Medicare in a Consumer-Choice Environment: Competitor or Residual Program?

Prepared by
Lynn Etheredge
Consultant

Health Insurance Reform Project, George Washington University
Prepared with support from the Robert Wood Johnson Foundation
Summary: The Medicare provisions of the reconciliation bill and President Clinton’s proposals would both allow many new health plans to compete for Medicare enrollees and structure a competitive, consumer-choice system. Medicare will enter this new environment with serious shortcomings. The logic of market competition will call for upgrading many aspects of Medicare if it is to be successful. Among Medicare’s features that need to be reconsidered are benefits, consumer focus, premium financing, payment policies, provider arrangements, performance accountability, management systems, risk adjustment, and market strategies, social mission responsibilities, and research and development.

The recent national political discussions about Medicare’s future reflect an apparent consensus that the 37 million elderly and disabled persons eligible for Medicare should have expanded choice of enrollment in private health plans. The 1996 reconciliation bill (H.R. 2491) passed by both houses of Congress allows many new health plans to compete for Medicare enrollees and structures a competitive consumer-choice market for Medicare and these other plans. President Clinton’s Medicare proposals, although differing in important respects, would also open the Medicare market to many new health plans and structure a competitive consumer-choice system. The apparent agreement on enhanced competition and consumer choice suggests a challenging future for the Medicare program, which remains a fee-for-service insurance program. For the under-65 population, competition by “managed care” health plans has rapidly displaced fee-for-service health insurance; managed care enrollments rose from 30% of workers in 1988 to 70% in 1995.

Medicare may not experience the same rapid demise as other fee-for-service plans. It is still the program of choice for 90% of the Medicare eligible population, and it has a strong “brand name,” the wide provider choice of fee-for-service insurance as well as its lack of limits on service use, and the important capacity to use government-set payment rates to help control costs. But Medicare’s past successes and popularity should not engender complacency about its potential future as a competitor with private health plans. Medicare decision makers and administrators have usually been able, over the past 30 years, to think and act as monopolists. That will no longer be the case. The future reality is that Medicare’s policy will need increasingly to take into account the demands—and limitations—imposed by a competitive, individual-choice market.

How should the Medicare program be redesigned for this new, competitive environment? What program areas need to be addressed to shape up the Medicare program’s shortcomings as a competitor in an individual consumer-choice market?

This paper aims to provide an overview of the Medicare program’s new competitive environment and of the specific Medicare policies that political decision makers, administrators, and constituency groups will need to reconsider. It is divided into two major sections:

- A summary of the basic areas of agreement between the reconciliation bill and the president’s proposals that would fundamentally change the competitive environment for the Medicare program. Even if Medicare reforms are not enacted this year, these areas of agreement provide a useful template for considering what statutory changes may be coming in future legislative sessions.

- A discussion of ten key aspects of the Medicare program that will need to be reconsidered as the Medicare market evolves and Medicare faces new challenges from competitive health plans.

MEDICARE IN A COMPETITIVE ENVIRONMENT

The reconciliation bill and Clinton’s proposals would create a much tougher competitive environment for the Medicare program. They would
can choose to enroll (or disenroll) in Medicare and its competing health plans. To assist in these choices, Medicare enrollees will have comparative information on the benefits and premiums offered by each plan, as well as other information. To date, Medicare has made little effort either to alert Medicare enrollees to their options for electing competitor health plans or to provide side-by-side comparisons. A new government-sponsored choice system may go far toward informing Medicare enrollees about the better benefits available in private health plans and encouraging them to give serious consideration to selecting one of these plans.

This apparent legislative consensus would address many of the competitive disadvantages that have limited the growth of the Medicare competitive market. It is reasonable to think that if this legislation is enacted the Medicare program will face much stiffer competition and, for the foreseeable future, the current rate at which Medicare's competitor plans are increasing their Medicare enrollments—25% to 30% annually—will continue or possibly accelerate.

In addition to having common elements in their approach to structuring the future competitive environment, the two proposals differ somewhat in other respects. The reconciliation bill would offer high-deductible plans and medical savings accounts, allow associations and unions to sponsor plans, permit premium rebates, and allow door-to-door marketing. The Clinton plan would add medigap policies to the annual open season enrollment competition.

MARKET-ORIENTED THINKING ABOUT THE MEDICARE PROGRAM

With the enactment of a consumer-choice arrangement, determinants of Medicare's future will shift from what goes on inside the Beltway (the political marketplace) to what goes on in local health care markets, as competing health plans target some of Medicare's 37 million eligible individuals to convince...
them to enroll. The logic of market competition will call for upgrading many aspects of Medicare if it is to be successful in this new environment.

For an overview of Medicare’s competitive position vis-à-vis private health plans, let us consider a hypothetical situation in which there are just two competitors for a market of 37 million individuals. One competitor can offer only a single product (developed 30 years ago) that has less attractive benefits than are being purchased by 80% of its customers, and it cannot offer supplemental benefits. This competitor can set only a single national price for its product, can pay its suppliers only by a national computer-based price schedule, must accept virtually all suppliers, and, as primarily a bill-paying organization, has little influence on supplier performance. This competitor also is not allowed to market its products, and it has to depend on its major competitors to operate its program. Its personnel and operating policies, regulations, and policymaking are subject to political decision makers and government-wide policies. It must bear social costs not paid by its competitor.

The other competitor can offer the range of benefits and supplemental packages wanted by consumers, and it can adjust its premiums to reflect costs and market opportunities. It can select its suppliers for economy, quality, and service; can hold them accountable for performance; and has organized management systems. It can advertise and market its products. This competitor uses private-sector administrative practices and can offer comprehensive benefits for $1,000 per person ($2,000 per couple) less expense. As the market grows from 37 million to 70 million persons by the time the baby boom generation is fully retired, most of the new customers will already be signed up with the second competitor, and the first competitor will have to persuade them to leave. Which competitor will be in the better position?

As a new competitive market system is initiated, Medicare will be in a competitive position similar to that of the first competitor. It will probably face a number of health plans that are similar to the second competitor in each major market area. Nearly all fundamental aspects of the Medicare program will need to be "reengineered" for it to be successful in this environment. Among the aspects of the Medicare program that will need to be reconsidered for their competitive fitness are the following:

- benefits,
- consumer focus,
- premium financing,
- payment policies,
- provider arrangements,
- performance accountability,
- management systems,
- risk adjustments and market strategies,
- social mission responsibilities, and
- research and development.

This agenda involves consideration of potentially far-reaching, even revolutionary, changes in the Medicare program. Given the apparent agreement that Medicare-eligible persons should have the benefits of better private health plan options and competition, its implications for Medicare’s future now need consideration. What kind of Medicare program do we want in the future? Shouldn’t we want the Medicare program to be a first-rate competitor with private health plans, one that is allowed to provide its enrollees with the benefits they want, and to adopt the best practices from private-sector health plans? Should public policy try to foster competition between a public Medicare program and competing health plans, with the view of trying to get the best of what the public and private sectors can offer? Or should public policy—explicitly or by default—leave Medicare basically unchanged and likely to become a residual program?

The following sections propose some starting points for new thinking about the Medicare program in each of the ten areas mentioned above and sketch some of the potential implications for Medicare’s future.
Benefits

Medicare’s benefits will need to be seen as a product—or a product line—that is in competition with other offerings in the marketplace.

The Medicare program now offers a single product designed to match the prevailing insurance plans of 30 years ago. It offers basic hospital coverage (90 days per benefit period, 60-day lifetime reserve, no coverage thereafter), steep hospital benefit cost-sharing ($736 deductible per benefit period, $184 per day for days 61 through 90, $368 per day for the 60 lifetime reserve days), and includes no limit on out-of-pocket expenses for physician service benefits (for which there is a $100 annual deductible and 20% copayment). Medicare does not cover outpatient prescription drugs. To fill in these amounts, 78% of Medicare enrollees obtain medigap or other supplemental coverage. Medicare’s competitors, in addition to offering comprehensive coverage, can also tailor benefit packages to Medicare markets and subpopulations with a variety of benefits and cost-sharing options.

For the future, the Medicare program will need to consider both improving its basic benefits and expanding its “product line” of supplemental benefits to enhance its competitive position. Such options could include:

- **Improved basic benefits**, offered either across-the-board or through high-option plans. The standard option could consist of the current Medicare benefits, and the high-option plan could include the comprehensive hospital benefits and annual out-of-pocket spending limit that are popular features of private medigap plans.

- **Supplemental benefit options** that have proved broadly attractive for Medicare’s competitor plans, for example, prescription drugs, eye exams and eyeglasses, and hearing aids. The medigap market now includes ten government-determined plan designs; potentially all ten could be offered by the Medicare program itself.

- A high-deductible and medical savings account option, if that is allowed for private-sector competitors. Medicare may have some competitive advantages in the administrative costs of setting up and operating such arrangements.

A decision to offer improved basic or supplemental benefits will draw the Medicare program into competition with the Medicare supplementary coverage market. In 1992, this market covered about 27 million Medicare enrollees, with premiums of $27 billion; about half of the policies were employer-sponsored benefits and half were medigap policies. The arguments for a competitive Medicare program offering such benefits, at least vis-à-vis medigap policies, are as follows: (a) Medicare can offer such benefits at significantly lower costs, for example, less than a 3% administrative expense versus an average premium retention of 15% for group medigap policies and 25% for individual medigap policies in 1993,2 and (b) the high costs of private medigap premiums (about $1,000 annually) mean that a Medicare enrollee must pay about $1,000 ($2,000 per couple) more for comprehensive Medicare-plus-medigap coverage than for comparable comprehensive benefits from HMOs that enroll Medicare beneficiaries.3 This is a significant market disadvantage for the Medicare program.

Consumer Focus

Medicare’s eligible populations will need to be seen as 37 million individual customers with differing needs and desires who can choose among competitor products.

Medicare has been described as an “IBM mainframe” program in what will be a “PC”

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1. Medicare’s economies come from lower marketing expenses (signup at the same time as SMI benefits); lower premium collection costs (automatic electronic deduction from social security checks, like the SMI premium); and reduced claims processing costs (automatic electronic adjudication along with basic benefits.)
future. Its design philosophy as a single national program with a monopolistic viewpoint will be increasingly challenged as its customers have a variety of choices from health plans that are actively marketing to them, designing products to meet their needs and desires, pricing them competitively, and seeking to satisfy customers. There is considerable diversity among Medicare’s enrollees. In a consumer-choice environment, each of these individuals will be able to choose annually to stay with one health plan or switch to another one. Increasingly, newly eligible persons will already be enrolled prior to age 65 with a competing employer-based health plan that is working hard to retain their enrollment. Medicare will need market research about consumer preferences with respect to Medicare and its competing plans, such as is carried out by private insurers. This research will need to include:

- Analyses of “joiners” and “leavers” to determine their characteristics and the comparisons between Medicare and its competitors that entered into their decision.
- Analyses of “stayers” to determine what factors account for “brand loyalty” to the Medicare program and to its competitors.
- Focus groups and opinion research polls to better understand what changes Medicare’s customers would like to see in the program.

**Premium Financing**

Medicare’s financing from beneficiary premiums will need to be assessed in terms of the value provided compared to marketplace premiums for its competitor plans.

Medicare now charges a uniform national premium (the SMI premium) of $42.50 per month for its single national policy. Since the Medicare spending for the SMI program varies by more than 2 to 1 among states, the federal premium subsidy amount varies. With no flexibility for pricing its product to reflect actual costs, Medicare may be at a competitive disadvantage in some areas. In contrast, competing private health plans can adjust their enrollee premiums, as well as benefits and copayments, to match actual costs and market conditions. Over time, Medicare may need to consider allowing the beneficiary premiums to vary with the costs of insurance coverage, in order to bring Medicare’s premium closer to a competitive market amount.

**Payment Policies**

Medicare’s fee-for-service payment policies will need to be assessed to identify where national payment formulas result in over- and under-payment of market rates and how such payments affect the program’s competitive position with beneficiaries and providers.

As a near-monopoly bill-payer for 37 million individuals, the Medicare program has been able to use its financial leverage to set hospital (DRG) and physician (RBRVS) rates, unilaterally, at amounts needed to meet budget projections. Medicare’s major budget-control strategy, for more than a decade, has been to tighten its payment rates to below average market prices and to restrain annual rate updates. This strategy is continued in both the reconciliation bill and the Clinton proposals; specifically, budget control for the Medicare fee-for-service system would be exercised by reducing Medicare payment rates, on a sector-by-sector basis, if spending exceeded legislatively set targets. Using national payment rates—and nationally uniform adjustments in these fee schedules—is the only major competitive strategy allowed to the Medicare program in the current reconciliation legislation.

The competitive world of the future will introduce two new constraints on the usefulness of this strategy. If Medicare’s payment rates drop below what hospitals and physicians can receive from private health plans that compete with Medicare (for example, provider-sponsored networks), providers will have financial incentives to join (or start) such plans and encourage their Medicare patients to enroll in them. If Medicare’s payment rates drop far enough below market rates to impinge on access to services, consumers interested in leaving
Medicare will also have many more health plan options to choose from.

The Medicare program will thus need to be alert to the potential failures of its principal competitive strategy. Among the options that may need to be considered are for Medicare to move away from national computer-formula price schedules and nationally uniform adjustments and begin to set its prices on a market-by-market and a service-by-service basis. In some areas, Medicare may be able to achieve greater economies than now provided by the DRG and RBRVS systems; in other cases, it may need to pay more so that it does not induce providers and patients to switch to competitor plans.

**Provider Arrangements**

Medicare's provider arrangements will need to evolve so that Medicare can become an effective purchaser of health care services and adopt the best practices of private health plans to manage costs, quality, and service.

Medicare is now among the last of the "any willing provider," fee-for-service insurance plans; the resulting inability to manage quality and volume of services is its major competitive disadvantage vis-à-vis private health plans. The Medicare program runs the risks of being the "mother lode" for all of those hospitals and physicians that, because of their unacceptable costs, quality or service, are not included in private-sector managed care plans. Medicare currently holds out to such providers the lure of a population with large medical needs and a program with little control on quantity of services.

The Medicare program will need to consider developing various forms of preferred provider networks, so that it can build its future around those providers offering the best quality, costs and service but still allow individuals to use out-of-network providers of their choice (for higher copayment or premium amounts). This would help to preserve the basic Medicare program by protecting it from being driven out of the competitive market by a concentration of uncompetitive providers. Many other specific changes would also help to further Medicare's evolution from a bill-paying insurer to an effective purchaser of health care that can use the best practices of private health plans; these are discussed in an earlier Health Insurance Reform Project paper (Reengineering Medicare: From Bill-Paying Insurer to Competitive Purchaser). As discussed in that paper, such changes should be selective and targeted at specific program management problems.

**Performance Accountability**

Medicare's performance accountability will need to reflect the same "report card" data and accreditation standards as applied to its competitor plans.

The Medicare program needs to recognize that it will be in competition based not just on benefit packages and costs but also on quality of care and effectiveness in improving health of its enrolled populations. There is ample evidence of quality problems in the Medicare program to warrant more effective quality-oriented efforts, particularly to deal with chronic and preventive care concerns. To identify—and deal with—its own competitive weaknesses vis-à-vis private health plans, Medicare needs to (a) adopt a new mission philosophy of accountability for health of its enrolled population and (b) assess its performance—nationally and by market area—through "report card" information that the reconciliation bill and Clinton plan propose be required from Medicare's competing health plans. Using the same logic, Medicare should also apply the accreditation standards required for its competitor health plan to its own contractors (intermediaries, carriers, and peer review organizations [PROs]) to assure that they have the quality, internal processes, and effectiveness in improving health status needed in the new health care market.
Management Systems

Medicare's management systems will need to evolve to deliver a range of products, to many different customers, at cost, quality and service performance that meets or exceeds competitive standards.

Medicare’s management system has the potential strengths of a unique public-private partnership. Nearly all of Medicare’s day-to-day operations are carried out by private-sector contractors, primarily health insurance companies and the PROs. The ability to seek out new management partners gives Medicare a potential for partnering with state-of-the-art performers in the private sector as well as potential flexibility and innovation capability that would be far more difficult in a government-run program. Medicare will increasingly need to consider establishing relationships with new sets of contractors and using private-sector contractors to accomplish its new tasks.

The Medicare program will also need to consider issues that will arise because its most important contractors—particularly, Blue Cross and Blue Shield plans and other insurance companies—have growing conflicts of interest with the Medicare program. These insurers will own and operate some of the Medicare program’s major competing health plans; the Blues and Prudential, as well, are the leading writers of medigap benefits, which Medicare may want to incorporate into its own product line in competition with medigap policies. These contractors may have considerable difficulty in resolving these difficulties in ways that best serve the Medicare program’s needs: Will they put their best resources and efforts into the success of their own ventures or into that of a major competitor, the Medicare program? The medical society-sponsored PROs may also have conflicts of interests if medical societies form provider-sponsored networks to compete with the Medicare program. Possibly, there may be ways to build “fire walls” and other means by which these companies can be effective Medicare partners while their private operations seek to prosper by attracting Medicare enrollees. Medicare’s resolution of these issues is complicated by the statutory franchises guaranteed to its contractors. These franchises include the “provider nomination” clause that allows hospitals to choose the Medicare contractors that will audit their bills and cost reports, the reservation of Part B contracts to insurance companies, and the preference for medical society-sponsored groups as PRO agents. Medicare should have new administrative flexibilities to use whatever private-sector organizations will best serve the public in the future.

The Medicare program is also at a disadvantage with private business operations since its authorities for hiring, promotion, and compensation are set by civil service regulations; its major policy changes need to be approved by both houses of Congress and the president; and its administrative practices, governed by the Administrative Procedures Act, involve a three-year-long process for establishing new operating policies. All of these characteristics will also need to be reconsidered.

Risk Adjustments and Market Strategies

Risk adjustments between Medicare and its competing health plans are essential to providing a market in which competition is based on cost, quality, and service rather than on risk selection. Medicare will also need to develop differentiated market strategies for a variety of competitive environments.

The shortcomings of the current risk-adjustment (AAPCC) methodology for paying Medicare’s competing health plans puts Medicare at a competitive disadvantage. It encourages its competitor health plans to engage in risk-skimming and means that such practices will drive up Medicare’s average per enrollee costs. As many fee-for-service insurance plans have discovered over the past decade, such (uncorrected) competitive practices are quite dangerous and can quickly make fee-for-service insurers irreversibly and fatally noncompetitive. Without better risk-adjustment approaches, the
Medicare program is in considerable peril of becoming a residual program with a concentration of the highest-expense populations that private health plans do not wish to enroll. Moreover, as discussed above, Medicare's ability to continue to compensate for this shortcoming through reducing provider payments will be constrained. The serious problems facing Medicare in this regard, and the possibilities of better options, are discussed in a recent Health Insurance Reform Project paper by Stanley Jones (Why Not the Best for the Chronically Ill?).

Medicare will also need to develop market strategies that recognize the differences among competitive market areas. Medicare was designed with a great deal of uniformity in enrollment, benefits, financing, provider payment policies, regulations, and administrative structure. But, at the health market level, it is far from a uniform or steadily changing program. There is great diversity in nearly every dimension of service use, rates of increase, and expenditures. Even on a regional basis, Medicare enrollees' use of hospital care varies by a ratio of 2 to 1—from 1,735 days per 1,000 enrollees in the western states to 3,455 days per 1,000 enrollees in the northeastern states in 1992. From 1986 to 1992, Medicare Part B expenditure growth varied by more than 3 to 1 among states—from 4% to 5% annually in California and Hawaii to between 13% and 16% annually in South Carolina, Delaware, Kansas, Nevada, and North Carolina. Medicare needs strategic planning that recognizes the great diversity of the problems it faces and the need for differentiated management strategies tailored to its problems in individual markets.

The competition for the Medicare program from competing health plans also varies widely among areas and results partially from the AAPCC payment methods. As of January 1995, 2 states alone—California and Florida—accounted for nearly 60% of Medicare HMO enrollment, while 19 states had no Medicare HMO enrollees and 32 states had 1% or fewer of their Medicare-eligible populations enrolled in HMOs. In some areas (for example, Los Angeles), 50% of Medicare enrollees have already opted for private health plans. Medicare needs strategic planning that recognizes the diversity of the competition that it faces and the need for market-focused analyses, including how different premium risk adjusters can affect competitor behavior. Such capabilities will be particularly important in adjusting to the rapid changes that would follow enactment of Medicare reform legislation.

Social Mission

Medicare's social mission responsibilities—such as funding for graduate medical education and disproportionate share hospitals—will need to be reconsidered for financing that will not result in Medicare's being at a competitive disadvantage.

The Congress has given Medicare a number of social missions—and financing responsibilities—that are not required of its competitor health plans. These include financing for graduate medical education and hospitals with disproportionate shares of charity populations. In 1993, these expenses were $5.4 billion for graduate medical education and indirect medical education and $3 billion for disproportionate share hospital payments. As Medicare must increasingly compete with private health plans, political decision makers will need to consider various alternative financing for such burdens, including removal of these expenses from Medicare, with new financing provided from general revenues or other government sources, and/or requirements that Medicare's competitor plans provide equivalent payments.

Research and Demonstrations

Medicare's research and demonstrations need to provide the basis for an integrated strategy for shaping Medicare's future in a competitive, consumer-choice market.

The Medicare research and demonstration authorities have often had a focus oriented to the Washington political process. Increasingly, Medicare will need to be market-oriented and
start out in a disastrously noncompetitive position. How well Congress, HCFA, and constituency groups understand and respond to the needs for some of the changes described above will help to determine whether Medicare will be an effective competitor or a residual program in the future.

The author thanks Stanley Jones and a number of other health insurance experts for discussions about Medicare and its competing health plans.

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BEGINNOTES

