AN ASSESSMENT OF THE PRESIDENT'S PROPOSAL TO MODERNIZE AND STRENGTHEN MEDICARE

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CONTENTS

LIST OF TABLES

EXECUTIVE SUMMARY

The Clinton Administration first announced its proposal for Medicare reforms in June 1999, and revised it moderately for its fiscal year 2001 budget submission. This proposal represents an alternative to the plan developed for the National Bipartisan Commission on the Future of Medicare. Although the approach of the Administration proposal is more incremental, the plan nonetheless offers a broad range of changes that could have a dramatic impact on the program. This paper discusses four elements of that proposal: improving the benefit package, enhancing the management tools available for the traditional Medicare program, redirecting competition in the private plan options, and adding further resources to ensure the program's security in the coming years.

IMPROVING THE BENEFIT PACKAGE

The provision of additional benefits and a move to a more rational cost-sharing structure are key elements of the Administration plan. Many policymakers and analysts contend that the creation of an expanded benefit package would modernize Medicare and that such improvements would reduce or eliminate beneficiaries' need for supplemental coverage, which creates inefficiencies in the current program. While this proposal would move Medicare in that direction, it would do so only modestly.

The Clinton plan's two major benefit expansions are a voluntary, subsidized prescription drug benefit, and the elimination of deductibles and cost-sharing requirements for preventive services. It would also add cost-sharing to laboratory services and index the Part B deductible so that it would rise gradually over time.

The prescription drug benefit would pay up to $2,500 of the cost of enrollees' prescription drugs; beneficiaries would be liable for a 50 percent copayment. They would also receive negotiated discounts on drug prices. Medicare would offer this coverage to beneficiaries at initial eligibility, and it would charge a premium to cover 50 percent of the costs of the insurance. Those with incomes up to 150 percent of the poverty level (about $12,000 for a single person) would not have to pay the premium and, in some cases, they would be exempt from copayments as well. The estimated 10-year cost of this drug benefit is $127 to $131 billion. In addition, the President's 2001 Budget adds $35 billion for an unspecified catastrophic benefit.

These changes may partially satisfy one group of critics who argue that the cap on the drug benefit—proposed as a way of keeping costs in line over time—fails to protect beneficiaries who have very high (and thus costly) health care needs. Moreover, the

benefit expansions will not eliminate the need for Medigap or other supplemental coverage. Another group argues that the plan is too expensive because it is universal—i.e., it would be offered to all Medicare beneficiaries. A number of counterproposals would target any federal drug benefit at those with low incomes.

The Administration's proposed drug benefit would improve protection for more than half of all beneficiaries—a proportion that might rise over time if, as seems likely, current private sector coverage is scaled back. If Medicare's coverage failed to attract a substantial share of beneficiaries, voluntary enrollment in Medigap and private managed care prescription drug benefits would create problems because of the natural adverse risk selection that such offerings create. Sicker people are likely to be attracted to the plan that offers the most generous benefit. This problem already plagues the private supplemental market. Although enrollment in the Administration plan is voluntary, the substantial premium subsidy it offers should help to attract a large number of beneficiaries, thus reducing risk selection problems.

Another issue for prescription drug coverage, one cited largely by pharmaceutical companies, is whether this benefit would lead to strong federal price controls that might undercut other insurers and squeeze drug companies enough to stifle research and development. The Administration plan tries to address this possibility by contracting with prescription drug benefit management plans or other entities to negotiate on behalf of Medicare enrollees. Even so, Medicare might have a great deal of market power.

FOCUS ON TRADITIONAL MEDICARE

Improving traditional Medicare through a variety of reforms and demonstrations aimed at giving the Health Care Financing Administration (HCFA) more flexibility is another major theme of the Clinton proposal. Virtually no major restructuring proposal presumes an immediate elimination of the traditional part of the Medicare program—it should remain an important part of the program for a long time to come. However, if traditional Medicare is to be a competitor in a reformed system, it will need to adopt techniques that are more like those that private sector plans use.

The Administration's proposals to directly control the costs of care are:

- Contracting with preferred provider organizations (PPOs) to offer beneficiaries an alternative insurance arrangement. PPOs seek to identify providers who offer high-quality care at low cost and provide enrollees with incentives to use such providers.

- Increasing the number of Centers of Excellence. Facilities designated as Centers of Excellence would have to meet stringent quality standards and would be paid a single rate for a particular procedure or admission.

- Giving HCFA the flexibility to competitively bid or negotiate rates, to use competition to select intermediaries and carriers, to create bundled payments for certain types of care, and to offer bonus payments for group practices. A related proposal offers bonus payments for physician group practices that limit excessive use of services while providing high-quality care.

The Clinton Plan proposes other changes that would allow Medicare to offer additional services and oversight that could save money and improve the delivery of care as well. These include:

- Implementing primary care case management (PCCM). This idea borrows from one of managed care's theoretical strengths: using the primary care physician to manage patients' access to specialized services. Physicians are generally paid an additional fee for care coordination; beneficiaries' participation would be voluntary.

- Offering disease management services to enrollees who have certain high-cost, chronic health conditions. This has the potential to improve care and outcomes while reducing unnecessary or inappropriate care that often results from a fragmented system.

- Attempting to provide better information and educate beneficiaries with special attention to those who are dually eligible (i.e., for Medicare and Medicaid). Although the details remain sketchy, this is an area of considerable need.

While these strategies represent potentially important advances in modernizing the basic fee-for-service program, questions about how they would be implemented remain. HCFA's critics question its ability to adapt to change. Would these efforts truly achieve 10-year savings of $54 billion, as the Administration suggests, or would they save only $49 billion—the Congressional Budget Office (CBO) estimate? (See Table 1.)

Another important question is whether or not these strategies can be applied universally. Managed care is still uncommon in some areas of the country—rural areas in particular. If

the proposed reforms in traditional Medicare are also concentrated in only a few areas, perhaps those where choice of private plans is already in place, residents of areas where managed care is more limited would be at a disadvantage.

ENHANCING COMPETITION IN MEDICARE

Tying payments to managed care plans to 95 percent of the fee-for-service spending in local areas was initially intended to achieve modest savings for the federal government. However, the hoped-for savings were more than offset by adverse risk selection: healthier patients signed up for private plans while the less healthy—and hence more expensive—remained in traditional Medicare. It has proven difficult to change the way Medicare pays health plans because this pricing mechanism has resulted in the need to offer additional benefits to those who enroll, and beneficiaries are not anxious to lose these benefits. Meanwhile, these additional benefits also contribute to a perception that the program is no longer fair.

The Administration proposal takes a tack quite different from that of current Medicare+Choice with its administered prices, and from more aggressive proposals to revamp the Medicare program. Essentially, it would stress price competition, with savings to be shared between the federal government and beneficiaries who choose the new plans. Health plans would compete with each other on Part B premium charges for a standardized set of benefits (one with prescription drug coverage and one without).

The Clinton proposal is more restricted than the competition envisioned by those who propose a premium support approach. Health plans would compete through price differences in the premium. Because this is less flexible than options that would allow private plans to offer additional benefits in the basic package, critics say it limits choice. On the other hand, a price-based comparison is easier for beneficiaries to understand and may limit plans' ability to use additional benefits to attract those who are better risks.

Critics also contend that the Administration's competition approach offers fewer incentives for plans to bid low. If this were in fact the case, prices would be slower to come down over time. However, given the private health plans' opposition to competitive bidding demonstrations and the inexperience of both plans and the federal government in this area, a go-slow approach may be appropriate for the foreseeable future.

Another drawback of the Clinton framework is that regional differences in the costs of care are locked into place. The Balanced Budget Act of 1997 (BBA) attempted to reduce

payments to private plans in high-cost areas—an action that is likely to continue to be an important part of needed changes over time. By maintaining these differentials, the Administration forgoes some possible savings, as well as the ability to equalize premiums in different parts of the country.

THE NEED FOR NEW REVENUES

The Administration plan would shift additional resources into the Part A trust fund using future budget surpluses projected for the next few years. This tactic has been criticized because it relies on funds that exist only as projections and not as achieved surpluses. Still, it implicitly recognizes that Medicare will need additional resources over time. Without saying so specifically, the Administration is advocating the use of general revenues to supplement Medicare's financing. This sidesteps debate on exactly which revenue sources should be tapped. The proposal also focuses only on the needs of Part A, but both parts of the program will need additional revenues in the future.

CONCLUSION

The Clinton Administration's proposal offers a comprehensive, but incremental, approach to Medicare reform. It would avoid major structural changes that would alter the role of the traditional fee-for-service portion of Medicare and it would not create new administrative structures. At the same time, it addresses the major issues that the Medicare program faces: the need to improve the benefit package, the importance of adopting improvements in management of Medicare's dominant fee-for-service portion, the need for payment reforms in the private plan portion of Medicare, and the long-term requirement for additional revenues to bolster the system.

AN ASSESSMENT OF THE PRESIDENT'S PROPOSAL TO MODERNIZE AND STRENGTHEN MEDICARE

INTRODUCTION

The Clinton Administration's Medicare reform proposal, an alternative to the proposal that a majority of members of the National Bipartisan Commission on the Future of Medicare endorsed, was announced in June 1999 and modestly revised as part of the Fiscal 2001 Federal Budget submission. Both the current Clinton proposal and the Bipartisan Commission plan stake out major sets of choices for the future of Medicare; the Administration's plan contains a number of elements that differ from the commission's proposal. The Clinton plan would offer a subsidized prescription drug benefit to all Medicare beneficiaries. It would explicitly protect beneficiaries who choose the traditional fee-for-service portion of the program from efforts to expand competition among private plans. It also promotes improvements in the traditional Medicare program and adds new resources—derived from future expected budget surpluses—to the Part A trust fund. Although the Clinton approach is more incremental than the commission's, it nonetheless offers a broad range of changes that could have a dramatic impact on Medicare.

This paper examines the Administration plan and suggests areas where research and analysis might offer insight into some of its components. Understanding all of its elements will require further work—already there is substantial disagreement over the plan's budgetary effects, although the 2001 cost estimates for the Congressional Budget Office and the Clinton Administration are closer than when estimates were made in 1999 (see Table 1). The following sections focus on four of the plan's key themes: improving the benefit package, improving the traditional Medicare program, redirecting competition among the private plan options, and adding further resources to secure Medicare's future.[1]

Table 1[2]
Administration Estimates of the 10-Year Cost of the President's Reform Proposal vs. CBO Estimates
(in billions of dollars)

	Administration Estimate	CBO Estimate
Medicare Outlays		
Prescription Drug*	126.6	130.6
Changes to FFS Medicare	-54.1	-48.6
Competitive Defined Benefit	-11.9	-13.7
Expanded Eligibility	2.9	0.2
Subtotal	63.5	68.6
Medicaid Cost of Drug Benefit	33.7	18.7
Tax Credits for Medicare Eligibility	1.6	8.4
Total	98.8	95.7

[1] Other features of the proposal—additional fraud and abuse efforts and a buy-in for some people ages 55 to 64—are not discussed here.

[2] Congressional Budget Office. "An Analysis of the President's Budgetary Proposals for Fiscal Year 2001," U.S. Government Printing Office, April 2000.

* Excludes the $35 billion proposed but not specified for catastrophic drug protections.

IMPROVING THE BENEFIT PACKAGE

The proposal contains two major elements aimed at improving Medicare's benefit package: the provision of additional benefits, and a move to a more rational cost-sharing structure. Many policymakers and analysts advocate such improvements on two grounds. First, an expanded benefit package would allow the provision of additional coverage and an adjustment of the cost-sharing structure so it would be more closely aligned with private sector cost-sharing. Second, such improvements would reduce or eliminate the need for supplemental coverage, which creates inefficiencies in the current program. Fully achieving such improvements, however, has been difficult because of the additional costs they would generate. Although the Clinton proposal goes further than many other Medicare proposals made thus far, it too is limited.

The plan's two major benefit expansions are a voluntary, subsidized, prescription drug benefit, and the elimination of deductible and cost-sharing requirements for preventive services. At the same time it would add copayments for laboratory services and index the Part B deductible so that it would rise gradually over time. These changes are intended not only to raise revenues but also to improve Medicare's cost-sharing structure. Their net effect would be a substantial increase in the cost of the Medicare benefit package. Over 10 years, the Administration estimates that the prescription drug benefit would add $160 billion in Medicare and Medicaid costs, while the cost-sharing changes would reduce Medicare spending by about $7 billion.[3] The CBO's estimate places the 10-year costs for the drug benefit at $149 billion.[4]

A related set of changes would create a new Medigap (private supplemental) option that would strengthen coverage for catastrophic costs, while retaining cost-sharing for other conditions. Current Medigap plans shield beneficiaries from most copayments, and many analysts argue that such first-dollar coverage should be discouraged. The proposed changes would move the combination Medicare/Medigap cost-sharing structure more into line with that of other fee-for-service plans. Other changes in Medigap would make coverage

[3] The general description of the proposal (unless otherwise indicated) comes from Office of the President, *The President's Plan to Modernize and Strengthen Medicare for the 21st Century,* Detailed Description. Washington, D.C., National Economic Council and Domestic Policy Council, July 2, 1999. More details are available from this document, but changes made in the 2001 Budget submission have been incorporated. Cost estimates are from: Executive Office of the President, *Budget of the United States Government Fiscal Year 2001.* www.access.gpo.gov/usbudget.

[4] Congressional Budget Office. "An Analysis of the President's Budgetary Proposals for Fiscal Year 2001," U.S. Government Printing Office, April 2000..

accessible to disabled beneficiaries under age 65, and ensure that beneficiaries who leave managed care plans would be able to buy Medigap coverage.[5]

Issues Stemming from a Universal Prescription Drug Benefit

The prescription drug benefit in the President's plan would be offered on a voluntary, subsidized basis to beneficiaries at the time of initial eligibility. Enrollees would be liable for a 50 percent copayment. They would also be required to pay 50 percent of the costs of the insurance—the premium is expected to be about $48 per month in 2009 when the full benefit is in place. (The plan would begin in 2003, a delay from 2001 as previously proposed.) Once fully phased in, the maximum coverage would be $5,000, of which the federal government would pay a maximum of $2,500. This cap would be indexed to the Consumer Price Index each year after that. Enrollees would also receive discounts on drug prices as negotiated by private prescription benefit management firms (PBMs), which would help stretch the $5,000 limit. In addition, those with incomes up to 150 percent of poverty (about $12,000 for a single person) would pay no premium, while those with incomes up to 135 percent of poverty would be protected from both the premium and copayments. Finally, the Administration set aside $35 billion from 2006 to 2010 to provide protection against catastrophic drug costs. No details on that piece are available, however.

By contrast, the drug coverage now available to Medicare beneficiaries ranges from ample to nonexistent. Medicaid, for the very poor, and employer-sponsored retiree benefits, for those who are well off, provide generous coverage. For others, drug benefits are often limited and very expensive. Medigap beneficiaries must pay the full expected cost of covered drugs, as well as premiums that include administrative costs, which can add another 25 or 30 percent to the premium. The existence of a prescription drug benefit has been one of the major inducements to enrollment in Medicare+Choice plans, but most limit coverage. By 2000, about one-third of plans are expected to have a limit of $500 or less.[6] The proposed drug benefit, therefore, would be an improvement in protection for more than half of all current beneficiaries. That number might well rise in the future if the downward trends in employer-subsidized retiree benefits and Medicare+Choice prescription drug coverage continue.[7]

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[5] That is, this legislation would broaden some of the changes made under the Balanced Budget Act of 1997 to expand the number of plans to which the beneficiary could turn after leaving a managed care plan and extend the length of time in which to make these arrangements.

[6] Robert Pear, "Medicare HMOs to End Free Drugs, Report Says," *New York Times,* September 22, 1999.

[7] When Medicare was introduced in 1966, about half of all eligible enrollees had existing drug coverage from other sources, but the perceived benefits of having universal coverage won the day.

Perhaps because prescription drug coverage has become an important political issue, the President's plan has been criticized on both ends of the political spectrum since it was unveiled in June of 1999. These criticisms focus on three issues: the way in which the benefit is structured, whether a drug benefit should be universal or targeted, and how much control this program would exert over drug prices.

The Structure of the Benefit

Establishment of a $5,000 cap on the drug benefit offered in the June 1999 proposal drew particular criticism because it fails to address Medicare's traditional lack of catastrophic protection for those with very high health care needs. People with multiple health care problems—e.g., arthritis, hypertension, and other chronic conditions—can incur drug expenses of as much as $400 to $600 per month. But this basic benefit would certainly help those with unusually high expenses because it would lower their overall costs and allow them to continue to buy drugs at a discount after the $5,000 cap had been attained. For those who still face catastrophic expenses, the Administration set aside $35 billion to develop further protections.[8] No specifics of this addition have been provided, however, so it is difficult to anticipate whether this would resolve the major concerns with the Administration's proposal.

The major justification for adopting limits on coverage is the issue of the cost of coverage over time. Cost estimates for prescription drug benefits grow most rapidly when plans offer catastrophic protections and least rapidly when they include a cap like that found in the Administration proposal.[9] Without such a limit, future costs are expected to rise rapidly. Even in an alternative benefit package that had catastrophic protection and initially cost the same as the Administration's, costs would grow more quickly. With a cap, however, over time, beneficiaries would be increasingly exposed to higher out-of-pocket costs. Could a restricted program such as that proposed here be designed to aid those who exceed the cap? At first only a small minority of persons would be affected. In 1996, for example, only 0.5 percent of all Medicare beneficiaries spent more than $5,000 for drugs; another 0.5 percent spent between $4,000 and $5,000.[10] Thus, most current beneficiaries would not hit the cap, although inflation in drug prices will push more people above this limit in the future. Further, special efforts would be needed to keep costs of drugs subject to catastrophic protections from rising substantially.

Targeting vs. Universality

[8] Executive Office of the President, op cit.
[9] Michael Gluck, *Prescription Drugs,* Medicare Brief, National Academy of Social Insurance, 1999.
[10] Bruce Stuart, unpublished data from the *Medicare Current Beneficiary Survey,* 1999.

Many critics of the Administration proposal argue that offering this benefit to all Medicare beneficiaries makes it too expensive. Why, they ask, should such a benefit be available to those who already have prescription drug coverage or to those with very high incomes? Consequently, a number of counterproposals would limit any federal drug benefit to people with low incomes. A commonly cited level for such targeting would limit benefits to those with incomes of less than 135 percent of poverty (about $10,500 per year for a single person).[11] This is less generous than the low-income protections that the Administration would offer (up to 150 percent of poverty), but it is more in line with existing protections that Medicare beneficiaries receive through the Medicaid program.[12]

Perhaps the most important argument for universal coverage stems from the issue of the unequal distribution of the costs of prescription drugs. The more beneficiaries who participate, the less expensive per beneficiary it becomes. Without universal or nearly universal coverage, offerings of prescription drug benefits on a voluntary basis by Medigap and private managed care plans would be problematic because of the natural adverse risk selection that such offerings create. Sicker beneficiaries are likely to be attracted to the plan that includes the more generous benefit. When that happens, not only do the costs of the drug coverage become very expensive, but all other insurance costs—such as those for hospital and physician services—are also higher.

This situation has clearly occurred in many Medigap plans (and to HMO plans as well)[13]. The addition of drugs to the other services covered results in costs that that exceed what a basic drug benefit alone would cost, thus necessitating premiums that price many beneficiaries out of that market. The large differences in premiums between plans that have prescription drug coverage and those that do not illustrate this problem. Medigap plans are required to offer standardized packages. Two prescription drug benefits are available, one with a limit of $1,250, the other with a limit of $3,000. In either case, enrollees must have much higher expenses to qualify for these maximums because each has a deductible and a 50 percent coinsurance requirement. Thus few beneficiaries will reach the maximums.

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[11] This is the level of protection proposed in the cochairmen's proposal to the Medicare Commission. See The National Bipartisan Commission on the Future of Medicare, *Building a Better Medicare for Today and Tomorrow,* Washington, D.C., March 16, 1999.

[12] It could be argued that the Administration proposal is a targeted benefit, with limited protections for all beneficiaries and more generous benefits for those with low incomes.

[13] See for example, Marsha Gold, Amanda Smith, Anna Cook, and Portia Defilippes, *Medicare Managed Care: Preliminary Analysis of Trends in Benefits and Premiums, 1997–1999,* Washington D.C.: Mathematica Policy Research, 1999; and National Bipartisan Commission on the Future of Medicare.

Comparisons of annual premiums for Medigap plans that are similar except for prescription drug coverage in localities that represent a range of low- to high-cost Medicare counties are shown in Table 2.[14] The premiums quoted in each area are those for a 65-year-old woman. Thus, in Dade County Florida, the difference in premium costs between plans that offer drug coverage and those that do not ranged from $777 for the low-cost prescription drug option to $2,469 for the high-cost option.[15] The premium differential is lower in lower-cost areas, but it may still exceed the actuarial value of the drug benefit. A recent *Consumer Reports* study found similarly large differences in the median price of Medigap plans that differed mainly in coverage of prescription drugs.[16] This underscores the strong rationale for not making drug or other "natural risk selection benefits" optional.

Table 2
Medicare Supplemental Insurance Premium Differentials, 1999

	Moderate Coverage*			Extensive Coverage**		
Covered Person's Location	No Drugs	With Drugs	Differential	No Drugs	With Drugs	Differential
Butler County, KS 67010	$852	$1,236	$384	$960	$2,076	$1,116
Multnomah County, OR 97204	$972	$1,560	$588	$1,116	$2,640	$1,524
Sacramento County, CA 95814	$1,284	$1,860	$576	$1,464	$3,144	$1,680
New York County, NY 10112	$1,404	$2,064	$660	$1,704	$3,552	$1,848
Dade County, FL 33128	$2,088	$2,865	$777	$2,377	$4,846	$2,469

* The moderate plan with no drugs is Option E, which includes coverage of basic benefits, the Part A deductible, SNF coinsurance, foreign travel emergency services, and preventive care services up to a maximum of $120. Option H is the same except that it adds basic drug coverage (with a limit of $1,250) and excludes preventive care.

** The extensive plan with no drugs is Option F. It adds coverage for Part B deductible and excess physician charges (although it excludes preventive care). Option J adds preventive care and prescription drugs up to a maximum of $3,000.

Source: www.Quotesmith.com.

Further, risk selection is a major stumbling block in the struggle to improve competition among private plans in the Medicare+Choice program, or even to move to more extensive reforms that seek managed competition for Medicare. Specific adjustments for risk differences have had only limited success. At the same time, prospects for major improvements in the future suggest that risk adjustment efforts may also necessitate standardization of some benefits in order to reduce opportunities and incentives for plans

[14] The quotations included here come from www.Quotesmith.com, which provides information on a broad range of Medigap plans by geographic area, and age and gender of the beneficiary. In each case we took premiums from the same company in that location. Other differences besides drugs account for only small variations in actuarial amounts.

[15] In the first example, the plan without drugs also includes preventive services that are excluded from the drug package. Thus, the actual additional cost of drug coverage is understated.

[16] "Medicare: New Choices, New Worries," *Consumer Reports* 63 (September 1999):27–38.

to seek only healthy beneficiaries. If that is the case, it makes sense to include prescription drugs in a standardized package.[17] Universal coverage of prescription drugs could therefore help efforts to generate constructive competition in the Medicare market. While the Administration proposal is voluntary, its substantial premium subsidy should help attract a large number of beneficiaries and reduce this risk selection problem.

An alternate approach to universality would target prescription drug benefits to those with low incomes. The challenge here lies in where to set the income cutoffs for such protection. Special prescription drug benefit programs that some states offer outside of the Medicaid program set income cutoff levels as high as $18,000 for a single person (or about 225 percent of poverty).[18] The question is, at what level of income does buying one's own drug coverage become affordable? Even for the limited option H Medigap plan described in the notes for Table 2, a person in Portland, Oregon who has $15,000 in income would have to pay about 4 percent of that income just for the drug portion of that insurance. Yet this person's income would be well above the approximate $10,500 cutoff level often proposed for such targeted plans (e.g., the Medicare Commission's).[19] However, moving the cutoff level up the income scale quickly makes many millions of beneficiaries eligible, thus undercutting the whole principle of targeting. A cutoff of $30,000, for example, would include over 24 million people—about two-thirds of all Medicare beneficiaries.[20]

Finally, the practical administrative complexities and costs of an income-related proposal cannot be disregarded. The most practical alternatives rely on existing mechanisms. The Medicare program has traditionally relied on the state Medicaid programs for low-income protections. This has resulted in low (and highly unequal) participation across the states. Indeed, problems with participation in the Qualified Medicare Beneficiary and Specified Low-Income Medicare Beneficiary programs have led to calls to move these programs out of Medicaid. Alternatively, if the cutoffs were indexed so that higher income beneficiaries are charged more (or excluded altogether), the most practical administrative mechanism to use is the Internal Revenue Service—an option that has often been rejected for looking too much like a tax. Establishing separate administrative systems would be expensive,

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[17] See Henry J. Aaron and Robert Reischauer, "The Medicare Reform Debate: What is the Next Step?" *Health Affairs* 14 (Winter 1995):8–30; and Len Nichols, "Competitive Pricing by Medicare's Private Health Plans: Be Careful What You Wish For," in Marilyn Moon, ed., *Competition with Constraints: Challenges Facing Medicare Reform.* Washington, D.C.: The Urban Institute, 2000.

[18] David Gross and Sharon Bee, *State Pharmacy Assistance Programs.* Washington, D.C.: AARP, April 1999.

[19] National Bipartisan Commission, op. cit.

[20] One popular argument leveled against a universal benefit is the cost of subsidizing a drug plan for millionaires. In practice, there are very few such individuals on the Medicare program and it is

although some states have had success, relying on self-reporting with spot-checks of compliance.[21]

Government and Price Controls

A final issue related to prescription drug coverage—one raised largely by pharmaceutical companies—is whether this benefit would lead to strict federal price controls. Since Medicare would become a very large purchaser of drugs, some fear it could dominate the market, undercutting other insurers, and squeezing drug companies enough to stifle research and development. The Administration's approach tries to soften this possible impact by seeking negotiated discounts for beneficiaries. It proposes that Medicare contract with prescription drug benefit management plans or other entities to negotiate on behalf of enrollees in regional markets. While there would be many details to work out, including the issue of assuring equity across regions if some management firms are better at getting discounts than others, this strategy could ameliorate some of the concerns about government price-setting. On the other hand, since the prescription drug management firms would negotiate on Medicare's behalf, they would carry the clout of a consumer of one-third of all the drugs sold in the United States. And, if catastrophic protection is added, drug companies could raise prices without concerns about beneficiaries' ability to pay; the federal government in that case would need to take an active role in some type of control or negotiation on price.

Because the elderly and disabled spend substantially higher shares of their incomes on prescription drugs, it would seem that these groups have a greater need for discounts than those who now receive them through employer-subsidized or other plans. If Medicare exerted its market power to get lower prices, the most likely effect would not be to force decreased spending on research and development, as the pharmaceutical industry claims. Instead, costs for those who now get big discounts would probably go up, leading to a more consistent set of prices for everyone in the process.

Reducing the Need for Medigap

Despite major changes in the way health care is delivered in the United States, Medicare's benefit package has been altered little since 1966. The program has adapted to the shift of services from inpatient to outpatient settings because both are covered services. However, major gaps in coverage have arisen in cases in which a service was not covered or for which cost-sharing was established haphazardly. Further, as noted above, the lack of

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unlikely that they would find it to their advantage to enroll. The costs of their inclusion are likely to be substantially below the costs of administering an income-related benefit.

prescription drug coverage has left Medicare deficient in one increasingly important area of insurance coverage. Medicare's cost-sharing provisions were never based on principles of disciplining the use of services—the usual justification for such requirements. Instead, they were seen as a way to lower the costs of the program.[22] Thus, for example, the hospital deductible is now much higher than the Part B deductible ($768 versus $100 in 1999), even though many actuaries and others believe that cost-sharing for outpatient physicians and other services are more likely to affect use of services than are such requirements for hospital services. And unlike most private insurance plans, Medicare has no upper limit on the amount beneficiaries must pay in cost-sharing. Absent such a limit, a high-cost illness can wipe out the savings even of middle-income families.

Medicare beneficiaries have sought additional coverage through supplemental plans almost from the program's beginning. One of the stated goals of the Medicaid program, passed at the same time as Medicare, was to fill in the gaps that Medicare had left, and the market for private supplemental insurance emerged to serve higher income people who were not covered under employer-sponsored retiree health plans. This so-called "Medigap" market serves an important need, but it has long been criticized for its inadequacies and for marketing practices that inappropriately pressured beneficiaries to buy multiple policies, (although these have been reduced by regulatory reforms).[23] Medigap is still heavily criticized for creating first-dollar coverage that encourages overuse of services, for pricing practices that make benefits increasingly unaffordable for older beneficiaries, and for high overhead costs that exacerbate the high costs that older people bear.[24]

The Administration proposal would improve, but not eliminate, such problems. It does not place an upper benefit on cost-sharing, so it is unlikely to eliminate beneficiaries' desire for Medigap coverage since it would not reduce the high copayments that many beneficiaries now incur when they have a serious illness. Even the prescription drug benefit would leave room for supplemental plans to offer further drug coverage unless the unspecified catastrophic benefit is comprehensive. Recognizing that Medigap will remain, the Clinton proposal seeks to offer new Medigap options that provide catastrophic protections but without first-dollar coverage. For example, the proposal takes notice of the need for an upper-limit protection from the cost of prescription drugs, but it does not

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[21] For example, this is the approach that the state of Pennsylvania takes in its very large Pharmaceutical Assistance Contract for the Elderly program.

[22] Marilyn Moon, *Medicare Now and in the Future* (2nd ed.). Washington, D.C. The Urban Institute Press, 1996.

[23] Peter Fox, Thomas Rice, and Lisa Alecxih, "Medigap Regulation: Lessons for Health Care Reform?" *Journal of Health Politics, Policy and Law* 20 (1995).

[24] Aaron and Reischauer, op cit.

contain specifics on what these improvements would be. Instead, the National Association of Insurance Commissioners would be asked to recommend changes.

Still, changes in Medigap could help that market avoid the problems that can arise from first-dollar coverage only for those who choose such options. But the President's plan falls short here as well. Without major overhauls, other problems—such as pricing structures that result in substantial premium cost differences by age—are likely to remain. The elderly population's insurance costs rise as their ability to pay falls. And if the benefits in the new options focus more on catastrophic protection, the age differentials might actually be greater in these new plans because health care spending generally rises with age. Finally, Medicare beneficiaries who buy Medigap policies will still have to absorb administrative loads in excess of 25 percent in order to obtain this catastrophic protection—another major source of inefficiency in the current system.

Full modernization of the traditional Medicare option would require a more comprehensive benefit package than the Administration has proposed if beneficiaries are to be induced to forgo supplemental insurance. Interestingly, one source of opposition to benefit expansion is the managed care plans that serve Medicare. These plans argue that they can be attractive only if they are allowed to offer a benefit package richer than that of traditional Medicare. Thus a key issue for the viability of private plans may turn on whether competition is based on offering extra benefits—as is now the case—or on price—as described below in the discussion of the competition section of the Administration proposal.

FOCUS ON TRADITIONAL MEDICARE

Another major theme in the Clinton proposal is to modernize traditional fee-for-service Medicare by the use of a variety of reforms and demonstrations intended to give the Health Care Financing Administration (HCFA) more flexibility to respond to the changing health care delivery system. Even if the long-term emphasis is to be on private plans and their participation in the program, a strong argument remains for modernizing traditional Medicare. Virtually no major restructuring proposal presumes an immediate elimination of the traditional part of the Medicare program. Since it serves a sicker and more disabled population than do private plans, per capita spending in traditional Medicare is high and is likely to remain so.[25] Thus, traditional Medicare is where much of Medicare spending will occur for the foreseeable future and any concern about slowing spending needs to take this into account.

[25] Gerald Riley, Cynthia Tudor, Y. Chiang, and Melvin Ingber, "Health Status of Medicare Enrollees in HMOs and Fee-for-Service in 1994," *Health Care Financing Review* 18 (Summer 1996).

Another reason to concentrate on traditional Medicare is the issue of whether it will be treated as a competitor—with the consequent need to adopt techniques more like those of private plans—in a reformed system. If traditional Medicare is to be just one option among many, and if those who choose traditional Medicare are subject to premiums related to its costs, then it must be given an ability to compete.

Before examining the Administration proposals specifically, it is useful to consider some principles that might be used to govern how Medicare can and should change over time. These are likely to involve constraints that should be weighed when evaluating options for altering this part of the Medicare program. First, traditional Medicare is now, and is likely to be for a long time to come, the "default" plan for beneficiaries. About 83 percent of all current Medicare enrollees are in the fee-for-service portion, and even optimistic projections of growth in private plans suggest that this number will be no less than 62 percent in 2008.[26] This may necessitate special protections and guarantees of access that will differentiate Medicare from private plans that operate with different goals.

Second, Medicare is likely to be the only national plan operating for the foreseeable future, which will create additional demands on the program. This would mean, for example, that innovations should be judged on whether they can be made consistently available around the country. The option of choosing a private plan is unavailable to many beneficiaries who live in rural and other underserved areas; thus it is important to put a special premium on ensuring that the traditional option serves these beneficiaries as well as possible. This may be particularly challenging. For example, some suggested innovations require sophisticated groups of physicians or tertiary care hospitals—characteristics found in relatively few areas of the country.

The problems and advantages inherent in Medicare's enormous size also pose important challenges for those seeking ways to improve the cost-containment tools that traditional Medicare has at its disposal. If Medicare exercised its market power fully, it might be unfair to other insurers. Medicare could cross-subsidize its premiums to keep them lower in areas with stiff competition. It could sign exclusive contracts with providers, squeezing out private plans. These plans probably don't have such activities in mind when they suggest that Medicare should compete on a "level playing field" (and it is unlikely that such use of power would be allowed).

[26] Congressional Budget Office, *The Economic and Budget Outlook: Fiscal Years 1999–2008,* U.S. Government Printing Office, 1998.

On the other hand, traditional Medicare faces limits on its flexibility that would make it difficult for the program to be instantly responsive to change even if HCFA were given more discretion. For example, Medicare is likely to face higher standards of accountability before it denies coverage. Due process requirements for government programs make Medicare less flexible but enhance its ability to protect providers of care and patients alike.

Finally, HCFA is often accused of having a conflict of interest because it is both an insurer and a negotiator with other insurance plans. However, private companies often operate successfully in a similar way—managing their own self-funded PPOs and negotiating contracts with HMOs.

The special challenge that a fee-for-service system poses is in finding new ways to increase the accountability of providers of care and beneficiaries alike. Physicians who do not work under the financial incentives of a capitated system have little motivation to oversee the utilization and appropriateness of other services their patients receive. In fact, actively providing patients with prescriptions and tests may be a way to justify spending less time with them. This problem can also arise in a capitated system, but it is easier to design economic incentives to discourage such behavior there. The usual approach in a fee-for-service system is to use copayments to discipline patient behavior, but this can have negative effects on the sickest and poorest beneficiaries. By contrast, new ways of overseeing care are being introduced in the private sector. And changes in payment policy can have an important impact on service utilization even in the Medicare fee-for-service sector. This is another area that calls for more creativity. What other noneconomic incentives might be useful?

The Administration proposals are all essentially aimed at giving HCFA the flexibility to adopt techniques that private sector plans—both indemnity and managed care—have employed, or to expand policies already in place on a more limited scale. Proposals to directly control the costs of care include:

- Offering beneficiaries an alternative insurance arrangement by contracting with preferred provider organizations (PPOs);

- Expanding Centers of Excellence to procedures other than those with which HCFA has already experimented; and

- Giving HCFA the flexibility to competitively bid or negotiate rates for Part B items and services, to use competition to select intermediaries and carriers, to

create bundled payments for certain types of care, and to offer bonus payments for group practices that meet certain standards.

In addition, the Administration's proposal seeks other changes that would allow HCFA to offer additional services and oversight that might save costs and improve the delivery of care. These include:

- Instituting primary care case management (PCCM) and paying physicians who coordinate care;

- Offering disease management services to beneficiaries with certain high-cost, chronic health conditions; and
- Attempting to provide better information and to educate beneficiaries in general, with special attention to those who are dually eligible for Medicare and Medicaid.

While these options have the potential to create some important advances in modernizing the basic fee-for-service program, a number of questions about how they would be implemented need to be addressed. Would they be viable? Would they achieve the level of savings that the Administration suggested—$54 billion over 10 years—or the lower CBO estimate of $49 billion?[27] CBO's estimates, for example, are much lower than the Administration's for the PPO and Centers of Excellence options. The answers to these questions turn in part on Congress's expectations about HCFA's ability to adapt and its willingness to let HCFA do so. In addition, each of these areas of potential change gives rise to a number of specific issues.

Adding a PPO Option

The basic rationale behind the PPO model is to achieve savings by identifying providers who offer high-quality care at low cost and providing incentives to encourage beneficiaries to use those providers. Such physicians and hospitals are presumably those who employ cost-effective practice patterns—that is, they avoid excessive treatments and tests that contribute to higher costs of care. The Administration proposes that Medicare contract with successful private sector PPOs to offer this alternative to beneficiaries. The proposal also allows for a special Medigap policy designed to reflect the lower copayments that PPO beneficiaries would owe when they use in-network physicians.

[27] A substantial share of these proposed savings will come from efforts to hold down rates of payment growth. The 2001 Budget goals are less ambitious than those originally proposed in 1999.

How this new option would relate to the current fee-for-service program is not fully clear. Would PPOs under contract be reimbursed on a cost basis? If so, how would the payment levels match with current Medicare hospital, physician, and other fees? Since Medicare already pays fees that are lower than many private sector plans, does this alternative provide enough flexibility to achieve savings (especially if beneficiaries are charged lower copayments)?[28] Presumably, such savings would come when preferred providers order fewer tests and procedures, rather than from lower federal payments to providers. But this option would likely be viable only in areas where Medicare payment levels are high relative to other payers.

Further, how would out-of-network providers be paid and what constraints would be placed on them? While the rules under which Medicare now operates are generally consistent with private insurance plans that seek discounts from participating providers, there is one important exception: Medicare limits the amount physicians can charge when beneficiaries seek care outside the network. Medicare is unique in this area. While many private plans limit the amount they will pay and make that limit less generous than for in-network providers, the ultimate amount that the patient pays the doctor is not under the plan's control. Would the rules for Medicare PPOs be consistent with current Medicare fee-for-service policy or with that of private PPOs? This issue would be important when beneficiaries calculate whether a PPO option would be worthwhile.

Finally, would beneficiaries find the added complexity a burden if the addition of a PPO option results in a three-tiered payment structure rather than the current two-tiered system? Would this offset other desirable traits?

Centers of Excellence

Facilities designated as Centers of Excellence would have to meet stringent quality standards and would be paid a single rate for a particular procedure or admission. This rate would be equal to or lower than what the costs of providing that care would otherwise be. Like the PPO option, this service would be offered to beneficiaries on a voluntary basis. It would seem that HCFA is in a good position to extend this particular policy, since Medicare demonstrations have established such centers since 1991.

[28] Medicare Payment Advisory Commission, *Report to the Congress: Context for a Changing Medicare Program.* Washington, D.C., 1998.

Studies of these Medicare demonstrations for coronary bypass procedures indicate that savings were achieved.[29] A number of other studies covering hospital procedures for those of all ages indicate that the best outcomes are generally associated with facilities that perform large numbers of the procedure under study. So practice does seem to improve outcomes, suggesting that beneficiaries would be well served if the provision of certain technical procedures were concentrated among a few high-quality providers. The adequacy of the geographic distribution of these centers might be cause for concern for patients in rural areas (although this problem arises for Medicare in general).

Other Contracting and Negotiating Flexibility

A major source of higher costs occurs in categories (e.g., durable medical equipment) and instances in which Medicare has, by legislation or other constraint, been required to pay higher costs than other payers do.[30] The Administration proposal seeks increased flexibility to negotiate terms (e.g., simplified claims processing and billing) to provide incentives to suppliers to offer their goods at lower prices. Negotiating flexibility is also proposed to improve HCFA's oversight and payments to intermediaries and carriers that process the claims for the Medicare program. Many of the intermediaries and carriers have complained of unrealistic demands on their services at the same time that the GAO has called their performance into question.[31]

Another way the Administration proposes to reap savings is to bundle payments for services provided by a range of providers and suppliers at a specific site of care. The most common example of this practice is during a hospitalization when compensation for services provided by a hospital, physician, and others is combined into a single payment. A related proposal would offer bonus payments to physician group practices that demonstrate an ability to limit excessive use of services while providing high-quality care for a specified group of services. Again, this is an effort to begin to think of the delivery of care as a whole rather than focusing on one service at a time, which is the usual incentive under a fee-for-service system. Private plans have flexibility in these areas and HCFA could undoubtedly find good examples to emulate. As with some of the other proposals, however, it may be difficult to offer this program to rural residents.

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[29] Jerry Cromwell, Debra A. Dayhoff, and Armen Thoumaian, "Cost Savings and Physician Responses to Global Bundled Payments for Medicare Heart Bypass Surgery," *Health Care Financing Review* 19 (Fall 1997):41–58.

[30] An often-cited example of this situation is in the payment levels for oxygen services—Congress set them at a level above what a market-based approach could achieve.

[31] General Accounting Office, "HCFA Oversight Allows Contractor Improprieties to Continue Undetected," testimony, T-HEHS/OSI-99-174, September 9, 1999.

Primary Care Case Management (PCCM)

A case management system would rely upon a primary care physician to serve as a gatekeeper, coordinating care and overseeing the use of services by patients enrolled in this option. While a strict gatekeeper model would, for example, limit access to specialty physicians and/or to tests and procedures, the model envisioned here would likely be less restrictive since it would be optional to the patient. That is, this approach would need to be offered as a means for helping patients with coordination of care rather than viewed as a means for limiting access. Medicaid programs in many states have used PCCM as a way to coordinate care and their efforts are generally viewed as having been successful, although they result in less coordination than a fully capitated managed care plan can achieve. PCCM has often been used in localities where managed care has not developed. This could become an important improvement in fee-for-service Medicare in these areas.

Physicians who coordinate care are generally paid an additional fee. Again, beneficiaries would volunteer to participate. PCCM programs can also result in better use of preventive services. This approach provides a potentially valuable service—particularly to beneficiaries who have multiple needs—while saving some additional costs. These savings might be small in the beginning because new payments would be made to physicians, but there could be long-term dividends.

Disease Management Services

The disease management model is related to PCCM, but the service is limited to those with high-cost illnesses. It involves the coordination of care for those with specific chronic diseases, such as diabetes or congestive heart failure. A number of private organizations that have developed models for treating certain chronic illnesses claim success in reducing costs for unnecessary hospitalizations or other services. The proposal calls for contracting with these private organizations, which would submit competitive bids for contracts to provide disease management services. Enrollment would be voluntary. Here again is the potential for improved care and better outcomes for beneficiaries while reducing unnecessary or inappropriate care.

Patients who are convinced that this is a means to improve their care rather than merely imposing barriers will be more likely to participate. Patient education and information would thus be an important piece of this approach. A number of managed care plans and others have used these organizations to help hold down the costs of care, and this seems to be a genuine area of innovation in health care delivery. It is particularly important in fee-for-service, where many of Medicare's sickest beneficiaries choose to remain.

Improved Information and Education

The details of the education and information initiatives designed to help beneficiaries use and understand the health care system are sketchy and difficult to evaluate. Nevertheless, the Administration has certainly identified an area of considerable need. Beneficiaries' poor level of understanding of both the basic Medicare program and the private plan options has been well documented.[32] HCFA has already made efforts, and has launched an initiative to communicate more effectively with those who are dually eligible for Medicare and Medicaid. Since choices available in Medicare are only likely to expand with time, the resulting complexity will make the availability of high-quality information a key to future success.

One of the difficulties this proposal presents, however, is determining who should be in charge of providing timely and often controversial information to beneficiaries. HCFA has been criticized for the complexity and lack of clarity of some of its materials. Given the practical limits on what any government agency can produce, an outside entity with considerable independence might do better. For instance, will HCFA be able to do more than provide basic quality scores on private plans? An independent entity could offer more directed advice and information, which may be what beneficiaries require. Some of this private activity will likely develop in any event in response to information the government makes available, but educating nearly 40 million people is an expensive task—one beyond the scope of most private organizations. Other major questions include how to ascertain the nature of what HCFA should do, whether to appropriate funds to aid other groups, and what limits should be placed on plans' advertising and marketing efforts.

Where to Put the Emphasis for Modernization

An important issue related to all of these proposals is whether or not they can be uniformly applied around the country. If these reforms actually do result in higher-quality care and lower costs (including lower beneficiary copayments), enrollees in areas where such services are more limited will be at a disadvantage.

Therefore, there should be careful oversight of the activities proposed here so as to ensure that they are distributed in a wide geographic area and to prevent HCFA from concentrating them only in areas most likely to be immediately effective. Further, some of these initiatives, e.g., PCCM, may be most needed in rural areas—the very ones that are not now served by managed care. Even if it is more difficult to undertake these initiatives

[32] Kaiser Family Foundation, "Americans Know Medicare Faces Problems, but not Ready to Make Hard Choices," press release on National Survey, October 20, 1998.

and generate savings in these areas, they may be essential in order to broaden the choices for beneficiaries who live there.

ENHANCING COMPETITION IN MEDICARE

The promise of savings to be gleaned by allowing Medicare beneficiaries the option of enrolling in private plans has yet to be realized.[33] Achieving modest savings was the original intent of limiting payments to managed care plans to 95 percent of the fee-for-service spending in local areas. However, those anticipated savings were more than offset by the uneven distribution of beneficiaries that resulted when healthier people signed up for private plans. This left the less healthy—and more expensive—group in traditional Medicare. Consequently, the bulk of careful studies on how much beneficiaries who sign up for private plans would have cost had they remained in traditional Medicare have found that on average, the federal government loses money on each private plan participant.[34]

On the other hand, changing the way in which Medicare pays plans has proven to be quite difficult. Changes enacted in the Balanced Budget Act of 1997 became quite controversial—private plans convinced many policymakers that the BBA had treated them unfairly. Furthermore, Medicare requires plans to use any savings they earn on the difference between the cost of providing care and what the federal government pays them to provide additional benefits for their enrollees. This rule had the unintended consequence of creating a system in which the recipients of these extra benefits became influential advocates for sustaining any overpayments. The plans and beneficiaries alike are now reluctant to acknowledge this differential as an implicit subsidy. Instead they often treat the extra benefits as part of their Medicare entitlement. Even though the payment levels for HMOs may unfairly benefit those enrolled in private plans, it is difficult to roll back the windfall gains that this pricing mechanism created because policymakers are sympathetic to the complaints of beneficiaries.

Thus, it is no surprise that the 1999 Balanced Budget Refinement Act (BBRA) softened several BBA provisions that affected private plans. In particular, the reductions in payments as compared with fee-for-service were reduced from 0.5 percent to 0.3 percent per year from 1999 to 2002. So the 1999 legislation is likely to retain at least a partial overpayment for Medicare+Choice for the foreseeable future. In addition, changes in fee-for-service payments (which will also raise private plan payments) and a further delay in

[33] Gerald Riley, Melvin Ingber and Cynthia Tudor, "Disenrollment of Medicare Beneficiaries from HMOs," *Health Affairs* 5 (September/October 1997):117–124; and Physician Payment Review Commission, *Annual Report to Congress.* Washington, D.C.: USGPO, June 1997.

[34] General Accounting Office, "Medicare and Choice: Reforms Have Reduced but Likely Not Eliminated, Excess Payments," HEHS-99-144, Washington, USGPO. Also see PPRC ibid.

implementing risk adjustment will further reduce the BBA's impact on Medicare+Choice plans.

Differences in benefits across regions of the country also contribute to a perception that the program is no longer fair. For example, beneficiaries in places like Miami or New York City can get prescription drug benefits at little or no extra cost, but plans in Minnesota don't offer similar additional benefits because of low payment levels. Situations like this feed a sense that Medicare is no longer a uniform national program that offers the same benefits to all. Ultimately, this may undermine support and confidence in the program.

It is difficult to imagine how to establish a competitive system within Medicare without first conducting experiments to ascertain the best way to establish a bidding structure. Although private employers have sought bids from managed care plans for many years, there has been great resistance on the part of Medicare plans to engage in the same types of activity. And, beneficiaries who fear they will lose extra benefits have allied themselves with plans in opposing such changes. The most recent attempt to mount demonstrations was killed by legislation in 1999 after two years of work to produce an independently-led effort. Without a good demonstration to develop a structure for bidding, it is likely that any movement in this direction will need to start with a more simplified approach to establishing payment levels for plans.

The Administration proposal would take a very different tack from that of the administered prices of Medicare+Choice or of some of the proposals that would revamp the Medicare program more aggressively (in that sense, this approach might be easier to layer onto the present system). Essentially, the Clinton plan promotes price competition among plans. Any savings generated would be shared between the federal government and the plan's beneficiaries by allowing plans to offer a rebate on the Part B premium. This premium, which all enrollees are required to pay, would cover standardized sets of benefits (one with prescription drugs and one without). Competition between plans would center on Part B premium prices, moving the system away from the existing practice of competing by providing extra benefits. Beneficiaries would still gain through lower premium payments.

The rebate on the Part B premium would be set at 75 percent of the difference between Medicare's total premium and whatever the private plan proposes to charge (which can range up to the full Part B premium). The federal government would keep the other 25 percent of those savings. For example, the Part B premium is expected to be about $60

per month by 2003 when this system would go into effect. Under it, a private plan that covers the basic services for $80 less per month than traditional Medicare could offer beneficiaries a zero Part B premium.[35] Since the Part B premium will represent about 12 percent of the overall costs of Medicare in that year, this offers considerable room for plans to pass on savings to beneficiaries. The addition of prescription drug coverage to this mix allows low-cost plans an even greater opportunity to buy down the Part B premium. Under traditional fee-for-service, prescription drug coverage would add substantially to beneficiaries' monthly premium payments. Thus, private plans that could hold their costs well below that of traditional Medicare could offer substantially lower premiums. Beneficiaries under the current system seem to be very attracted to plans that offer low or zero premiums—presumably they would find it easier to compare plans on the basis of the amount of the Part B premium.

The Administration's competition proposal is more restricted than that envisioned by those who propose a premium support approach. First, plans would compete by price differences in the premiums for a fixed benefit package. Because this is less flexible than options that allow private plans latitude in the package of benefits offered, it is criticized for limiting choice. On the other hand, a price-based comparison is easier for beneficiaries to understand and may limit plans' abilities to use benefit differentials to attract better risks. Beneficiaries would face an explicit tradeoff between price and the delivery differences implicit in managed care arrangements.

Another criticism related to limited competition is that the Administration approach will allow plans to peg their prices just below Medicare's fee-for-service costs in each area, restricting what plans might bid under a different system. Economists refer to this as "shadow pricing"—that is, seeking to set prices just low enough to be competitive with traditional Medicare and no lower. If this occurs, prices will be slower to come down over time than proponents of more competition hope. But given the opposition of private plans to the competitive bidding demonstration and the lack of experience of both plans and the federal government in this area, a go-slow approach may be appropriate for the foreseeable future.

This framework also has the disadvantage of locking differences in the costs of care around the country into place although the Administration's approach would be less disruptive initially. The BBA attempted to reduce payments to private plans in high-cost areas—an effort that is likely to continue to be an important part of needed changes over time. By reinstating some of these differentials, the Administration would forgo both some possible

[35] That is, the 75 percent share for beneficiaries' would total $60.

savings and efforts to move to more standardized benefits across the country. An alternative might be to use the plan's basic framework for competition, but base the Medicare fee-for-service benchmark in each area on a blended measure of local and national costs.

A related issue is to what extent beneficiaries should be insulated from these differences in the cost of care across the country. At present they pay a uniform national premium. The Administration proposal would seek to keep the principle of a uniform premium by using an adjustment mechanism to "normalize" the differences that exist. This retains the national entitlement nature of the program, but it precludes the use of premium differences as incentives to reduce the large geographic variations in spending levels that cannot be readily explained by health status or cost-of-living differences.

THE NEED FOR NEW REVENUES

The Clinton plan would shift additional resources into the Part A trust fund using projected future surpluses that the government may achieve in the next few years. Specifically, $15 billion would be assigned in 2001 and $13 billion in 2002, with a later credit of $271 billion from 2006 to 2010. The new dollars would extend the date when the Part A trust fund is projected to be exhausted. This proposal has been criticized because it relies on a source of funds that exists as a projection rather than an achieved surplus. However, the proposal at least implicitly recognizes that it will not be possible to take Medicare into the 21st century—when it will serve many additional beneficiaries—without adding additional resources to the program. Few other proposals have acknowledged this need, even when they emphasize the future problems of financing Medicare.

Without saying so explicitly, the Administration's reliance on the surplus advocates the use of general revenues to supplement Medicare financing. This sidesteps a debate that needs to take place on the specific revenue sources to tap if revenues are to be part of the solution for Medicare's future. The Clinton proposal also avoids the issue of the combined financing needs of Part A and Part B. Both parts of the program are likely to need additional revenues in the future.

CONCLUSION

The Clinton Administration's proposal presents a comprehensive, but incremental, approach to Medicare reform. It would avoid major structural changes that would alter the role of the traditional fee-for-service portion of Medicare and it would not create new administrative structures for managing the program. At the same time, it addresses the major issues facing the Medicare program: the need to improve the benefit package, the

importance of adopting improvements in management of Medicare's dominant fee-for-service portion, the need for payment reforms in the private plan portion of Medicare, and the long-term requirement for additional revenues to bolster the system.

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Will the Care Be There? Vulnerable Beneficiaries and Medicare Reform (January/February 1999). Marilyn Moon. *Health Affairs,* vol. 18, no. 1. The author examines four key issues: which Medicare beneficiaries will likely be best served by a system oriented around choice; what role traditional Medicare should continue to play and what changes will be needed; what protections are necessary for people with low and moderate incomes; and how these reforms could be incorporated into broader changes to make Medicare more viable over time. Copies are available from *Health Affairs,* 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133, Tel: 301-656-7401 ext. 200, Fax: 301-654-2845, E-mail: healthaffairs@projhope.org.

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