

**UNDERSTANDING THE EFFECTS
OF MAJOR MEDICARE SAVINGS**

**Marilyn Moon
The Urban Institute**

March 1996

EXECUTIVE SUMMARY

Most of the attention on the proposed changes in Medicare has focused either on the overall size of the spending reductions or on what will happen to the Part B premium. Since these issues can be translated into simple dollar differences, it is then tempting to suggest that all that is needed for compromise is to “split the difference” in the numbers. But the proposals of the Congress and the Clinton Administration differ on much more than the dollar magnitude of the changes. Key structural differences between the proposals need to be understood as well.

The Balanced Budget Act of 1995, which contained a comprehensive set of changes in the Medicare program developed by Congressional Republicans, sought to reduce Medicare spending by \$226 billion over seven years. This would include a number of important structural changes that differ from current law and signal a new direction for policy for Medicare. Overall, the Congressional approach to reform would stress moving Medicare beneficiaries into private plans of various types. While there has long been an option under Medicare to allow beneficiaries to enroll in health maintenance organizations (HMOs), the proposed legislation developed by the Congress would seek to expand the opportunities for the private sector to offer new types of plans and to change the way in which these plans would be paid and how they would interact with the traditional part of the Medicare program.

How does the Congressional proposal for Medicare found in the Balanced Budget Act seek to achieve savings? On the traditional fee-for-service side of the equation, proposed changes continue to rely upon restricting payments to the providers of services and less directly imposing limits on the use of services. Altogether, these changes would generate about two thirds of all the savings in the legislation. Limits on payments to health maintenance organizations and other private plans that enter this new market will be constrained with specific growth targets—growing an average of about 5.1 percent per year per capita through 2002 and a steady 5 per cent per year after that. And a new “failsafe mechanism” would penalize providers on the fee-for-service side of Medicare if growth rates exceed overall targets for the program—thus placing additional pressures on providers to limit the use of services. Overall, Medicare program payments would be allowed to grow at just 5.7 percent per year on a per capita basis as compared to a projected 7.9 percent growth rate if no policies change over the period.

The Administration's proposal, in contrast, would both generate more limited savings of \$97 billion and would reform managed care options on a more incremental basis. Premiums would be raised to a much more limited degree, and a number of key changes contained in the Republican proposal would not be allowed. The rate of growth of Medicare would fall from the 7.9 percent projected for the future with no policy changes to 6.4 percent—an amount considerably less than the Republican proposal, but still a substantial decrease. Moreover, this amount is lower than the 7 percent per year projected for private insurance plans over the next seven years and lower than that achieved either by Medicare or private insurance over the last seven years.

In addition to these differences in the overall magnitude of savings, the Administration and Congressional approaches differ in terms of how the program would change. Key structural reforms have been proposed by the Congressional Republicans. One important overarching thematic difference between the approaches can be found in attitudes toward oversight and control over the Medicare program. Across a broad array of elements of the program, the Congressional approach would relax limitations and restrictions on offerings of comprehensive private plans, allowing beneficiaries more choice and more exposure to both the benefits and vagaries of the private market. The Administration's changes are more incremental in nature and would retain tighter control, particularly over the expansion of private options for managed care contracts.

In addition, five key issues highlight how the Balanced Budget Act would affect Medicare. The first of these reflects a problem common both to the current system and to any proposal for retaining or expanding comprehensive private alternatives to Medicare—the issue of risk selection. If private plans can attract healthier than average patients, they can benefit at the expense of the Medicare program. Although risk selection is a problem that plagues any solution, by opening Medicare to many different types of private plans, such as medical savings accounts and association plans, the Balanced Budget Act may exacerbate the problem.

Second, a new failsafe mechanism could further de-stabilize the Medicare program. Under this new mechanism, if annual spending targets for Medicare are exceeded, the fee-for-service side of Medicare would be penalized. And this penalty would apply even if the problem in holding down spending growth arises from healthier beneficiaries enrolling in private plans and leaving the sickest patients to be cared for in traditional Medicare. Thus, if risk selection is a problem, the failsafe will penalize fee-for-service Medicare for caring for the sickest beneficiaries.

A third issue arises over whether Medicare is moving from a program that guarantees a specific level of benefits to one which assures only a dollar contribution towards the costs of such benefits. The current system for establishing premium contributions for private plan options—and that which would be retained by the Administration—ties payments to the fee-for-service side of Medicare. This is likely to result in payments that are higher than desirable to achieve savings. The Congressional approach to this problem would be to set an arbitrary limit on the growth in payments over time. While it would break the link to fee-for-service, it means that there would no longer be a promise that the contributions from Medicare would be sufficient to cover the costs of providing care, changing the guarantee from that of a defined benefit to that of only a defined contribution. Further, the Congressional approach would allow plans more latitude in charging premiums from beneficiaries.

Both the Congressional and Administration proposals to reduce geographic differences in payment levels for private plans need more careful study since they may generate some unintended consequences. Payment rates for private plans could rise much faster—or slower—than average in some areas of the country, both in comparison to other areas and in comparison to payment levels offered to traditional fee-for-service Medicare providers in a given area. This may lead to unfair advantages for some plans or providers.

Finally, opportunities for greater beneficiary burdens over time arise from several of the proposed changes in the Balanced Budget Act. While much of the attention in the media focused on differences in premium increases proposed, other structural changes in the Balanced Budget Act could also have important effects on costs to beneficiaries. In particular, some private plans could allow physicians to bill patients for amounts over and above fees deemed reasonable by the plans. Many beneficiaries might not understand this provision when choosing among plans. Further, private plans would have more latitude for establishing additional premiums for private MedicarePlus plans under the Balanced Budget Act and perhaps more incentive to do so when faced with strict limits on the growth in the amount that Medicare pays on behalf of enrollees.

INTRODUCTION

The 1995 budget debate on changes to the Medicare program appropriately recognizes that reductions in spending in the program need to be made to help restore the financial health of Medicare. Tough decisions will be needed, inflicting pain on someone: beneficiaries, providers of services, or taxpayers. But before it is feasible to decide what pace of change is needed or what mechanisms should be used, it is crucial to understand the likely impact on program beneficiaries and on the providers of health care services.

Neither the forecasts of catastrophe nor of painless change as a result of the Medicare changes under the Balanced Budget Act of 1995 are correct. Rather, the answer is somewhere in between. Similarly, the magnitude of changes proposed by the Clinton Administration is greater than often portrayed by both sides of the debate. Nor is it correct to argue that the proposals of the Congress and the Administration differ only in terms of the dollar magnitude of the changes or the willingness to raise premiums on beneficiaries. Key structural differences between the proposals need to be understood as well. Thus, in order to have an informed debate on this issue, it is crucial to make sense of both the numbers and the structural changes.

The essential goal of this paper is to focus on putting the overall structure of proposed changes in Medicare in context. Although both the Congress and the President have suggested some further changes in the overall target savings numbers beyond these initial proposals, a careful analysis of the two different approaches requires more detail than is available from the compromises put forth. Further, it is useful to focus on the full initial proposals in order to understand where significant differences exist in the philosophy and structure of the approach to reform.

SLOWING THE RATE OF GROWTH IN MEDICARE

The Medicare changes proposed by the Congress for the next seven years have been characterized by their supporters as simply slowing the rate of growth of the program. Thus, it is argued, this is not a “cut” in Medicare. Indeed, Medicare would still grow by over 6 percent per year after taking into account the \$226 billion in changes.¹ On the other hand, it is essential to ask what this

slowdown would mean—i.e. would people still be able to receive the same levels of services as before? Basically, if all of these changes could be achieved by instituting new efficiencies in the program, reducing fraud and abuse, and streamlining the delivery of care, then the slower growth would not represent a cut. But, if beneficiaries must pay more than under current law, if they must accept undesirable restrictions on their use of services, or if they receive lower quality of care, then it would be appropriate to categorize these changes as cuts as compared to the current Medicare program. It might still be important to make such changes, but their impacts should not be understated by dismissing them as merely slowing growth. Further, it is also important to contrast the Administration's December 1995 counter-proposal of \$97 billion in Medicare reductions to the Congressional proposal.

Both proposals, but particularly the Balanced Budget Act, would require higher premiums than under current law, and thus the changes can be seen as cuts to beneficiaries. The other criteria of whether the changes represent cuts are more problematic because of the difficulty in distinguishing between new efficiencies and cuts on the delivery side that affect quality or necessary care. Since characterizations of lower quality and inappropriate restrictions are hard to measure, it is not possible to make absolute judgements about where the line *should* be drawn in slowing growth. This uncertainty arises because it is difficult to predict beforehand how much growth in the program can be slowed with efficiencies or reductions in fraud.

Nonetheless, Medicare would face substantial challenges from attempting to achieve an unprecedented rate of change over the next seven years. If the rates of growth are set unrealistically low, the outcome would be disruptive to Medicare benefits and the health care system in general. Final judgements on how severe these changes turn out to be and whether they represent a cut in the system must wait for an evaluation after the fact. Nonetheless, it is useful to assess the likelihood that such change will be disruptive.

Several issues are relevant for examining how to evaluate the proposed reduction in spending growth as compared to baseline projections. First, some basic definitions are needed. For example, what is meant by a “baseline” against which these cuts are being compared? Beyond the definition of baseline, it is useful to look closely at the projections and what they imply. How optimistic should we be about the prospects for substantially reducing this baseline without restricting benefits or raising costs on beneficiaries? This latter question can be informed at least in part by examining historical trends and by comparisons to other parts of the health care sector. The starting point for these changes also matters substantially. How much slack is there in the current system, for example?

Defining the Baseline

For Medicare, the baseline represents the spending required each year to provide the current package of benefits—under the current rules concerning the delivery system and the methods of paying providers and plans—to all those eligible for the program. Thus, the baseline reflects projections of growth in the numbers of beneficiaries, increases in the prices paid for services, and increases in the services used under the existing benefit structure. Growth in the number of

beneficiaries depends mainly upon the rate of growth in the population over the age of 65—a number relatively easy to predict with some certainty.²

Prices for health care services and the volume of service use are more difficult to project. Prices depend upon the interaction of inflation and the payment rules established under Medicare. Moreover, since Medicare assures its beneficiaries coverage for medically necessary hospital, physician and other acute care services, the exact amounts of services used vary over time. As new technology becomes available or as new standards for various treatments and procedures evolve, spending on health care has tended to rise. (This affects not just Medicare, but other health care spending as well.) It is essentially this latter volume and intensity factor which has caused health care spending to rise at rates well above general inflation. Historically, the Congressional Budget Office (1993) has measured this increase in volume and intensity at about 6 to 7 percent per year, for example, and projects its future level at around 4 to 5 percent annually, implicitly assuming a slowdown in real health care spending.

All these factors are combined to generate an estimate of what it will cost to provide eligible beneficiaries with services covered by Medicare's insurance package over some future period. Estimating the baseline is no easy task, however, and considerable uncertainties arise in making a best “guess” concerning the future. In addition, this best guess changes periodically as new data become available. In fact, the recent re-estimate of Medicare's baseline by the Congressional Budget Office lowered the projected rates of growth of spending per capita from 8.4 to 7.9 percent over the seven years from 1995 to 2002, for example. Table 1 indicates the Congressional Budget Office December baseline for 1995 through 2002 shown both in aggregate and on a per capita basis.

Examining the Proposed Changes

The target savings under the budget resolution are expressed in terms of reductions off of the CBO baseline. Essentially, that means that these target numbers can just be subtracted from total spending to achieve estimates of how much growth will have to slow. After the recent re-estimate of the baseline, the earlier figure of \$270 billion in lower Medicare spending from the Balanced Budget Act was reduced to \$226 billion. But the average rates of growth allowed by the Congressional legislation in the December baseline remained basically the same.³ The average rate of growth allowed in Medicare would be 6.4 percent per year (also shown in Table 1)—or nearly a one-third reduction in the rate of growth in the program. The corresponding average rate under the Administration's proposal would be 7.8 percent.

When converted to a per capita basis, the reductions in growth between the baseline and the Congressional proposal are greater. This is because none of the proposals will reduce the numbers of persons becoming eligible for the program. Instead, all of the savings need to come from per capita spending—essentially either in premiums, in prices paid or quantities of services consumed. Thus, on a per capita basis, the rate of growth must slow from 7.9 percent per capita (the baseline figure) to 5.0 percent. This represents a 36 percent reduction in the rate of growth of spending—a tall order for reforming Medicare over the next seven years. The Administration's

December 1995 proposal essentially splits the difference, growing at 6.4 percent per capita—also a considerable reduction as compared to baseline projections.

Another crucial determinant of the impact of the savings targeted for Medicare in the Balanced Budget Act is where savings are achieved. That is, the discussion thus far has mainly focused on the issue of the rates of growth of spending and whether reductions are sustainable without harming the basic medical services received by individuals in the Medicare program. (The only specific proposal to receive very much attention has been the premium changes proposed by the Congress and opposed by the Administration.) But reductions in spending can actually occur along a number of different dimensions, with the greatest distinction arising between savings from holding the line on health care spending per se—e.g. by limiting how fast payments to physicians or hospitals are allowed to grow in the traditional Medicare program or how fast premiums can rise for private plans—and savings that instead vary the shares of who pays for the care. Thus, changes in the Medicare program that, for example, raise premiums do not alter the underlying rate of growth of spending on services, but would alter the share paid by government versus individuals.

These distinctions raise very different issues. The first refers to whether it is possible to sustain a consistently high quality of basic health care services over time after the imposition of severe limits on growth and the second strategy raises concerns about the ability of beneficiaries to meet the new financial burdens imposed by higher premiums. If the goal is to establish a target level of savings such as the \$226 billion outlined in the Balanced Budget Act of 1995, relying more on one strategy will reduce the necessity for large cuts in the other.

The emphasis here is on what limits on the level of spending are reasonable or feasible while maintaining the integrity of the delivery of health care in the U.S.⁴ Within the context of that discussion, it is appropriate to net out the effects of imposing a higher share on beneficiaries. Thus, to understand how severe these constraints are in terms of the delivery of care, consider the limits on growth rates net of the shifting of burdens onto beneficiaries. The resulting per capita growth rates are higher than if the full \$226 billion in spending reductions are assumed to apply to providers of services.

Because a beneficiary premium increase accounted for about a quarter of the Congressional spending changes, rates of growth in payments to providers would still be substantially constrained, but the levels will average 5.7 percent rather than the 5.0 percent per capita described above (see Table 2). This implicitly moderates the growth target, but still represents a major reduction as compared to the baseline rates of growth per capita. The Administration's numbers, in contrast, do not change very much from this adjustment since only a very small premium change was contained in that proposal. Provider-only savings consequently lead to a projected per capita growth rate of 6.5 percent.

And what types of savings are specified in these reductions? Fraud and abuse—a popular area for presumed savings total only about \$3.4 billion of the \$226 billion in non-beneficiary changes projected over the next seven years proposed by the Congress, and the Administration also had only a small fraud and abuse component. Consequently, there are only two remaining

areas for reductions—payments to providers of care and the quantity or intensity of the services received.

How does the Congressional proposal seek to achieve savings? On the traditional fee-for-service side of the equation, proposed changes continue to rely upon restricting payments to the providers of services and less directly imposing limits on the use of services (for example, by combining payments for services such as home health care into episode-based payments rather than payments per service used). Altogether, these changes would generate about two-thirds of all the savings in the legislation. And a new “failsafe mechanism” would penalize providers further if growth rates exceed the targets—thus placing additional pressures on providers to limit the use of services.⁵ In fact, because the initial estimates of savings are insufficient to meet the desired totals, the CBO numbers suggest that nearly \$12 billion in additional savings would need to be generated using this mechanism in the first seven years. And if these projections turn out to be wrong, the failsafe mechanism could play a much larger role, arbitrarily lowering payments to providers of services.

Limits on payments to health maintenance organizations and other private plans that enter this new market would be constrained with specific growth targets—to growing an average of about 5.1 percent per year per capita through 2002 and a steady 5 per cent per year after that. This implicitly means the plans, and not the government, would decide how to allocate resources, likely relying strongly on limiting use of services—such as expensive tests or referral to specialists. In addition, since plans will have considerable discretion over any extra benefits to offer, such as preventive services, tight budget limits may simply translate into fewer extras provided by these plans as compared to current private plan offerings. Finally, the bill allows plans to pass some additional costs onto beneficiaries as another method of meeting tight limits on spending growth.⁶

Table 2 also disaggregates the rates of growth allowed between private plans and the traditional fee-for-service portions of Medicare.⁷ But in comparing these two, it is important to recognize that private plans will face some ability to shift costs onto beneficiaries—both in the form of extra premiums and by allowing providers of services to bill beneficiaries for additional fees—while the traditional fee-for-service sector will not. And, if the fee-for-service side retains the sickest patients, this differential may not be sufficient to accommodate the implicit shifting of costs from private plans to traditional Medicare that may occur (as discussed in more detail below).

As Table 2 also indicates, the Administration's proposal results in a distinction in growth rates between the fee-for-service side of Medicare and managed care plans. This occurs largely because of one aspect of the Administration's bill—the proposal to pull out of the annual payment for managed care plans the amount implicitly built in for supporting medical education and payments for hospitals that serve a disproportionate share of low income patients. This change would effectively reduce the base payment to private plans by about 5 percent in the first year. After that, the payment levels would grow at the same rate as the fee-for-service side of Medicare—which is the way payment levels are now adjusted. But that single change drops the

average annual rate of growth substantially—creating an average difference of 0.8 percent annually between managed care and fee-for-service over seven years.⁸

How easy would it be to continue these stringent limits on providers or private plans over a seven year period? To answer that question, it is useful to compare historical rates of growth and other projected growth in health care spending.

Putting the Numbers in Historical Perspective

Based on experience of the recent past, how optimistic should we be about the rates of growth proposed in the Balanced Budget Act of 1995? The mid 1980s through early 1990s were periods in which Medicare spending was slowed substantially by various policy initiatives. Growth rates fell consistently between 1980 and 1986. And, with the exception of 1989 when Medicare was temporarily expanded through the short-lived Catastrophic Coverage Act, Medicare growth rates have remained below their pre-1983 levels. Over the decade from 1983 to 1993, for example, per capita growth rates averaged 7.6 percent for Medicare (Moon and Zuckerman 1995). During this period there were aggressive efforts to lower spending growth, which averaged a much higher 14 percent per capita from 1976 to 1983.⁹ The relevant question then is to ask how feasible is it to expect Medicare to slow its growth rate substantially after a long period of cost control efforts for the last decade?

Another possible source of historical comparison is with private insurance. This is particularly appropriate since it has become fashionable to tout the possibilities of moving Medicare into private plans to take advantage of private market innovations. Over the last decade, however, Medicare's per capita growth rate was substantially lower than that for private insurance—7.6 percent as compared to the 9.4 percent per capita in private insurance. And if a more consistent set of covered services are compared, the differences are even more dramatic—7.0 percent as compared to 9.0 percent (Moon and Zuckerman 1995). Thus, Medicare has already done better than the private sector for some considerable period of time.

The counter argument made to this observation is to look at a much shorter period to assess the private insurance sector's success. Spending rates in the private sector are expected to be quite low in 1994 and 1995, for example. Many of the reforms proposed for Medicare have been taking place in private insurance in just the last few years, so a shorter time period might be appropriate. But care is needed to ensure comparability. For example, one statistic prominently offered as evidence of what Medicare could do is a number from Foster Higgins which indicates that spending on private insurance by large employers declined by 1.1 percent in 1994. While this is an impressive number, it can and has been misused.¹⁰ First, it is important to note that this is not an indication of holding the line on a “baseline” of health care spending; rather, it indicates how much could be saved when large numbers of employees are shifted from higher cost to lower cost plans. In fact, a more complete look at the Foster Higgins numbers indicates that no category of insurance plans declined in price in 1994.

Further, several other factors need to be considered. First, changes in the private insurance sector achieve savings in part because they start from a much higher spending base. The

comprehensiveness of employer indemnity insurance and the higher payment levels offered to doctors, hospitals, and other service providers as compared to Medicare mean that it may be easier to find ways in the private sector to dramatically cut spending levels for one or two years. Moreover, a one year experience is quite different than attempting to sustain slower rates of growth over a seven-year period. Sustaining savings over time poses a more difficult task, particularly if the savings we are now observing under private insurance are one-time benefits from shifting to lower cost plans or taking advantage of excess capacity in the health care system.

In addition, if Medicare shifts to individual enrollment in various private plans, the appropriate market for comparing how fast health care spending will likely grow would be the small group or individual insurance markets. Like those markets, private plans will need to advertise, to enroll individuals and perhaps to collect premiums on a person-by-person basis—all activities that add considerably to the administrative costs of insurance. These higher expenses will need to be absorbed by private plans, casting further doubt on how well they will be able to operate within the strict growth limits proposed for private plans.

For purposes of comparison, Table 3 indicates aggregate and per capita average annual rates of growth for the most recent seven year period in the past (1986 to 1993) and for the period 1995 to 2002. Finally, to make comparisons over time, it is useful to control for the rate of underlying inflation. A period of generally high rates of price increases certainly affects growth in health care spending. The inflation adjustment used here is the Consumer Price Index (CPI).¹¹ For the period from 1995 to 2002, the index suggests about a 3 percent rate of growth annually in prices (CBO 1995). This would leave about a 4.9 percent allowance for changes in intensity and technology under the baseline numbers, but only about 2.7 percent after changes proposed in the Balanced Budget Act. This latter figure is thus much lower than what the CBO has projected in future baseline growth or what we have experienced in the recent past for incorporating the costs of new technology and procedures (CBO 1993). Even the Administration's December proposal is lower than the amount projected for private insurance sector growth over the next seven years—that is, 3.4 versus 3.9 percent respectively.

KEY STRUCTURAL ISSUES

The Balanced Budget Act would make a number of important structural changes that differ from current law. And while the Administration's proposal would also result in a number of differences, much less in the way of structural change is proposed. Since most of the savings in the bill would arise from changes in the traditional fee-for-service side of the Medicare program and most of the attention on specifics has focused on the Part B premium, it is tempting to ignore the other differences in the reform strategies. But a number of elements in the Balanced Budget Act are significant and signal a new direction for policy for Medicare. Although these structural changes largely have been overlooked while attention has focused on the relatively small amounts that most beneficiaries would have to pay in high premiums, the implications of these reforms would have profound impacts on beneficiaries, providers and private plans.

Overall, the Congressional approach to reform would stress moving Medicare beneficiaries into private plans of various types. And while there has long been an option under Medicare to allow beneficiaries to enroll in health maintenance organizations (HMOs), the proposed legislation developed by the Congress would seek to expand the opportunities for the private sector to offer new types of plans and to change the way in which these plans would be paid, what they could charge beneficiaries, and how they would interact with the traditional part of the Medicare program.

An important overarching difference between the Congressional Balanced Budget Act proposal and the Clinton Administration is the approach to oversight and control over the Medicare program. Across a broad array of elements of the program, the Congressional approach would relax limitations and restrictions on offerings of comprehensive private plans now found in Medicare, allowing beneficiaries more choice and more exposure to both the benefits and vagaries of the private market. The Administration approach would also expand some choices for opting out of traditional Medicare as compared to current law, but at a considerably slower pace and with more oversight on competition. For example, the Balanced Budget Act would provide little coordination between offerings of the private supplemental (medigap) policies that are used in combination with traditional Medicare and open season for its MedicarePlus comprehensive private plans—an important activity if beneficiaries are truly going to be able to shift between the traditional fee-for-service side and MedicarePlus. The Administration, on the other hand, proposes to take this on directly with further oversight and requirements for medigap policies to ensure a smooth transition. Further, the Congressional approach would de-emphasize federal oversight of MedicarePlus plans with regard to loss ratios and other criteria to control the market. Establishing the appropriate level of oversight represents an important philosophical position that needs to be carefully debated and assessed.

In addition, five key issues are important for determining how these new incentives would operate under the Balanced Budget Act and how they differ from either current law or the Administration's proposals. The first of these reflects a problem common both to the current system and to any proposal for retaining or expanding comprehensive private alternatives to Medicare—the issue of risk selection. The remaining four arise from specific structural changes built into the Republican legislative proposals. For example, a new failsafe mechanism would exacerbate the problem of risk selection and place traditional fee-for-service Medicare at risk. Third, the caps placed on payments to private plans would affect the basic guarantee in the Medicare program of access to a set of benefits. Fourth, geographic differences arising under Medicare would be altered by changes in the way in which payments are made, and finally, opportunities for greater beneficiary burdens over time arise from several of the proposed changes in the Balanced Budget Act.

Risk Selection as a Continuing Problem

Most research conducted on the operation of the current health maintenance organization (HMO) option for Medicare suggests that those attracted to this alternative tend to be healthier

than the average beneficiary in the same age, sex and other categories used to adjust the payments provided by Medicare. As a result, even though Medicare attempts to limit payments to HMOs to 95 percent of the cost of the average beneficiary in its risk categories, it likely overpays private plans. The most extensive study of this issue found that, in practice, enrollees cost the plans only about 89 percent as much as the average beneficiary (Brown et al 1993). As a result, the HMO option currently raises the cost of Medicare because Medicare overpays HMOs while sicker (and hence more expensive) beneficiaries remain in the traditional fee-for-service program. As a result, rapid expansion of the private options for Medicare thus may not save as much as it would at first appear. As yet no one knows how to satisfactorily resolve this issue.

Moreover, expansion in the types of private plans allowed under the Balanced Budget Act—including medical savings account/catastrophic plans that may naturally attract healthier beneficiaries and association plans that would help to fragment the risk pool—are likely to exacerbate the existing problem with risk selection.¹² Allowing too much choice in Medicare can also generate problems, for example, by allowing plans to carefully package extra services to appeal only to certain beneficiary groups. Thus, although a longer term strategy of promoting private plans and more choice may make sense, in the near term, expansions that worsen the risk selection problem could be harmful to the stability of the Medicare program, particularly in concert with the application of the failsafe mechanism described below.

The Administration's approach is a more cautious one, expanding the range of managed care plans permitted to participate, but not allowing the broad range of options that the Republicans advocate. The most troublesome types of plans—medical savings accounts, association plans, and private fee-for-service plans—would not be allowed by the Administration. Both approaches would, however, allow new provider service networks—new organizations that would allow doctors, hospitals and other providers of care to organize their own plans. These new entities need careful scrutiny as well.

Inequity and the Failsafe Mechanism

A new element of Medicare would be added by the Balanced Budget Act—a failsafe mechanism to enforce overall spending limits on Medicare. If all of the changes enacted failed to hold aggregate Medicare spending to the level sought, this mechanism would be triggered to ratchet down levels of payment under the traditional fee-for-service side of the program. Within the confines of the fee-for-service program this approach makes some logical sense. It would penalize the fee-for-service program if, for example, use of services rose more rapidly than was projected. This should help to encourage providers to limit excess use of services.¹³

A severe problem would arise, however, when penalties are imposed on the fee-for-service sector for excess spending that represents a failure not in fee-for-service, but rather elsewhere. If there is significant risk selection in Medicare's private plans, costs of fee-for-service will naturally rise. This would then inappropriately trigger lower payments to providers through the failsafe mechanism. Consider a simple example. Assume that the average cost of treating Medicare beneficiaries is \$5000 and that half of all beneficiaries choose private plans. These plans

are given a \$4750 payment to treat the patients (that is, 95 percent of the average costs). But if these are healthier individuals and their costs of care would only have averaged \$4500 in the fee-for-service sector, Medicare has overpaid on their behalf. But even more important, the half who are left would cost Medicare \$5500 on average, not because of inappropriate use of services, but because they are sicker. The failsafe would be triggered since spending would average \$5125 per capita overall and the result would be a penalty on doctors and hospitals who treat the sicker patients.

A failsafe mechanism that punishes one part of the system for problems caused elsewhere is inequitable and likely to be unsustainable as public policy over time. Its end result could be to drive payments so low under the fee-for-service portion of the program that providers become increasingly unwilling to participate, especially if they can still attract Medicare beneficiaries through private plans. This raises the issue of the reasonableness of sustaining the Balanced Budget Act's overall spending limits over time, particularly after several years of tight restrictions have occurred.

Moving from a Defined Benefit to a Defined Contribution Approach

A crucial element of the Congressional reforms for Medicare—but not in the original Administration proposal—would be to establish a fixed rate of growth in payments made to private plans on beneficiaries' behalf. Year to year changes in these payments would be set by law and not by changes in the cost of a particular benefit package. Thus, each year a specified rate of increase would be used to adjust payments that could be higher or lower than the actual costs of maintaining a particular level of services. Beneficiaries would thus be entitled to a level of payment (hence a “defined contribution”) rather than a set benefit package. This is a major departure from the current guarantees in the Medicare program.

This approach does not represent a full move to a voucher program since beneficiaries would retain the option of remaining in the traditional Medicare program where the benefit would still be guaranteed. But if the failsafe mechanism puts increasing pressure on traditional Medicare, discouraging providers of service from participating, then many beneficiaries may find it increasingly difficult to remain in traditional Medicare.

Further, whether the structure of Medicare would devolve to a defined contribution plan also depends upon the level of payments provider by Medicare to private plans. If the level of payments to MedicarePlus plans closely track variations in the costs of providing services, then there would be little impact from moving to a defined contribution approach. But since the goal of the Balanced Budget Act is to lower the rate of growth of health care spending, tight limits on payment growth should be expected. Indeed, the Balanced Budget Act would result in an average per capita rate of growth over seven years of 5.1 percent per year, and after 2002, the amount would be permanently affixed at 5 percent. This amount is above the projected growth in the rate of general inflation (of about 3 percent per year over the period), but considerably less than the historical differences in health spending growth. As indicated in Table 3, this would imply a rate

of growth about half that expected in the private insurance sector over the next seven years and less than half what was spent under Medicare over the last seven years.

The payment growth rate per capita in the Balanced Budget Act starts out at a generous 8 percent level in 1996, but quickly falls after that. For example, it would be only 3.8 percent the next year. If the private plans start out as relatively well paid (in part because of the selection issue described above), the early years of the program would not experience substantial problems. However, as the rates of growth are kept low over time, any surpluses in the payment levels would be absorbed.

The growth limits apply only on payments from the federal government to MedicarePlus plans, however. Thus, if plans cannot stay within these limits through improved efficiency or lower payments to providers, they do have recourse. MedicarePlus plans have considerable flexibility to either scale back any supplemental benefits offered (assuming additional services were initially part of the package) and/or to raise premiums on beneficiaries over time. The Congressional legislation would allow premiums up to a limit and unlimited premiums for supplemental benefits. Although plans can now also charge premiums or limit supplemental benefits, the major change in this legislation is that by imposing strict limits on the rate of growth of Medicare's payment, the risk of any higher costs over time is shifted directly to plans and/or beneficiaries. There would no longer any mechanism to recognize extraordinary growth in the costs of health care. The Administration's approach errs in the other direction, continuing to link the payment levels to fee-for-service costs in an area. A better strategy would be to seek ways to tie the payment levels to what is happening in the broader health care market.¹⁴

By 2002, premiums on private plans over and above Medicare-covered services would be allowed to be as high as about \$100 per month, offering considerable opportunities for shifting of additional costs onto beneficiaries.¹⁵ Indeed, for a plan that begins in 1996 as a zero premium plan, the ability to raise premiums would allow a plan receiving the average growth rate of 5.1 percent over seven years, to recoup enough of a premium to enable a 7.9 percent overall rate of growth over the period—an amount even higher than the expected growth in the costs of plans in the private insurance sector, for example. Thus, it would be possible for private plans to shift all of the increased risk that Medicare does not cover onto beneficiaries. The amount of such premium growth will depend on the degree to which plans are able to hold down cost growth and on the competition they face in local markets, but shifting at least part of the costs seems to be a likely strategy for private plans over time.

Thus, the Balanced Budget Act approach raises three separate issues: whether the principle of defined contribution is desirable, whether the limits on contributions are reasonable, and whether insurers should be allowed to pass risks on to beneficiaries in the form of higher premiums over time.

Geographic Variations

All of the discussion thus far has assumed that private plans would be treated the same throughout the United States. In practice, there would be considerable variations in how private plans would

be treated, and in the balance between the fee-for-service sector and private plans within geographic regions. The Balanced Budget Act and, to a lesser extent, the Administration's proposal would seek to reduce the variation in payments provided to private plans that now exists across the country. For example, at present the highest paid counties receive payments nearly four times as high as those in the lowest paid counties. Some of this differential reflects differences in the costs of providing care, but some also reflects differences in the patterns of service use that we may not wish to maintain.

Recalibrating the payments for private plans and then disassociating them with the actual experience of traditional Medicare raises the possibility that in some areas of the country, private plans will be given substantial advantages over the traditional Medicare program, while in other areas private plans may end up at a considerable disadvantage. For example, the new minimum payments under the Balanced Budget Act would boost payments to about one-third of all the counties in the U.S., some of them by well over 50 percent in just two years. Over the seven year period, we estimate that the areas with the highest growth rates would average 15.7 percent per year as compared to the 5.8 percent expected for Medicare's fee-for-service program. Other areas where payment levels are high would experience growth averaging as low as 2.7 percent per year over the seven year period. This may affect substantially the range of choices available to beneficiaries—limiting private options in some areas and placing traditional fee-for-service at risk in others. Careful study needs to be undertaken to determine the possible impacts of these adjustments and whether they will hinder or help the expansion of alternative opportunities under Medicare.

Shifting Burdens Onto Beneficiaries

One area that has received considerable attention is the difference between the Congressional and Administration approaches to requiring beneficiaries to pay higher premiums over time. The Balanced Budget Act both sets the standard Part B premium at 31.5 percent of Part B costs and adds a new income-related premium on high income families. The Administration's approach raise premiums only after 1999, keeping them at 25 percent of Part B costs, and does not include an income-related piece. In part because of the ease of explaining these differences, much has been made about the premium change. But while this does constitute a clear difference in approach, even the Congressional proposal would only moderately raise premiums for beneficiaries who have reasonable levels of income; here, the most troubling element is the lack of protection for low income beneficiaries, particularly if viewed in concert with proposed changes in the Medicaid program. Moreover, even if the focus is just on impacts on beneficiaries, the other structural issues posed here are likely to be more serious than the premium changes.

In addition, the Congressional approach would also raise the prospects for higher burdens on beneficiaries in two other ways. As discussed above, private plans would have considerable latitude to raise premiums on enrollees. Not only does this potentially mean higher costs to beneficiaries than what would at first appear to be the case, but it is also possible that premiums could themselves be used as a device to help attract healthier patients. In general, those

beneficiaries with higher incomes tend to be healthier, so some plans might intentionally offer more extensive supplements and higher premiums in order to attract a specific type of enrollee.¹⁶

Further, the protections that beneficiaries now have to limit balance billing—that is, extra charges beyond what Medicare deems reasonable—would be eliminated under a number of the private plans offered allowed in the Balanced Budget Act. As a result, some beneficiaries might face higher out-of-pocket costs from an area that has increasingly declined in importance as Medicare has limited these opportunities in recent years. For example, the CBO has estimated that in constant dollars, balance billing reached a peak of \$109 on average per beneficiary in 1985 and has since declined to \$36 in 1995.

Arguments are sometimes made for allowing increased balance billing as one way to induce participation by some physicians, particularly those in high paid specialties where Medicare's payment levels are less than in the private insurance sector. By allowing only a partial lifting of the balance billing limits in some MedicarePlus plans, however, this enticement could be used by plans that wish to attract certain physicians and hence particular beneficiaries. That is, plans could seek to attract higher income beneficiaries by promising them access to the “best” health care providers. For example, physicians who are at present unhappy with traditional Medicare may not be able to forego treating all Medicare patients. But if they can join private insurance networks and in that way assure access to some Medicare patients, they may be able to decline to deal with traditional Medicare fee-for-service. Thus, this change in policy could both increase beneficiary liabilities and be used to make the traditional Medicare fee-for-service sector, where balance billing would still be restricted, less attractive to patients if providers are no longer willing to provide care under traditional Medicare.

CONCLUSION

Much of the debate concerning the Medicare proposals advanced in the Balanced Budget Act has offered confusing information regarding whether Medicare is being cut and has missed the important structural changes proposed, focusing on only the much less critical issue of increasing the Part B premium. The Balanced Budget Act proposes to slow the rate of growth of spending beyond what we have ever been able to achieve historically and beyond what projections indicate will likely occur in the private sector. Even the Administration's proposal would require a substantial slowdown. These comparisons suggest that this slower growth would require painful choices and cuts in Medicare. But they also indicate that there is certainly room for a considerable effort to slow the rate of growth below what the baseline for the Medicare program now projects.

The magnitude of changes necessary to slow growth to the level sought in the Balanced Budget Act implies—despite rhetoric concerning offering more “choice” to beneficiaries—that Americans will be facing the prospect of having less say in the types of services received and/or the way in which care is provided than at present. The nature of managed care or prospective payment systems (in the case of changes in Medicare's traditional fee-for-service) is that we are seeking ways to limit the use of services. The major unanswered question is whether these

restrictions will be accepted by beneficiaries as a neutral or even positive change or whether they will be viewed as a deterioration in the guaranteed benefits.

What about the specifics of the Congressional proposals? If adequate protections were available to low income beneficiaries, the increase in the Part B premium to 31.5 percent would constitute only a moderate increase in burdens on beneficiaries. An inordinate amount of attention has focused on this issue. But it might be relevant if the premium increase is just viewed as a symbol of concern about the impact on beneficiaries to changes in Medicare, since there are a number of overlooked structural changes that may put beneficiaries at risk. In particular, the application of a failsafe mechanism, which may inappropriately disadvantage the fee-for-service sector, and the strict limits on payments to MedicarePlus plans deserve careful debate and analysis before being adopted. What is the risk of promoting major shifts in the delivery of care under Medicare in the context of unprecedented caps on spending? The answer will be whether irreparable damage will be imposed on the health of beneficiaries and/or the system of delivering health care in the United States if we move too precipitously. At this point, these questions are not answerable; but it is the uncertainty about the future that makes discussion of the likely impacts of these proposals too important to be ignored.

Table 1: Comparison of Growth Rates in Baseline Medicare Spending

	1996	1997	1998	1999	2000	2001	2002	Average Annual Growth
Aggregate Growth								
Revised Baseline	10.7%	9.9%	9.5%	9.1%	8.8%	8.8%	8.7%	9.4%
Balanced Budget Act (\$226 Billion in Savings)	7.1%	6.4%	5.7%	4.8%	6.7%	6.9%	7.3%	6.4%
Administration Proposal (\$97 Billion in Savings)	10.1%	9.0%	8.2%	6.8%	6.3%	7.5%	6.9%	7.8%
Per Capita Growth								
Revised Baseline	8.9%	8.2%	8.0%	7.8%	7.3%	7.4%	7.3%	7.9%
Balanced Budget Act (\$226 Billion in Savings)	5.4%	4.7%	4.3%	3.4%	5.3%	5.5%	6.0%	5.0%
Administration Proposal (\$97 Billion in Savings)	8.4%	7.3%	6.8%	5.4%	4.9%	6.1%	5.6%	6.4%

Table 2: Disaggregated Per Capita Growth Rates
in Medicare under Savings from Balanced Budget Act
and Administration's Proposal*

Per Capita Adjusted For:	Balanced Budget Act	Administration's Proposal
Full Program Savings	5.0%	6.4%
Provider-Only Savings	5.7%	6.5%
Private Plans	5.1%	5.7%
Traditional FFS	5.9%	6.6%

*Based on CBO December Baseline.

Table 3: Comparison of Historical and Projected Average
Annual Growth Rates

Per Capita Adjusted For:	Aggregate		Per Capita	
	Nominal	CPI Adjusted	Nominal	CPI Adjusted
Historical (1986-1993)*				
Private Insurance	10.1%	5.8%	9.7%	5.5%
Medicare	10.5%	6.2%	8.4%	4.2%
Consistently Covered Services				
Private Insurance	9.9%	5.6%	9.5%	5.3%
Medicare	9.4%	5.2%	7.4%	3.2%
Projected Medicare (1995-2002)**				
Baseline	9.4%	6.2%	7.9%	4.7%
Balanced Budget Act	7.2%	4.1%	5.7%	2.7%
Administration's Proposal	7.9%	4.8%	6.5%	3.4%

*Moon and Zuckerman (1995).

**Based on various CBO publications.

REFERENCES

Brown, Randall, Dolores Clement, Jerrold Hill, Sheldon Retchin and Jeanette Bergeron. 1993. "Do Health Maintenance Organizations Work for Medicare?" *Health Care Financing Review* 15 (Fall): 7 - 23.

Claxton, Gary and Larry Levitt. 1995. "Risk Selection Issues Under Medicare Reform Proposals." Ballston, VA: Lewin-VHI, mimeo.

Congressional Budget Office. *Trends in Health Spending: An Update*. Washington, DC: Author, June.

Congressional Budget Office. 1995. *The Economic and Budget Outlook*. Washington, DC: Author, December.

Foster-Higgins. 1995. *National Survey of Employer-Sponsored Health Plans/1994*. New York: Author.

Moon, Marilyn. 1995. "Medicare's Part B Premium and Social Security COLAs." Report produced for the Commonwealth Fund, December. Photocopy.

Moon, Marilyn and Stephen Zuckerman. 1995. "Are Private Insurers Really Controlling Spending Better Than Medicare?" Henry J. Kaiser Family Foundation Discussion Paper, July. Photocopy.

Rodgers, Jack and James W. Mays. 1995. "Medical Savings Accounts for Medicare Beneficiaries." Henry J. Kaiser Family Foundation Discussion Paper, August. Photocopy.

ENDNOTES

- 1 The Congressional Budget Office re-estimated savings (previously set at \$270 billion) under the Balanced Budget Act using a new December baseline. Unless otherwise noted, these numbers will be used here.
- 2 The other major group of eligibles are persons with disabilities who qualify for Medicare. While this population has grown rapidly in recent years and is more difficult to project, eligibility requires that a person receive Social Security disability benefits for two years, allowing considerable advance warning about changes in eligibility for Medicare. Moreover, elderly beneficiaries still make up 90 percent of the Medicare population so even some uncertainty in disability does not affect the baseline by very much.
- 3 This is because the Congress established a cap on total spending on Medicare that is unaffected by the baseline change. Since the 1995 levels change by a small amount, the average growth rates that compared the starting point with the aggregate dollar caps also change very little.
- 4 The impact of the premium increase on beneficiaries is also important and is discussed later in this paper and in Moon (1995).
- 5 This failsafe mechanism will also penalize the fee-for-service side of Medicare for any failures of the program to adequately adjust payment levels for the different health risks of those enrolling in private plans. This is discussed in the section below on structural changes.
- 6 Plans that offer just Medicare-covered services could charge premiums up to the amount of the value of any cost sharing that is lower than found in the traditional Medicare program. That is, the value of cost sharing in 1995 has been estimated at \$790 (Committee on Ways and Means 1994), so a plan that had no cost sharing could charge an annual premium up to \$790. Further, if a private plan offered any benefits beyond what Medicare now covers, any premium they would charge would not be subject to any limits. By offering only an enriched plan, private companies would face essentially no constraints on what they could charge beneficiaries.
- 7 The estimate for the rate of growth in the fee-for-service portion of Medicare is actually calculated as a residual after accounting for a shift of beneficiaries into private plans.
- 8 The intent of such a change is to bring managed care plans into line with actual costs since such plans contract with hospitals for discounts in the provision of care and effectively seek to avoid paying for the costs of medical education or of treating indigent patients.
- 9 If adjusted for inflation, however, these two periods would look more similar since the 1976 to 1983 period was one of rapid inflation.
- 10 Many of those who use the -1.1 percent figure, however, imply that Medicare should also be able to achieve such savings. The efficiency of private insurance industry is cited as the reason for this low number which is then contrasted to higher Medicare growth rates. Overall, we should expect rates of growth of spending to come down in private insurance since there has been such a movement to change the nature of the benefits received. This is not necessarily bad; it simply does not support the claim that we can simply slow growth painlessly through greater efficiency.

- 11 Some observers argue a better measure is the GDP deflator, which uses a very different concept. However, the GDP deflator is undergoing a major revision, so the CPI measure is used here.
- 12 For example, medical savings accounts are viewed as naturally attractive to healthier beneficiaries who are most likely to benefit from a higher deductible plan (Rodgers and Mays 1995). And, since associations can selectively decide whether to participate depending upon the general health status of their members, we would again expect to see greater participation among plans who would likely profit from a differential risk pool (Claxton and Leavitt 1995).
- 13 A major problem with this approach has been characterized in the economics literature as the “free rider” issue. The penalty on any single provider from misbehaving is very small and since the penalty is applied equally to all providers, there is little real check on anyone's behavior. In fact, the losers are those who play by the rules while others violate them since everyone is penalized equally.
- 14 The Democratic Congressional approach, which was adopted in later negotiations by the President, would instead tie payment growth rates to growth in the private insurance market. This is an area where more careful thought is needed to both generate savings to Medicare, but also encourage participation by good private plans.
- 15 This is the monthly actuarial value of Medicare cost sharing projected to 2002 using the 5.7 percent per capita spending growth allowed for fee-for-service in the Balanced Budget Act (as shown in Table 3).
- 16 It is the absence of a good risk adjustment mechanism that makes this a problem, however, and that could be mitigated if such adjustors are improved.