Reforming Medicare: Impacts On Federal Spending And Choice Of Health Plans

Reductions in Medicare spending are likely to occur only if beneficiaries' premiums go up.

by Kenneth E. Thorpe and Adam Atherly

ABSTRACT: The rising cost of Medicare and well-documented problems plaguing Medicare+Choice (M+C) have increased interest in "reforming" the program. To improve efficiency, most reform proposals would rely on competitive bidding to establish payments to M+C plans. At the same time, beneficiaries would be given financial incentives to select low-cost M+C plans. A major unknown is the extent to which Medicare reforms would generate federal budgetary savings. To examine this issue, we develop three illustrative Medicare reform options that differ greatly in how Medicare would establish its payments to plans. Our results highlight the fact that Medicare should expect modest savings from reforming the program. However, other goals of reform, such as establishing more efficient payments to plans, would be achieved.

Growing bipartisan interest in the need to "reform" Medicare has been driven by three problems: the rising share of the federal budget and gross domestic product (GDP) consumed by Medicare; an outdated benefit package; and distortions and inefficiencies in the payment methodology for Medicare+Choice (M+C) plans. It is hoped that solutions to the third problem can help to provide solutions to the first two. Several recent proposals for reforming payments to M+C plans have suggested abandoning the current administrative pricing system in favor of some form of competitive bidding among M+C plans. It has been suggested that competition among plans, combined with price incentives for beneficiaries to select lower-price plans, may serve to slow the overall growth in health care costs and Medicare payments.

Under the current system, payments for M+C plans are unrelated to plans' underlying costs. Instead, payments are derived from costs

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in the fee-for-service (FFS) sector. Prior to the 1997 Balanced Budget Act (BBA), managed care payments were 95 percent of average costs in the FFS sector (the adjusted average per capita cost, or AAPCC). Since the BBA, M+C payments have been established by a complicated formula that is the greater of a minimum payment (floor), a minimum update from the prior year's payment, or a blend of local and national rates, all of which are related to some degree to the 1997 AAPCC. The blend is subject to a budget-neutrality constraint, and no plan received the blended payment in 2001.

This system has a number of problems. First, for plans above the floor (65.6 percent of projected M+C enrollment in 2002 is in counties where the payment rate is above the floor), payments are still linked to the 1997 AAPCC. Second, from the plan perspective, year-to-year adjustments in payments are volatile; as a result, some plans exit the Medicare market and others are deterred from entering new markets. Finally, payments vary by county. Commercial plans and those in the Federal Employees Health Benefits Program (FEHBP) base payment on larger geographic units, such as metropolitan statistical areas (MSAs) or plan service areas. Plans operating in large MSAs, with a single provider network, face multiple reimbursement rates. For example, in 2002 the reimbursement rate in Bronx County, New York, will be $812 per beneficiary; however, in nearby Queens plans will receive only $735.

Competitive bidding could alleviate these problems by assuring that plan payments reflect underlying costs and that, over time, payment increases reflect the costs of efficient health plans. Properly structured, the use of competition in Medicare should equate Medicare payments in the M+C sector with the (efficient) cost of delivering services by M+C plans.

Despite these advantages, the extent to which M+C payment reform will generate federal budget savings is unknown. In concept, competition could reduce growth in Medicare spending in two ways. First, the competitive bidding process could result in additional efficiencies and lower payments to health plans than those established through regulation. Savings then could be realized if Medicare beneficiaries enroll in the lower-price health plans. Second, Medicare could collect additional premiums from beneficiaries choosing to remain in more expensive options. Most reform proposals provide financial incentives for beneficiaries to choose lower-price plans, although many will choose to remain in traditional FFS Medicare. Whether a competitive bidding process would reduce overall Medicare spending depends on the resolution of key design issues and how beneficiaries respond to them. This paper examines these issues using three illustrative Medicare reform options.
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through the reforms and the willingness (price-sensitivity) of Medicare beneficiaries to enroll in lower-price plans.

Few studies have examined beneficiaries' price-sensitivity. Those that have suggest that Medicare beneficiaries are relatively insensitive to price. If this is correct, Medicare beneficiaries not currently enrolled in an M+C plan would require substantial financial incentives to switch to such a plan, and those currently enrolled in an M+C plan would require incentives worth at least the value of the additional benefits they receive today to remain enrolled under reform. However, providing beneficiaries with large financial incentives runs the risk of exhausting the efficiency gains produced by M+C plans, leaving little (if any) savings for the government. Thus, savings to the Medicare program will depend on the rules establishing the government's contribution, beneficiary payments, and the price-sensitivity of beneficiaries. To illustrate the importance of these design issues, we compare three different approaches for setting Medicare's and beneficiaries' contributions.

**Establishing What Medicare And Beneficiaries Pay: The Reference Premium**

The method used to establish the RP is among the most important design issues in Medicare reform. Most, although not all, reform proposals would solicit bids from M+C plans based on their cost of providing the core Medicare benefit package. This is the approach we explore here. Under such reforms, Medicare could set its contribution equal to the lowest (plan) bid in a market, the median (either nationally or in a market), or even traditional Medicare.

Under current law, there is wide geographic disparity in M+C plan payments. County-level variation in plan payments is intended to reflect differences in underlying costs but actually overstates these differences, leaving high-cost counties overpaid and low-cost counties underpaid. This raises equity issues, since M+C plans in high-cost/high-payment counties tend to offer generous supplemental benefits and not charge a premium. In contrast, M+C plans in low-cost/low-payment counties tend to offer few, if any, additional benefits and charge a monthly premium. Changes to the system therefore may seek to reduce geographic disparity. But geographically smoothing M+C payments without increasing overall spending would lead to payment reductions in the high-cost/high-payment counties—the same counties where the bulk of M+C enrollment now resides.

- **The Illustrative Plans.** We present three illustrative plans to highlight the trade-offs involved in the establishment of the RP (Exhibit 1). Each proposal will have a different impact on Medicare
program savings and what beneficiaries pay for M+C plans and traditional Medicare. The first two illustrative plans are similar to proposals developed by the National Bipartisan Commission on the Future of Medicare and, more recently, the Medicare proposals (S. 357 and S. 358) advanced by Senators John Breaux (D-LA) and Bill Frist (R-TN) in the 107th Congress. The third, which is similar to an approach outlined by Roger Feldman and Brian Dowd, would limit Medicare's contribution to the average bid from a qualified plan in a market.

Under Option 1 the RP is county-specific and explicitly linked to the FFS sector (similar to S. 358). This approach is similar to the current Medicare program. Beneficiaries enrolling in lower-cost plans would pay lower premiums. In Option 2 the RP is based on a national enrollment-weighted average premium (similar to the FEHB design and S. 357). Following the logic in S. 357, beneficiaries would pay 80 percent of the difference between the cost of the plan they enroll in and 85 percent of the national enrollment-weighted average premium.

Option 2 differs from Option 1 in two important respects. First, it breaks the explicit link between FFS costs and M+C plan payments. The RP is weighted for enrollment and is therefore a weighted average of costs in the FFS and managed care sectors. To the extent that
managed care plans generate savings, this will lead to a lower overall RP. Second, the link between county costs and the RP is severed. Under both current law and Option 1, M+C plans in high-cost counties receive much higher plan payments. Under Option 2, some of the geographic variation in the RP is removed.

Option 3 would set the RP equal to the average M+C bid in the county. For rural counties, where no M+C plans operate, this would be the FFS plan. Like Option 2, Option 3 breaks the link between FFS costs and M+C plan payments. However, as in Option 1, payments under Option 3 would be determined county by county. Geographic variation in managed care costs would lead to variation in plan bids and hence plan payments. The government's contribution under Option 3 would be lower than under Option 1 because it is linked to the average M+C bid (for Medicare-covered services) and not the higher costs associated with traditional FFS Medicare.

Potential Impact Of The Proposals On Medicare And Beneficiary Spending

Data and methods. We calculated reference premiums and the cost of providing Medicare-covered services for both traditional Medicare and M+C plans for fiscal year 2002. From this information, we estimated annual premiums that beneficiaries would pay under each of the three options. Our approach assumes that bids submitted by M+C plans will approximate the plans' cost of providing Medicare-covered services in 2002. A key unknown factor is how quickly M+C plan bids will reflect underlying costs. Our analysis assumes an immediate competitive response; thus, estimated M+C costs for providing core benefits and bids are the same.

To estimate county-specific FFS costs, we began with the 1997 AAPCC. In 1997 the Centers for Medicare and Medicaid Services (CMS, formerly HCFA) estimated that the AAPCC was equal to 98.1 percent of FFS costs. We then inflated our estimate of 1997 FFS costs by the FFS growth rate reported by the CMS to produce a county-specific estimate of FFS costs in 2002. We also removed 100 percent of all graduate medical education expenses (direct and indirect) from FFS cost calculations to produce a county-specific estimate of the cost of providing the basic benefit package in the FFS sector.

We based our estimate of this cost on an unpublished study from the Congressional Budget Office (CBO) and the CMS, which reported that in 1997 managed care plans' costs to provide core Medicare benefits were approximately 80 percent of the AAPCC. A confirmation of this figure was recently reported by the CMS, which revealed that the bids submitted by managed care plans in Denver
for the equivalent of the FFS benefit package ranged from 25 percent to 38 percent below the BBA payment rates. We trended these costs to the year 2002 using data from major M+C plans (PacificCare and Aetna) on growth in medical costs (not plan payments) for their Medicare products. On average, we assumed that managed care costs for Medicare-covered services increased 5 percent annually during 1997–2002.

We first examine markets that currently have M+C plans, using data from the CMS. In these markets we estimate that it costs traditional Medicare, on average, approximately $7,096 per year to provide the basic benefit package (weighted by Medicare enrollees). In those same counties it would cost the average M+C plan $5,947 to provide the same set of core Medicare benefits for the same population, although we estimated that it cost M+C plans $6,456 to provide services for their enrollees because M+C enrollment is concentrated in high-cost/high-payment counties. M+C plans are paid an average of $7,272 per year for their enrollees (again reflecting the concentration of enrollment in high-cost counties). Thus, today M+C plans are providing, on average, approximately $816 more in additional benefits than they are charging in additional premiums.

Option 1. Under Option 1 the RP is established at the higher of the county FFS costs or the M+C payment rate. Under this option, which mimics current law, much of the current distribution of Medicare payments to M+C plans would be retained, and the RP would vary across counties. The average RP would be equal to the average current M+C reimbursement ($7,272). Beneficiaries choosing to remain in traditional Medicare under this option would pay a premium ($688 per year in 2002)—just as under current law (Exhibit 2). Beneficiaries choosing a lower-cost plan, such as a typical M+C plan, would pay a lower premium—$76 in the average county (the traditional Medicare premium less 75 percent of the difference between $7,272 and $6,456) per year in our example. Beneficiaries could use their savings (at least $612 per year relative to current law) to purchase supplemental benefits such as prescription drugs, vision care, and other services not covered by Medicare.

Option 2. The RP for Option 2 is the average of FFS Medicare and each M+C plan, weighted by enrollment. In our illustration this weighted (using 2001 enrollment) average is $6,599. The RP for Option 2 is far lower than that for Option 1, for two reasons. First, it is partially based on the lower-cost M+C sector. Second, it is based on the national average in the FFS sector, which includes many low-cost counties where no M+C plans now operate. The premium for beneficiaries joining plans with a bid equal to the RP is higher than the current-law Part B premium—$792 per year (80 percent of