



NIHCM

REFORMING MEDICARE

Prepared For:

**The National Institute For
Health Care Management,
The National Governors' Association, and
The Federation of American Health Systems**

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REFORMING MEDICARE

INTRODUCTION

Medicare provides health benefits coverage to 36 million individuals who are elderly, disabled, or have end-stage renal disease (ESRD). The Congressional Budget Office (CBO) estimates that Medicare spending in FY 1995 will reach approximately \$176 billion dollars -- Medicare is one of the largest and fastest growing items in the federal budget.¹

- o Over the last five years (FY 1990-FY 1995), Medicare spending has increased from \$107 billion to \$176 billion -- a 10.5 percent annual increase. During this time period, Medicare increased from 9 percent to 11 percent of federal spending.
- o The growth is expected to continue in the future. CBO estimates that Medicare spending will increase to \$286 billion, or 14 percent of federal spending by the year 2000. From FY 1995-FY 2000, Medicare spending will increase by an average of 10.2 percent annually --nearly double the 5.3 percent annual growth in total federal spending.
- o Under intermediate (mid-level) assumptions, the Board of Trustees of the Medicare Hospital Insurance Trust Fund estimates that the fund will go broke by the year 2001.²

Policy makers have identified a number of options for reforming Medicare, aimed for the most part at bringing down the rate of increase in program spending. The options encompass a broad range of potential actions -- from incremental options to complete redesign of the program. This issue brief provides a brief overview of Medicare and the options under discussion for reforming the program.

¹Congressional Budget Office (CBO), The Economic and Budget Outlook: Fiscal Years 1996-2000, a Preliminary Report, January 5, 1995.

²Board of Trustees of the Federal Hospital Insurance Trust Fund, 1994 Annual Report, April, 1994.

MEDICARE PROGRAM

Overview

Medicare is a nationwide health insurance program for the aged and certain disabled persons authorized under Title XVIII of the Social Security Act.³ The program has two parts.

Part A of Medicare, Hospital Insurance, provides coverage of inpatient hospital care of up to 90 days in a benefit period (individuals can also draw upon an additional 60 day lifetime reserve before their inpatient benefits expire). The inpatient hospital benefit is subject to a deductible (currently \$716) and coinsurance of \$179 /day for days 61-90 and \$358/day for lifetime reserve days. Part A also includes up to 100 days of skilled nursing facility care (with coinsurance of \$89.50/day for days 21-100), home health care, and hospice care.

Part B of Medicare covers physicians' services, and other medical and health services, subject to a \$100 annual deductible and 20 percent coinsurance for most services.

Medicare spending is dominated by spending on inpatient hospital care (50 percent of total spending in 1995) and physicians' services (23 percent of spending in 1995), as noted in Table 1 below.⁴ The share of program spending attributable to inpatient hospital services has declined from 66 percent of total spending in 1980 to 50 percent in 1995. Spending for long-term care services -- skilled nursing facilities, home health, and hospice services -- has increased as a portion of program spending in the same time period, growing from 3 percent of spending in 1980 to 13 percent of spending in 1995.

³ For complete description of program, see: House Committee on Ways and Means. 1994 Green Book, July 15, 1994. This reference provides an overview of Medicare as well as detailed reviews of components of the program.

⁴House Committee on Ways and Means. 1994 Green Book, July 15, 1994.

Table 1
Percent Distribution, Medicare Spending by type of Service
1980 and 1995

	<u>1980</u>	<u>1995</u>
Total	100 %	100 %
Inpatient Hospital	67 %	50 %
Physicians' Services	23 %	23 %
Outpatient Hospital	5 %	8 %
Skilled Nursing Facilities	1 %	4 %
Home Health	2 %	9 %
Hospice	0 %	1 %
Other medical and health	2 %	5 %

Most individuals age 65 or older are entitled to Part A of Medicare in the same manner that they become entitled to Social Security -- i.e., they have sufficient quarters of coverage under the Social Security system. Those not automatically entitled may purchase Part A benefits by paying a premium that reflects the actuarial value of the program. Individuals qualifying for disability payments under Social Security are entitled to Part A of Medicare after a two year waiting period. Approximately 32 million Medicare beneficiaries are aged, and 4 million qualify on the basis of disability.

Part A benefits are financed through the Hospital Insurance payroll tax that is currently 2.9 percent of wages: 1.45 percent paid by employees, and 1.45 percent paid by the employer. All individuals age 65 and over -- and all individuals qualifying for Part A benefits as a result of disability or ESRD -- may elect to enroll in Part B by paying a monthly premium, currently \$46.10 per month. That premium covers about 25 percent of the cost of Part B -- the other 75 percent is paid out of general revenues.

Medicare is administered through contracts with private health care "intermediaries" (who

administer Part A) and “carriers” (who administer Part B). These are typically private insurers who contract with Medicare and have responsibility for reviewing claims and making payments to providers for benefits provided under Medicare. Medicare pays the administrative costs of these entities, but retains the insurance risk -- the intermediaries and carriers conduct administrative and claims payment activities, but are not at risk for program spending.

Medicare pays providers using a variety of arrangements. For hospitals, payments are generally made through a Prospective Payment System (PPS), under which Medicare makes a fixed payment per admission based on the patient’s diagnosis, and adjusts that payment to reflect geographic differences in input prices. In addition, the payments are adjusted to reflect extra payments for certain types of facilities, such as teaching hospitals and hospitals serving a disproportionate share of low-income beneficiaries. For physician services, Medicare makes payments under the Resource-Based Relative Value Scale (RBRVS), which fixes payments for each type of physician service (e.g., office visits, operations, diagnostic tests), with geographic adjustments as well.

In addition, payments to physicians under Medicare are subject to a Medicare Volume Performance Standard (MVPS). The MVPS is a budget control device under which Medicare sets annual targets for Medicare spending for physicians’ services, monitors actual spending against those targets, and then makes adjustments in future physician payment rate increases to account for spending over (or under) the target.

The Medicare program is a fee-for service (FFS) plan in which payments are made to any provider seen by the beneficiary (subject to coverage and other limitations) -- it is based on the dominant model of health benefits coverage in place at the time the program was enacted in 1965.

Medicare Managed Care

Medicare has for a number of years also allowed beneficiaries the option to enroll in health maintenance organizations (HMOs) and competitive medical plans (CMPs), which are HMO-like entities. There are a number of payment arrangements, including cost contracts, but the basic HMO/CMP model calls for capitation payments that put the health plan at insurance risk. Under this program, Medicare determines an "Adjusted Average Per Capita Cost" (AAPCC) for Medicare benefits in each county in the country. This calculation is based on the amount that would be expended for benefits under fee for service (FFS) Medicare. The AAPCC amount is the monthly amount that is intended to cover the costs of the Medicare benefits, and is adjusted to reflect actuarial factors such as age, gender, Medicaid eligibility, and institutional status. Different rates are set for those qualifying on the basis of disability.

If beneficiaries opt to be enrolled in these plans in lieu of their basic Medicare coverage, Medicare pays 95 percent of the AAPCC to the HMO or CMP chosen by the beneficiary. In addition to the regular Part B premium paid to Medicare, the beneficiary may pay additional premium amounts to the HMO/CMP depending on its premium and additional benefits covered under the plan (a substantial number of such plans charge no premium).

The Health Care Financing Administration (HCFA) estimates that nearly three-fourths (74 percent) of Medicare beneficiaries had Medicare managed care products available to them in 1994 -- while 26 percent had no plan in their area.⁵ As of January, 1995, approximately 3 million Medicare beneficiaries -- about 9 percent of enrollees -- were enrolled in some type of managed care arrangement. Since 1990, enrollment in Medicare HMO risk plans has doubled. However,

⁵Health Care Financing Administration.

Medicare managed care enrollment still lags significantly behind employment-based enrollment in managed care -- which in 1993 exceeded 50 percent of enrollees, including 22 percent in HMOs and another 29 percent in preferred provider organizations (PPOs) and point of service (POS) products.⁶

ISSUES AND OPTIONS

A variety of options have been suggested for constraining the rate of increase in Medicare spending. The following discussion reviews options and approaches in two basic categories:

- o Budget and policy changes within the current program;
- o Program redesign options.

Estimates of the impact of the various options are taken, where possible, from the CBO's annual budgetary document "Reducing the Deficit: Spending and Revenue Options,"⁷ which provides estimates for the FY 1995-FY 1999 period.

Budget and policy changes within the current program

One approach is to constrain the rate of increase in Medicare spending within the general confines of the current program -- these can include benefit changes, provider payment changes, managed care features, and financing changes.

⁶Group Health Association of America. Karen Ignagni, statement on Medicare Managed Care, before the House Ways and Means Committee Subcommittee on Health, February 10, 1995.

⁷CBO. Reducing the Deficit: Spending and Revenue Options, March, 1994.

Benefit changes: changing the Medicare benefit package provides one option for achieving programmatic savings. The typical policy choices do not include elimination of benefits, but focus instead on increasing patient cost sharing for covered services in a number of different ways.

- o Increase the Part B deductible: the deductible, which was last increased to its current level of \$100 in 1991, could be increased to lower program spending. The CBO estimates that increasing the deductible to \$150, and then indexing for program growth in the future, would save about \$9.3 billion over five years.
- o Increase the number of services subject to 20 percent coinsurance in Medicare: Medicare patients typically pay 20 percent coinsurance under Part B for physician and other health services. However, certain services are not subject to coinsurance, including laboratory services and home health services.
 - Clinical laboratory services: CBO estimates that subjecting clinical laboratory services to 20 percent coinsurance would save \$6.2 billion over five years.
 - Home health: CBO estimates that subjecting home health services to a 20 percent copayment would yield five-year savings of \$19.8 billion.
- o Increase coinsurance rate to 25 percent for all services currently subject to 20 percent coinsurance. CBO estimates that this policy would yield five year savings of \$16 billion.

All of these changes would save Medicare substantial amounts of money. The further rationale for the deductible increase is that it “updates” the deductible to reflect increasing program costs; and extending the coinsurance amounts to clinical laboratory and home health is seen by some as standardizing coinsurance across a broader range of benefits. It is also seen as creating financial incentives against over utilization of two of the most rapidly growing sectors of Medicare. At the same time, such changes shift more of the cost of care to beneficiaries.

Provider payment changes: the typical budget reconciliation plan over the last decade has focused attention on reductions in the rate of increase in payments to Medicare providers -- either "across the board" reductions (i.e., flat percentage reductions applied to all providers) or targeted reductions for certain types of provider. Both approaches will remain on the table this year. Among the policies that are likely to be considered are the following:

- o Across-the-board reductions in provider payments: for example, CBO estimates that a one year freeze in payment rates under the Hospital Insurance program (hospital, nursing home, and home health payment rates) would yield \$8.5 billion in five-year savings under Medicare.
- o Targeted reductions in certain hospital payment adjusters that are incorporated in the PPS: two principal options that are discussed are:
 - Reductions in the special adjustment paid to teaching hospitals to cover the extra costs of the patients that they serve: for example, CBO estimates that reducing this adjuster to about 40 percent of its current value would yield savings of \$13.5 billion over five years.
 - Reductions in the disproportionate share adjuster -- a special adjustment paid to hospitals that serve a disproportionate share of low-income or public patients: CBO estimates that phasing this adjuster out over five years would yield savings of \$12.5 billion.

Such payment reductions have the advantage of saving Medicare money without cutting the Medicare benefit package or otherwise shifting costs to beneficiaries. In the past, as Medicare payment rates fell, costs were shifted to other payers (the provider charged other payers more to account for the Medicare shortfalls). As the private market has become more competitive, however, such costs shifts are more difficult, especially for institutions with a low percentage of private pay patients.

Incorporating options/incentives for managed care: there is a great deal of effort being devoted to developing options to expand managed care under the Medicare program. Some of

these approaches envision a complete restructuring of the Medicare program, and are described in the program redesign section later in this issue brief. Others envision a more incremental expansion in Medicare managed care. Such incremental measures include:

- o Expanding the types of managed care plans that can serve Medicare beneficiaries on a capitated basis: such an expansion would likely include some point-of-service (POS) products as well as preferred provider organizations (PPOs). Such products typically provide more complete benefits if beneficiaries use participating providers, but still allow out-of-plan use subject to payment of increased deductibles and copayments.
- o Phasing in changes in Medicare's payment methodology for health plans -- these range from technical changes in how the current AAPCC payments are computed to substantive changes in the method for determining payments. The change in method would base Medicare payments to health plans on premiums in the marketplace -- and hopefully take advantage of the competition among health plans to save beneficiaries and the government money.
- o Making changes in the marketing and distribution system for the various insurance supplements available to Medicare beneficiaries. This would include the HMOs participating in Medicare, which offer benefits in excess of Medicare's basic package, and the Medigap plans -- the private supplemental insurance plans that beneficiaries purchase to provide coverage for services that are not covered by Medicare. The idea is to provide for a process by which beneficiaries can make an informed choice among the options available to them.
- o Making changes in the ability of health plans to offer managed care products through the Medigap market. Specifically, the Medicare Select program provides a 15 state demonstration of a Medigap PPO -- which offers typical Medigap benefits but through a preferred provider network. The demonstration will expire in June, 1995, and advocates seek to have it extended nationwide as a means to enhance competition and cost control in the Medigap market through the introduction of more managed care products.

One of the key issues with movement to Medicare managed care is the extent to which CBO will "score" savings, especially if enrollment in managed care plans remains voluntary.

Financing changes: one final option for changes in Medicare relates to financing the program -- and specifically, the share of the Part B program paid for by beneficiaries. Two basic

approaches have been suggested for lowering government spending and increasing the beneficiary share of premiums.

One is an overall increase in the Part B premium. Currently, the Part B premium is set at about 25 percent of Part B program costs -- federal general revenues account for the other 75 percent. Some suggest that the beneficiary share of premiums should be higher -- in fact, when the program first started, beneficiaries paid 50 percent of Part B costs. CBO estimated that raising the premium to 30 percent of program costs would save the federal government \$17 billion from 1995-1999.

A second option is to increase the premium for higher income elderly -- raising the Part B premium, but only for those Medicare eligibles with income above some threshold amount. CBO modeled an approach raising the Part B premium above 25 percent of program costs for individuals with income above \$50,000 -- the premium would be capped at 50 percent of program costs at \$60,000 in income. For couples, the comparable lower threshold would be \$65,000 and the upper threshold would be \$80,000. CBO estimated that this option would raise \$6 billion over five years.

Program redesign

Policy makers can also move toward a complete restructuring of the Medicare program, with the rationale being that incremental changes are not enough. The Medicare redesign approach assumes that a program based on a 30 year old model needs to be redesigned to reflect current health plan models in the private sector. Three basic types of redesign can be envisioned.

Medicare as “sponsor” model: provide Medicare coverage through enrollment in one of a choice of health plans: One option is to phase-in a system in which Medicare beneficiaries are required to enroll in one of a choice of health plans that Medicare would contract with to provide the basic Medicare benefit package and any additional supplemental benefits that beneficiaries may wish to buy. This is often referred to as the large employer or Federal Employees Health Benefit Plan (FEHBP) model.

Medicare would function as the plan sponsor. HCFA would set rules for participation by health plans (including FFS plans) and monitor those plans, establish enrollment processes, and determine the Medicare contribution level. Beneficiaries would then select their plan and pay the difference (if any) between the plan’s premium and the Medicare contribution level. Given the interest in Medicare managed care approaches, the following reviews one potential scenario for such a model.

Health plans: beneficiaries would have a choice of health plans meeting standards for quality, access and solvency. The choices would include a full range of the types of plans available in the community -- fee for service plans, HMOs, and other managed care options that are evolving in the marketplace. A variant of this option would be to retain Medicare’s current FFS plan -- but to price it like a competing health plan -- charging a premium based on its costs under the model below.

Payments by Medicare: Medicare would determine its payment for its share of the premium under one of two methodologies.

- o One option is a variant of today’s method: Medicare would determine the actuarial value of Medicare benefits using some type of standardized pricing methodology -- and adjust those payments for local areas.

- o A second option is a “market-based” model: health plans would establish their premiums for Medicare benefits based on their costs and the competition in the local market; and the government would set its contribution level at some percentile of those premiums (for example, the government could pay at the 25th percentile of premiums in a local market).

Under either approach, it is presumed that the government would have to make its payments on an accurate actuarial basis reflecting an assessment of the prospective risk of each enrollee -- using standard classifications already used by Medicare for age, gender, institutional status, and welfare status. In addition, many believe that additional adjustments should be made to better reflect the potential cost of enrollees -- e.g., better “risk adjusters” -- because of the traditional insurance problem of “risk selection.” The payment rates must reflect the actuarial difference in insurance risk, otherwise health plans will succeed or fail based on attracting healthy or sick enrollees rather than on providing services efficiently.

It is clear that the government must be able to assure that its total contributions fall within whatever budgetary constraints are set by the Congress. Thus, under whatever methodology is used for setting Medicare’s contribution, the program will likely reserve the right to make some type of pro-rata reduction in the level of payments to achieve the budget targets.

Payments by beneficiaries: Once Medicare’s contribution is set, the beneficiary faces a choice of out-of-pocket premiums for the plans -- the difference between the premium set by the plan and Medicare’s contribution level. The theory is that this will provide an incentive for health plans to seek enrollment through competitive premiums and service levels -- and an incentive for beneficiaries to choose the more price-competitive plans.

Benefits: all health plans seeking to participate would have to provide and separately price the statutory Medicare benefit level, and rules would be set for additional benefits supplemental to

Medicare. A key issue is what to include within the definition of the Medicare "benefit" package. For example, does it include Medicare's protections that prohibit or limit provider "balance-billing" -- charging patients additional amounts if the provider's charges exceed the program's payment rates?

Enrollment/marketing: the enrollment and marketing mechanisms would be designed to assure that beneficiaries have informed choices. This requires that health plans provide information in a manner that allows for comparisons among plans; and open enrollment periods in which a beneficiary has available the full range of health plan choices.

The theory underlying this model is that Medicare, as the nation's largest purchaser of health benefits, should move to a purchasing model used by other large purchasers - large employer sponsors and/or the FEHBP approach used by the government as an employer. Given the proper premium incentives, and risk adjusters to mitigate against adverse selection, beneficiaries will migrate to the plans that are best able to control costs and provide quality services.

Voucher model: the voucher approach includes many of the features of the Medicare as sponsor model in providing beneficiaries a choice of health plans in which to enroll. The key difference is that, rather than contracting with plans and making its contribution directly to the plan chosen by the beneficiary, Medicare would provide some type of voucher directly to the beneficiary which the beneficiary could then use, along with additional out-of-pocket premium contributions if necessary, to buy health benefits coverage.

As with the model in which Medicare acts as sponsor, Medicare would have to determine the value of the voucher, using some calculation based on the government's estimate of prices or

a market-based price -- again, with some type of adequate actuarial adjuster to mitigate against risk selection. And Medicare would have to determine standards for health plans that could qualify for the voucher, as well as some type of rules for enrollment in health plans.

As regards benefits, the voucher model could rely on the Medicare benefit package, but some suggest additional benefit options. Beneficiaries might be able to purchase different benefit packages with the voucher amount and any out-of-pocket premiums that they incur. For example, they might be able to opt for a higher deductible, catastrophic coverage policy in lieu of the traditional Medicare benefits.

The voucher approach -- like the Medicare as sponsor approach -- is designed to provide beneficiaries a choice of plans and incentives to seek lower cost plans. As the choices expand -- and in particular, if individuals can choose benefit packages other than the traditional Medicare package for their basic coverage -- the adequacy of the actuarial risk adjuster in determining the value of the voucher becomes especially important. This is because of potential adverse selection problems arising if healthier and or wealthier individuals opt for higher deductibles and lower benefits -- leaving the less healthy, and more expensive enrollees, in the more traditional Medicare benefit plans.

Means-testing Medicare benefits. One final Medicare redesign approach would be to change the program into a means-tested program -- i.e., individuals would not qualify for benefits unless their income fell below certain specified levels. It is important to note that this differs substantially from the idea of income-testing beneficiary contributions noted above. Under that option, the basic Medicare entitlement would remain, but higher income individuals would pay a higher premium.

The means testing option would limit or deny Medicare benefits to individuals with income in excess of certain amounts -- targeting program spending on lower-income individuals, in a manner similar to the Medicaid program. The CBO, in an analysis of federal entitlement programs in September, 1994,⁸ reviewed a number of options, one of which was to deny benefits to individuals with income in excess of certain amounts. CBO assessed the following income cutoffs:

- o Lower threshold: Individuals with income below \$100,000 (couples with income below \$120,000) would lose no benefits.
- o Upper threshold: Individuals with income above \$110,000 (couples with income above \$130,000) would receive no benefits.
- o Individuals with income between these threshold amounts would lose one-half their benefits.

CBO estimated that the Medicare- specific impact of this approach was a savings of \$16.5 billion over the five-year period FY 1995-FY 1999.

CONCLUSION

Medicare's size and continuing growth at double the rate of the rest of the federal budget subjects the program to intense scrutiny as part of the federal budget debate, and the full range of options merits review. Whether policy makers address Medicare spending growth through the traditional array of budgetary measures or through longer-term programmatic redesign, Medicare will clearly be "on the table" as part of any debate to constrain the rate of increase in federal spending.

⁸CBO, Reducing Entitlement Spending, September, 1994.