock in” government savings estimated at more than \$200 billion over this period.

*Government is liable for rising costs —→
Individuals and providers are liable for rising costs*

This new paradigm would shift the liability for future costs above these prebudgeted amounts from the government toward individuals. The health plans would be required to offer basic Medicare benefits, but the government's per capita contributions would not be a guaranteed percentage of the future health plan premiums. If the premiums of Medicare's alternative health plans increased faster than the government's per capita contribution, the plans would be allowed wide latitude to increase out-of-pocket premiums charged to Medicare beneficiaries to make up the difference.

To afford beneficiaries a way to protect themselves against these potential premiums, the proposal would allow an annual “open season” in which individuals would be allowed to switch plan enrollments, and it would maintain the traditional Medicare program as a choice that could be purchased for a Part B premium specified in the law. However, the affordability of traditional Medicare would be accomplished through automatic fee cuts if the program's costs increased faster than the preset government benefits budget (minus per capita contributions to health plans). This would shift the liability for higher costs to providers.

*Government is at financial risk —→
Individuals and providers are at financial risk*

In the past, the government has borne the financial risk that Medicare costs would exceed budgeted amounts. Individual beneficiaries and health care providers would bear the

financial risk for how well the new system works. The Medicare beneficiaries, because of their need for health services and limited financial resources, would face the greatest consequences if other actors found ways to shift financial burdens. Health care providers that served traditional fee-for-service Medicare enrollees would bear disproportionate risk for payment cutbacks.

Social Insurance —→ Private Individual Insurance

A second defining characteristic of the Medicare program has been its structure as a social insurance program. Medicare's financing has been broadly shared through uniform taxes and premiums, it has guaranteed the same benefit package to all enrollees, and nearly all Medicare eligible persons have been enrolled in the same plan.

Medicare's ongoing efforts to offer alternative health plans shift the program away from the classical “social insurance” model toward a “private individual insurance” model in which Medicare beneficiaries shop among health plans and health plans develop a range of products, establish different prices, and market directly to beneficiaries as individuals. This new Medicare individual market is more heavily regulated than the current private individual health insurance market. The government enforces standards, including basic Medicare benefits, that health plans must meet before they can sell to beneficiaries and provides information and assistance to beneficiaries choosing plans. And health plans are required to take all applicants, guarantee renewal, and not impose preexisting condition restrictions.

*Government sets coverage and premiums —→
Market sets coverage and premiums*

With a new system of competing private health insurance plans comes changes in the coverage and premiums of Medicare beneficiaries, as well as in how those coverages and premiums are determined. For the past 30 years,

Medicare benefits and premiums have been nationally uniform and determined by politics and government policy. Under alternative health plans, Medicare is moving toward a system in which its coverage and premiums depend on how health plans choose to compete in the marketplace, what kinds of efficiencies or risk selection they can achieve, and what choices the Medicare population makes. Both congressional and ongoing Medicare reform proposals leave health plans' benefits free to float with the market, as long as they are not less than those currently provided under Parts A and B.

*Premium costs are shared collectively —→
Premium costs vary by individual and area*

As a social insurance program, Medicare has been financed by a nationally uniform system of financing, including the Health Insurance payroll tax, Supplemental Medical Insurance (Part B, general revenue) taxes, and a nationally uniform Part B premium. Within wide limits, current Medicare policy leaves private health plans' out-of-pocket premium charges to beneficiaries free to float with the market for any additional benefits over and above those of Parts A and B. The proposed reforms also leave premiums for Parts A and B benefits free to float with the market. Premiums thus vary by market area, as well as by individual choice of plan.

The fundamental questions to be asked if these shifts in government responsibility progress would seem to be: As government limits its own future Medicare costs and moves from social insurance toward individual health, how many of Medicare's 37 million elderly and disabled individuals and how many of its providers will be better off? How many will be worse off?

II. SHIFTS IN MEDICARE PROGRAM MANAGEMENT

Medicare's offer of alternative health plans and the proposed legislative reforms to accelerate it also require new ways of thinking

about Medicare management. With these reforms, the Medicare program is dividing into two very different, competing programs. One offers traditional Medicare and the other offers a choice of multiple privately administered health plans. Beneficiaries choose between them. The traditional program is becoming the residual or default pool for those who do not or can not choose a private health insurance plan. Management of both programs requires new government capabilities and organization and a new philosophy of how to manage each and the competition between them.

**Medicare Is a Universal Insurance Pool —→
Medicare Is a Residual Insurance Pool**

Traditional Medicare has been managed as one insurance pool. Ongoing and proposed reforms encourage many pools of Medicare beneficiaries. Private health plans determine the pools by the areas in which they choose to market, the benefits and types of plans they market, the premiums they charge, and the marketing tactics they use. Proposed reforms would give plans even broader latitude in all these respects, including defining the areas they chose to serve. Pools are likely to vary widely by benefits and premiums as well as by the health status of their members.

With the fragmentation of its risk pool, Medicare will change from being a universal insurance pool toward being a residual insurance pool for those who choose not to move to an alternative plan or who "default" into it. It is likely that private health plans will target their marketing toward younger, healthier Medicare eligibles; that individuals who are in poorer health and have close ties to their physicians will want to remain with the fee-for-service Medicare program; and that those who leave private health plans to rejoin Medicare will have more serious and expensive health problems than those who remain. The experience of large employers with indemnity plans in competition with multiple HMOs, PPOs, etc., has been that traditional programs are likely to retain sicker enrollees, or enrollees

who use more services than the average. All these factors will result in increasingly sharp differences between the populations enrolled in Medicare and those enrolled in its competitor plans.

The traditional Medicare program is not equipped to compete actively with the new alternative health plans offered to Medicare beneficiaries, nor is it to be given the necessary authorities to compete successfully by reform proposals. It would not be given the product design, premium flexibility, marketing prerogatives, and authority to manage care that is allowed to alternative health plans to contain costs, assure quality, and attract enrollees. Moreover, traditional Medicare would remain at a disadvantage in the competition because, unlike health plans, it could not fill in cost sharing, increase catastrophic limits, nor add benefits. Nor could it offer its own Medicare supplemental coverage, which is currently very expensive in the private individual insurance market and effectively increases the cost to the beneficiary of staying in traditional Medicare by \$1,000 per year.

Medicare for all —→ Medicare for disabled and chronically ill

The ability of the traditional Medicare program to compete for all enrollees will also increasingly be compromised by the lack of appropriate risk adjusters between Medicare and private health plans. Proposals for reform would require the DHHS secretary to limit risk selection by health plans and develop premium adjusters, so health plans could be paid based on characteristics of their pools. But there is no provision in reform proposals for using risk adjusters to increase traditional Medicare's share of the benefits budget and decrease payments to health plans to compensate for this adverse risk selection.

Moreover, the technology to adjust well for risk does not presently exist. The current Medicare AAPCC (average adjusted per capita costs) risk adjuster, while the most sophisticated in large-scale use, is badly flawed. New

technology would have to be developed to prevent the shift toward multiple choice and multiple pools from becoming a shift from "fair" to "unfair" distribution of government benefits among Medicare beneficiaries in the many insurance pools.

The traditional Medicare program's competitive disadvantages and risk segmentation will increasingly shift Medicare from being a program for all eligible populations toward being a program for individuals with disability, chronic illness, and terminal illness who will be "demarketed" by private health insurance plans. Traditional Medicare's challenge is likely to be finding ways to provide services more efficiently to these enrollees. Experimental authorities in the current program and in the reform proposals, such as expanded authority for purchasing by taking bids and selective contracting, might facilitate this. Developing strong premium adjusters or other new payment arrangements might ease the burden on Medicare by encouraging alternative health plans to work harder to attract the chronically ill out of the traditional program. But major efforts are needed to upgrade the capacities of the fee-for-service Medicare program to serve these populations, as well as to encourage competing health plans to do a better job.

Medicare Is a Health Plan Manager —→ Medicare Is a Multiple-Choice Administrator

In the past, Medicare has offered primarily a single (self-insured) health insurance program for the elderly and disabled, and it has paid doctors, hospitals and other providers for their services. In recent years, just like large self-insured employers, Medicare has offered a growing number of health plans as alternatives to the traditional plan.

One insurance program —→ Many insurance plans

The proposals to reform Medicare would hasten the program down this road from manager of a self-insured health plan toward

manager of multiple choice among competing health plans. Under these proposals, Medicare would need to structure an organized "open season" for its enrollees throughout the country and to qualify and oversee hundreds of new private health insurance plans.

Compared to private employers (and most public employers), the new alternative health plan administrator does not have much authority to manage these multiple choice offerings. Reform proposals do not greatly expand this authority. Medicare would not be able to negotiate with plans or to choose and offer a limited number. All plans that met the standard criteria would be permitted to sell their plans as alternatives to traditional Medicare. In contrast, the prevailing private sector practice is for an employer to use a competitive process for winnowing out plans and to offer a small selection to workers and their families. In 1993, only 11% of workers had a choice of five or more plans, while 6% had a choice of four plans, 12% could select among three plans, and 71% had only one or two plans available.² Government will likely have to manage a far greater number and variety of health plans than most employers—probably several dozen in major metropolitan areas—with far fewer tools to assure value for taxpayers and enrollees.

Government is responsible for costs and quality —> Health plans are responsible for costs and quality

The direction of ongoing reform and of legislative proposals also involves new conceptions about responsibilities for costs and quality of care. Traditionally, government has had responsibilities for Medicare's costs and quality, but with limited authorities to manage either aspect of performance. Offering alternative health plans shifts the accountabilities for costs and quality to private health plans and motivates Medicare beneficiaries to shop for the best values. By such shopping, beneficiaries hold health plans and providers responsible for holding down costs and assuring quality.

Whereas the traditional Medicare program purchases care from providers, the reformed program leaves it to health plans to contract with the providers of health services. Medicare is responsible for certifying alternative health plans as meeting minimum standards, offering information and assistance to beneficiaries in choosing among the plans, and making the government's fixed contribution to whatever plans Medicare beneficiaries choose. The health plans are accountable, as the "managers" of care, for the services they offer.

The fundamental question to be asked as these shifts in Medicare management roles progress would seem to be: To what extent can the federal government manage worthwhile competition among a field of competing accountable health plans and, at the same time, improve the traditional Medicare program as a high-value safe harbor for those among the elderly and disabled who can not or are not inclined to choose a private health plan?

III. SHIFTS IN THE ROLES OF DOCTORS, HOSPITALS, AND OTHER PROVIDERS

The traditional Medicare program, modelled on fee-for-service health insurance, deferred to health care providers on many issues of clinical freedom and fees. Today, managed care is bringing major changes for health care providers. Ongoing and proposed Medicare reforms bring these same changes to the Medicare population.

Appropriate Patient Care Is Determined by Independent Physician —> Appropriate Patient Care Is Determined by Plan-Physician Partnership

The clinical autonomy of physicians shifts in a managed care setting. Health plans' contracts with providers usually include agreements by the providers to have their services reviewed based on practice protocols accepted by the plan as defining appropriate care. As physicians and other providers follow

incentives to conform to these health plan protocols and to follow a plan's guidelines (e.g., prescription drug formularies), they are transferring clinical decision-making authority to the plan. If providers go so far as not to inform their patients of clinical options, because these are not paid for by the plan, they further erode their role as independent professionals.

Physician is clinical manager —→ Physician is clinical and cost manager

In the new paradigm, the physician's role shifts from one of clinical manager to one of clinical manager and cost manager. Physicians are called on to manage the costs of the care they are giving, and they participate in health plan efforts to construct treatment protocols and budgets for facilities and staff expansions to contain costs and keep the plans' premiums low and competitive. Such physician management can help contain costs in clinically acceptable ways, but it also divides the professional loyalty and accountability of the provider, who has to move from being concerned solely with a patient's welfare to being accountable also for a financial bottom line. There are, inherently, conflicts between these two roles.

Provider Is Paid by Medicare —→ Provider Is Paid by Health Plans

In the past, providers have treated most of their elderly and disabled patients under traditional Medicare fee-for-service arrangements. In the new paradigm, more providers will contract with health plans for more and more of such patients. Both ongoing practice and legislative proposals allow health plans to use a variety of contractual and payment arrangements with providers. Many of these arrangements, perhaps most, aim at making the provider a partner of the health plan in the sense that both the plan and the provider benefit financially from the health plan's success in attracting enrollees and containing costs.

Provider is paid fee-for-service —→ Provider is paid by capitation and risk sharing

Among these new ways of paying providers, health plans increasingly use a capitated or global fee basis rather than fee for service. The provider who can keep costs of services below the capitation amount on average profits, whereas those who provide too many services lose income and, perhaps, their contract with the health plan. Reform proposals, like existing Medicare law, would restrict capitation arrangements that give physicians excessive incentives to deny specific services to specific individuals. For example, when physicians are put at "substantial risk," they have to be given reinsurance arrangements. Capitation and other risk-sharing arrangements are part of the strategies to make physicians managers of both clinical care and costs.

Provider profits from too many services —→ Provider profits from too few services

The shift to capitation payment for health plans profoundly alters the financial incentives of fee-for-service medicine. There is extensive evidence of overservice in fee-for-service practice, where additional services produce additional revenues for the provider. In contrast, the new financial and some of the other contractual incentives between providers and health plans are inclining the provider toward rendering fewer services than in independent fee-for-service medicine. The shift toward fewer services that is under way could stop at "appropriate" care or it could go beyond to underservice.

Current Health Care Financing Administration practice and legislative reform proposals would measure the quality of health plan services according to quantifiable measures and make better information available to Medicare beneficiaries about the quality of care offered in various health plans. As with risk selection, however, quality measurement is still primitive. There is considerable room for underservice that could not be detected by quality measures.

Political system sets rates —→ Market sets rates

In traditional Medicare, provider payment rates are set by national formulas (such as DRGs and RBRVS), which were developed through cost-based analyses, adjust payment rates for a variety of local economic factors and policy considerations, and are determined in the political process. In contrast, Medicare health plans set provider payments based on market power that reflects the oversupply of many types of hospitals and physicians, particularly in some geographic areas. It is unlikely that many of the social costs factored into Medicare payments, e.g., disproportionate services for the uninsured and medical education expenses, will be paid by private sector purchasers.

Most providers participate in Medicare —→ Most providers avoid Medicare

Traditional Medicare has been the primary source of payment for Medicare services to the elderly and disabled, and nearly all providers have participated in the Medicare program. In the new paradigm, providers care for Medicare eligible patients through a variety of health plans. The vetoed reform legislation would have allowed them to set up their own health plans, or “provider-sponsored organizations.” Traditional Medicare’s leverage on providers is likely to decrease as providers gain more, perhaps better, options. Providers might find it increasingly possible to decline to treat patients who have stayed with traditional Medicare if they come to dislike its fees or other arrangements.

Several factors, already experienced by private employers, might drive down provider fees in the traditional Medicare program and make it less attractive to providers. The costs of traditional indemnity plans have been rising faster than the costs of managed care plans; they have also risen faster than the increases in the proposed Medicare benefits budget, with or without risk selection. In addition, sicker enrollees tend to stay back in the traditional insurance

plan. If sicker enrollees remain in traditional Medicare, this adverse risk selection will drive up its costs even more rapidly. There are no risk adjustment provisions in the reform proposal between Medicare and its competing plans to compensate for this adverse risk selection. For both of these reasons, the formula in the congressional proposal (the “look-back” provision) for reducing fees to providers to make up for any excess Medicare costs above the fixed expenditure limits would very likely be invoked in future years. This would be likely to have the effect of driving Medicare’s payment rates to below what providers could receive from private health plans and of driving the providers out of the program, particularly since, under the reforms, they would have other places to go.

The fundamental question to ask as these shifts progress would seem to be: To what extent can professionalism be relied upon to shape providers’ relations with health plans, their practice patterns, and their relations to patients to assure a balance between too many services and too few?

IV. SHIFTS IN THE ROLES OF BENEFICIARIES

The transition in the role of the Medicare beneficiary is the critical element of Medicare reforms. Both ongoing and legislative reforms would assign to beneficiaries a far greater role in determining the shape of their coverage and health care and a far greater burden of holding health plans and providers accountable for providing service at an affordable price. For these reforms to work, Medicare beneficiaries need to become smart shoppers and buyers of health plans and health care. To the extent that informed consumer choice produces health plan competition based on excellence in quality, service and economy, the reforms might benefit the Medicare consumer. But to the extent that health plans are able to prosper in other ways—e.g., by skillful advertising and salesmanship, by skimming the market, by inducing high costs patients to disenroll, or by underservice and poor quality—the reforms

might produce a worse Medicare program. Whether Medicare beneficiaries understand these new expectations, are willing to become active purchasers and shoppers, and have the tools to carry out these roles are all still unknown factors; there are particular concerns about many of the vulnerable members of this population and their capacities to deal with alternative health plans.

Beneficiary Is Entitled to Coverage —→ Beneficiary Is Entitled to Choice

Under traditional Medicare, government has entitled beneficiaries to standard benefits structured to meet average needs. But beneficiaries have not been able to choose among alternative plans structured to meet individual needs, as many employees in the private sector can. In the new paradigm, Medicare beneficiaries are entitled to choose the health plan with the benefits, providers, and services arrangements they want. But whether the exact benefits and service arrangements meet their needs is their responsibility, not government's.

Standard benefits and premiums —→ Varying benefits, premiums, and other features

The complexity of understanding and evaluating the many new plan offerings (including de facto limitations that are not publicized by plans) is a formidable challenge. Ongoing reforms and legislative proposals allow health plans to compete by offering as broad a benefit package as they can for the most attractive price possible. They have to offer Medicare Parts A and B benefits but can vary cost-sharing or add benefits. (The congressional proposal allows rebates and a catastrophic plus a medical savings account option.)

Under legislative proposals, health plans would vary in their provider networks and in cost-sharing for out-of-plan services, such as “point of service” plans; providers not under contract would be allowed to “balance bill” for amounts not paid by a plan, except for emergencies. Under the existing program, health plans can use their own treatment protocols

and definitions for what constitutes appropriate care for a given condition to determine what services they offer under Parts A and B benefits. Thus, while managed care plans may advertise the same benefit package as traditional Medicare, their management practices may represent a change in what services will be authorized for a patient compared to traditional Medicare, especially in areas such as home health, rehabilitation, and mental health. Because they manage the provision of service, not just payment for services, health plans can deny provision of these services, not just payment.

Choice of doctors and hospitals —→ Choice of health plans

Under traditional Medicare the beneficiary has been able to use almost any physician or hospital. The only financial difference is whether a physician takes Medicare's payment as payment in full or bills the patient for the additional 15% allowed under current law. Hospitals take Medicare payment for covered services as payment in full.

Under the new paradigm, plans are able to restrict the providers they use. Medicare beneficiaries can find that their favored physicians or other providers contract with some plans but not others or only with traditional Medicare. They have to weigh the advantages of the plan, including its price, against the availability of their past providers. The new paradigm requires plans to have an appropriate number, variety, and geographic spread of providers to assure adequate access throughout their service area. However, it gives wide latitude to health plans in defining their service areas and allows them to avoid areas or providers that might result in greater-than-average-expense enrollees.

Beneficiary with Rights —→ Subsidized Buyer with Options

The government has treated Medicare eligibles as beneficiaries who are entitled to be assured that covered health services are

available, of acceptable quality, and paid for. Under the evolving paradigm, the Medicare-eligible person is given a great deal more autonomy to operate as a buyer in a market, without the same government protections.

Health plans have autonomy to sell directly to Medicare beneficiaries. The congressional proposal would allow plans to use door-to-door sales representatives and sign up Medicare eligibles on the spot. All proposals, like existing law, would require the government to approve health plans' marketing materials in advance. But the ultimate judge of performance in the new paradigm is the buyer, not government.

Trusting patient —→ *Questioning consumer*

Just as Medicare beneficiaries increasingly have to shop among health plans, they also have to learn to be questioning buyers when it comes to doctors, hospitals, and other providers. In the past, physicians have been more or less free to assume the role of advocate for the patient against Medicare, with a high degree of assurance that services they felt warranted would be paid for. As providers enter into partnerships with health plans that include both financial incentives and protocols for treatment or as they organize and own their own health plans, patients can count less on them to be their agents. Medicare beneficiaries are likely to come to think of themselves as "buyers" of health care as well as "patients" and of their physicians as "sellers" as well as doctors.

Legislative proposals would establish government standards for health plan quality that would require the plans, rather than the government, to hold providers accountable. In addition, they would encourage Medicare beneficiaries to hold the plans accountable for assuring quality by leaving the plans that they felt provided poor care and joining those that provided good care. For example, the proposals would require health plans to report to the government and beneficiaries their performance against quality measures and to make the

review protocols they used available to the enrollee, when requested. The goal would be to equip beneficiaries to hold health plans accountable.

Holding Government Accountable by Voting —→ **Holding Plans Accountable by Shopping**

All of these changes add up to shifting the Medicare-eligible population from forcing improvements in their insurance by lobbying and voting for politicians to obtaining improvements by shopping wisely among health plans. In electoral politics, it is frequently the "swing" voters that have the greatest effect on outcomes; in the evolving Medicare health plan market, it remains to be seen how many potential "switchers" there will be and how effectively they will be able to influence the health plan market.

Individuals wary of politicians —→ *Individuals angry at health plans*

In the current political climate, it has proven dangerous for politicians to advocate publicly for Medicare cutbacks that would adversely affect beneficiaries. Elderly citizens' groups (and members of the opposite party) are ever-vigilant. If politicians make specific cutbacks themselves, they face the prospect of voters' retaliating at the polling booths. A system in which Medicare enrollees are induced to join health plans and the health plans (and their physicians) become the agents for persuading enrollees to accept fewer services may transfer future anger to health plans. In some calculations, this ability for government to crank down its future benefit costs without directly taking the heat will be a political imperative in light of the enormous increase in Medicare costs projected to hit when the baby boom generation retires. If the proposed reforms do not work out, however, it is possible that both health plans and politicians who voted for them would hear from the Medicare constituencies.

The fundamental question to ask as these shifts in beneficiary role progress is: To what extent will Medicare beneficiaries be able to shop and purchase effectively in their own best interest from health plans and providers whose economic self-interest may incline them to underservice?

WHAT TO WATCH FOR

If Medicare reforms proceed in the direction of these new paradigms, policy research might focus on a number of indicators of how fast they are moving and whether reform is producing welcome results. Some examples include the following:

How is the value of Medicare eligibility to the beneficiaries themselves changing as a result of the paradigm shifts?

- How are the cost and value of Medicare coverage changing year to year? How is the Medicare eligible's out-of-pocket premium relative to benefits received changing from year to year in alternative health plans and traditional Medicare?
- To what extent are health plans increasing or decreasing coverage through medical protocols that are different from those of traditional Medicare, for example, how are levels of home health, psychiatric, rehabilitation, and other services changing relative to traditional Medicare? Relative to desirable levels for specific diagnoses or conditions?
- How satisfied are Medicare beneficiaries with their health plans? What is the "return rate" to traditional Medicare from health plans? The rate of movement between plans? The return and movement rate for people sold door-to-door? What is the grievance rate and what types of grievances are filed in each of these areas?
- Are some groups of Medicare beneficiaries doing less well than others in choosing for themselves? For example, how are the very old, the cognitively impaired, or those who have trustees doing on the above measures?

Is government succeeding in continuing traditional Medicare as a safe choice for Medicare beneficiaries?

- How do trends in alternative health plan benefits and premiums compare to traditional Medicare? To trends regarding non-Medicare health plans? To the specified rates of increase in per capita costs paid by government?
- How do Medicare physician and provider fees compare to health plan fees?
- How is the participation rate in traditional Medicare with regard to physicians of various types and other providers changing over time?
- To what extent are providers treating traditional Medicare patients differently from other patients?

Is government succeeding as a manager of traditional Medicare and of multiple choice?

- Are Medicare beneficiaries being sufficiently equipped to shop and choose? To what extent are beneficiaries shopping and making choices in their own economic best interest? How is the weighted average ratio of benefits to costs of health plans changing over time? Are beneficiaries taking the costs and benefits of Medicare supplemental policies into account in choosing between traditional Medicare and health plans?
- To what extent are health plans offering better or worse benefit-to-cost ratios over time in terms of total premium? In terms of out-of-pocket premium?
- To what extent are health plans offering what Medicare beneficiaries looking for?
- How competitive are health plans with each other as reflected in their benefits, pricing, and marketing policies or in terms of the number of competing plans in the same area? How do plans use their pricing flexibility? Is there evidence of shadow pricing?

- To what extent is risk selection being corrected for by premium adjustors adopted by the DHHS secretary over time? For example, what is the prior-year claims experience of Medicare beneficiaries leaving traditional Medicare during traditional open seasons compared to that of people staying? What is the following-year claims experience of people returning to traditional Medicare compared to that of people leaving?
- Is the system "fair?" How much does the economic value of Medicare eligibility vary from Medicare enrollee to enrollee as a result of their choices? By age, sex, geography? By type of condition?

2. Preliminary data from the Robert Wood Johnson Foundation Employer Health Insurance Survey, courtesy of Steve Long.

How is the role of the physician as patient advocate versus plan partner changing?

- How many physicians are partners in health plans serving Medicare enrollees? What types of equity, capitated, and contractual arrangements are there and how do they affect physician behavior? What are the rates of referrals and high technology utilization in health plans compared to those in traditional Medicare? In health plans where physicians are partners compared to those in traditional Medicare?
- As we move from incentives to overserve to incentives to underserve, is the pendulum stopping in the right place, i.e., on appropriate care? What changes in practice patterns for various conditions are detectable in health plans? What is the meaning of the changes clinically? Economically?

The authors offer special thanks to Mike Hash of Health Policy Alternatives, Inc.

ENDNOTES

1. For a workman-like review, see "Overview of Medicare Provisions," prepared by Health Policy Alternatives, Inc., for the Henry J. Kaiser Family Foundation, February 1996.