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The Not-So-Simple Economics (and Politics) of Medicare Reform

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Despite an unprecedented amount of policy attention since 1995, the U.S. Congress has been unable to agree upon an approach to long-term or structural Medicare reform. This chapter will explain why Medicare reform is important but difficult, both economically and politically. It will contrast the two leading proposals for Medicare reform, from the current congressional health policy leadership and the Clinton-Gore Administration, respectively. This chapter concludes with a brief discussion of a possible compromise that could be crafted from these proposals, if the political will and leadership is forthcoming after the 2000 elections.

THE IMPORTANCE OF MEDICARE

Medicare is our most sacred social contract precisely because it binds the generations together with the promise to pay for the health care needs of the elderly today in exchange for the expectation that future generations will pay for the needs of the current generation of workers. In 1965, when the Medicare program began, only about half of the elderly had any health insurance. Insurers were reluctant to sell to the elderly who manifested health problems, and the poverty rate was sufficiently high that many elderly simply could not afford insurance even if it was priced with actuarial fairness. Public intervention was absolutely essential for all seniors to have access to insurance and care. Today, over 39 million people get insurance and health care

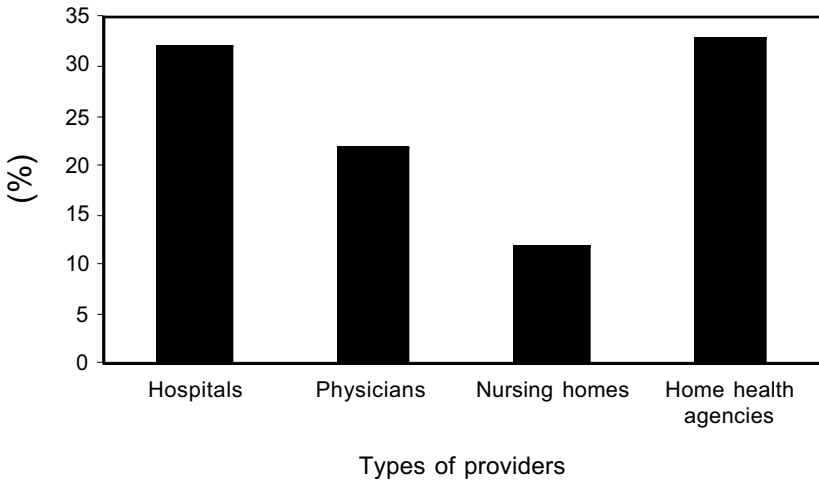
through Medicare, and of these, 34 million are aged and 5 million are nonaged disabled.

Medicare is also an extremely important income support program for health care providers. Figure 1 shows the percent of revenue from different types of providers that is derived from Medicare. Hospitals and home health agencies are obviously dependent upon Medicare, and physicians and nursing homes are seriously affected by Medicare payment policies as well. Thus, providers are major stakeholders as well as beneficiaries and taxpayers. This fundamental duality of the Medicare program—an insurance program for the elderly and severely disabled as well as an income support program for all major providers—makes the politics of Medicare reform even more complicated than it would otherwise be.

THE LONG-RUN FINANCING CRISIS

Since Medicare is mostly payroll-tax or income-tax financed, there are two fundamental sources of Medicare’s long-run financial strain.

Figure 1 Medicare’s Share of Provider Revenues



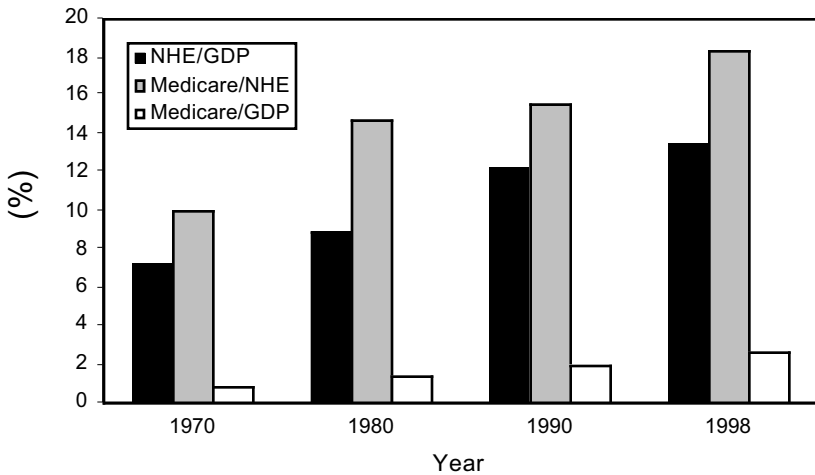
SOURCE: Health Care Financing Administration Office of the Actuary, 1998 data.

The first is purely demographic: there were 3.9 workers per beneficiary in 1998, and by 2030 there will be only 2.3. The second source of strain for Medicare is cost growth. Medicare costs, in the aggregate and per beneficiary, have grown even faster than health care spending in the United States generally. These two facts require that unless some structural change is implemented, the Medicare program may become unsustainable in the future.

Figure 2 puts the cost growth problem into some perspective. It shows total national health expenditures (NHE) as a share of gross domestic product (GDP), Medicare's share of NHE, and Medicare's claim on GDP. As most readers know, health care is a normal good: as incomes rise, most people and societies purchase more of it; thus, it is not surprising that NHE/GDP has grown from about 7 percent in 1970 to over 13 percent in 1998 as the promise and efficacy of medical treatment has absorbed increasing shares of our national income growth. The relative growth of Medicare spending is illustrated through the increasing share of NHE and of GDP that it claims, almost doubling and more than tripling, respectively, from 1970 to 1998.

Comparing Medicare to general NHE on a per enrollee or per capita basis is perhaps most instructive. Medicare costs per beneficiary

Figure 2 Shares of Health and Revenue Related to GDP



SOURCE: Health Care Financing Administration, Office of the Actuary.

have grown in real terms—over and above general inflation—at slightly more than 5 percent per annum since 1970. Overall NHE per capita, by contrast, has grown at 4 percent per year. Thus, while overall health care costs have been rising as a share of income and in real terms, Medicare costs have risen even faster than general health care costs for the last 30 years.

A bit of slightly oversimplified algebra will make clear the stark nature of the long-term Medicare financing problem.¹ Let B = the number of elderly beneficiaries, c = the expected costs of covered health service per beneficiary, p = the fraction of those costs paid for by beneficiaries through premium payments, w = the average earnings of workers, L = the number of workers in the society, and t = the payroll tax rate required to finance the Medicare program. In equilibrium, program costs in a pay-as-you-go insurance program like Medicare are completely financed by beneficiaries and taxes

$$\text{Eq. 1 } cB = pcB + twL.$$

Now the total population (T) is divided into the share that is young and ineligible for Medicare (y), and the nonyoung ($1 - y$) who are. Only some fraction of the young (f) work. Therefore $L = fyT$, and $B = (1 - y)T$. Substitution into Equation 1 and solving for t , the required payroll tax rate, yields

$$\text{Eq. 2 } t = [(1 - p)c/w][(1 - y)/fy].$$

The first bracketed term represents the publicly financed Medicare costs per dollar of average earnings, and the second term is the ratio of beneficiaries to workers. The required tax rate increases with both of these ratios. Note that health policy can affect only two of the five key parameters in our pay-as-you-go tax rate equation: p , the fraction of Medicare costs that beneficiaries are asked to pay in premiums, and c , the average covered cost per beneficiary.

As our society ages, y will continue to decline. So unless labor force participation increases enough to offset this, fy will continue on its current downward path (as it is for most OECD countries and some developing countries as well). Then at least one or more of three things must happen: 1) growth in cost per beneficiary must be curtailed, 2) the

fraction of covered health costs borne by the elderly and their families must increase; or 3) the payroll tax rate must increase. Clearly, the more success we have with the first, the less political pain we must inflict with the second and/or third.

To illustrate the order of magnitude of the problem we face, if we hold p constant at today's level (9.8 percent) and current growth trends continue for all variables on the right-hand side of Equation 2, the required payroll tax rate t will increase from today's implicit 5.5 percent to 14.4 percent in the next 20 years.² A doubling of the current beneficiary share, p , reduces the required tax rate in 2018 to only 13.2 percent. Given the nature of our political discourse over the last few years, it is hard to imagine that double-digit payroll tax rates for Medicare alone will ever be politically acceptable, at least not in the first one-third of the twenty-first century.

Reducing annual real growth in cost per beneficiary from the historical 5 percent to 3 percent and doubling the beneficiary premium share would bring the required payroll tax rate down to 8.9 percent by 2018. As a final example, if we were somehow able to reduce the annual real growth in costs per beneficiary to 1 percent, then we could keep p on its current trajectory to 12 percent and the payroll tax rate would have to rise to a level no higher than 6.6 percent.

One important inference from this set of exercises is that some payroll tax increase is inevitable and reasonable to expect as the share of our population over 65 increases in the first half of the twenty-first century. Another lesson is that controlling the rate of growth in costs per beneficiary is the key to minimizing that tax increase, which will surely remain a goal even as we preserve our commitment to all the elderly. This chapter focuses on alternative paths to reduce the growth in c , the Medicare-covered health services cost per beneficiary.

PRINCIPLES OF STRUCTURAL REFORM

We have established that the fundamental goal of long-term Medicare reform is to reduce the real rate of growth of costs per beneficiary. This can only be accomplished by a fundamental restructuring of

incentives for beneficiaries, health plans, and fee-for-service (FFS) Medicare as well.

Beneficiaries must have incentives to choose lower-cost health plan and health service delivery arrangements, or plans and providers will have no incentive to become more efficient. The simplest way to impart these incentives is to take serious steps toward implementing market principles—letting low-cost providers charge beneficiaries less, and requiring high-cost providers to charge beneficiaries more—while assuring that quality remains within acceptable bounds. There may indeed be a natural trade-off between cost and quality, but the basic idea behind structural Medicare reform is to allow beneficiary preferences to play a larger role in defining the appropriate place along that trade-off than they have in the past, rather than relying exclusively on executive branch determinations and dictates pursuant to legislative instructions.

In addition, policymakers have to define other trade-offs with efficiency, like those with equity arising from income differences—price incentives contradict ensuring access for the poor, for example—or risk differences. Ultimately, legislation determines how much people of different income and health risk will pay on average, though the Health Care Financing Administration (HCFA) could be given the assignment to create incentives within certain bounds as defined by Congress and the White House together. Finally, the complex issue of appropriate geographic adjustment could present a set of subtle and not-so-subtle trade-offs. Pursuing payment and benefit equity across the country may be impossible in a geographically heterogeneous nation like ours, where not only payment rates but utilization patterns vary tremendously as well. We will return to geographic adjustment issues again in the proposal section, for they are among the thorniest in Medicare reform.

Incentives for private plans to become efficient providers of acceptable or higher quality care would also be easier to implement through a new pricing system than any other known way. In many ways, structural Medicare reform is really about how to get health plan pricing policy right. Today it is highly inefficient because payment is formulaic and administered and is based ultimately on FFS Medicare costs. This is not a linkage that promotes efficient behavior by either health

plans or FFS providers, and thus is not in the long-run interests of either Medicare beneficiaries or taxpayers.

A short digression is worthwhile at this point to clarify that managed care is consistent with the original intent of the architects of Medicare. A fair reading of the legislative history of the Medicare program indicates that the original intent was to provide our elderly with the same kind of health insurance that most workers were offered. In 1965, that was indemnity coverage for FFS medicine, typically through a Blue Cross-Blue Shield plan. Today, the private industry norm is some kind of managed care. Thus, Medicare actually lags the private sector by quite a bit in moving most of its beneficiaries to managed care.

In my view, some form of managed care is here to stay, notwithstanding the increasingly emotional debate about patient protection acts in the current Congress that reflects the current backlash over cost-control techniques. Now, some managed care policies and plans surely need changing, but to argue that we can do away with care managers trying to balance cost and quality in clinically appropriate ways is to delude ourselves that 1) all health providers and styles of care are equally outstanding, and 2) we have unlimited resources to spend on health care in this country. Both propositions are patently false, and stakeholders that oppose managed care—for example, physicians who want their unquestioned autonomy and higher incomes back, hospitals who want to charge what they want in order to avoid changing the way they are organized, and politicians willing to exploit a small number of genuine horror stories for political gain—are exaggerating the problems of managed care to further their own self-interests.

That said, ensuring that quality can be properly valued in the Medicare marketplace will not be easy. Advances in measurement are occurring, but there is still much work to do by plans, providers, and beneficiary/family education specialists alike. This work is vital to the future of a competition-driven health system. But while we may wait for the perfect set of quality measures to be devised, to do nothing and just trust unmanaged FFS medicine to solve all our quality and resource allocation problems is clearly not the answer either, as the recent Institute of Medicine report shows (Kohn, Corrigan, and Donaldson 2000).

Trying to make health plan pricing policy more efficient also creates two other types of trade-offs: conflicts with special missions of providers and perhaps of the Medicare program itself, and geographic equity. Academic medical centers that train our future health professionals and conduct the clinical research that improves medical practice—such as teaching hospitals, hospitals that have historically provided a disproportionate share of uncompensated care to the poor and the uninsured, and hospitals that are the only source of medical care in some semirural areas of the United States—all provide more or less public goods for which competitive market forces will always underpay. But forcing health plans to become more efficient through Medicare payment reform will reduce their ability to implicitly subsidize these activities. The wise thing to do would be to take the funding for these activities out of Medicare and Medicaid and have a clear and honest debate about how much research, teaching, uncompensated care, and rural provider support we want to provide, and then fund these activities directly with public funds, federal, state, and local. But wisdom and U.S. health policy are not often included in the same sentence, and while the Balanced Budget Act of 1997 took an important step by removing some graduate medical education payments from Medicare payments to health plans and instead paying them directly to teaching hospitals, providers of these public goods have strong incentives to resist fully efficient Medicare pricing policy until some alternative funding stream for most of their current special activities can be assured.

Geographic equity is also complicated by a zealous pursuit of efficiency. Basically, efficiency would require that prices be set locally at the minimum level to attract services from efficient providers of acceptable quality. But given the geographic heterogeneity of the U.S. health care system and the statutory principle that beneficiaries should pay a premium equal to a fixed percentage of the costs of average Medicare (ambulatory, or Part B) benefits, local efficiency would make it impossible to charge beneficiaries the same amount nationwide. But absolute geographic equity—defined as spending the same amount of money per beneficiary nationwide—would also be problematic, because the same money would buy very different amounts of health care in different parts of the country. Thus, balancing geography and efficiency requires judgment about a complex trade-off, and this issue

is one in which the major Medicare reform proposals differ substantially, as we shall see in this chapter.

ALMOST IDEAL MEDICARE HEALTH PLAN PRICING SYSTEM

Given the principles of structural reform, a useful conceptual experiment might be to ignore the real world constraints on the Medicare program for a moment and discuss the larger features of an almost ideal pricing system, and then examine how the constraints on Medicare do and do not force deviations from the ideal.

In many ways, the best example of an organized health plan purchaser for Medicare to emulate is that of a large, multistate employer with nationwide union contracts that force benefit packages to be equivalent everywhere. Health care, like politics, is local, and private employers do not seem to be troubled by this; they just adapt their health plan arrangements to fit local conditions within the context of their company-wide labor–management agreements. The simplest way to start, and a way that Medicare could surely emulate, is to define a standard benefit package that will be purchased everywhere. In the modern world of twenty-first century health care, that package should include reasonable prescription drug coverage in addition to the current statutory Medicare benefit package. Health plans would then be asked to bid on this package. The government payment amount would be fixed near the middle or lower end of the bid distribution, and beneficiaries would have to pay extra out of their pockets to enroll in high bidding plans. This competitive bidding arrangement would encourage all plans to become more efficient so that they could bid lower and offer premium rebates to attract beneficiaries. Again emulating the best private purchasers today, Medicare would collect and disseminate comparative quality data on plans and their affiliated providers, for this would give beneficiaries the maximum feasible information on which to base their enrollment decisions. Finally, after some reasonable time for remedial action, Medicare would exclude plans and providers who failed to meet acceptable quality or performance targets.

This sort of almost ideal health plan pricing system would have three main virtues. First, it would impart maximum incentives for health plans to become more efficient over time. Second, it would guarantee access to the same set of benefits nationwide. This is in contrast to today, where beneficiaries in Miami get zero premium (above their statutory Part B payment) prescription drug coverage through Medicare Plus Choice plans, and beneficiaries in Minneapolis have to pay large amounts out of pocket to get plans to offer prescription drugs to them, all because the current payment formulas are based on local FFS costs and practice patterns and make very little analytic sense. The third advantage of an almost ideal health plan pricing system is that it allows Medicare to price all health plans locally and avoid the thorny problems of deriving and administering geographic adjusters, which are inherently imperfect.

There are two major risks of the almost ideal health plan pricing system. First, while it does guarantee standard benefits nationwide, it cannot guarantee that beneficiaries will pay the same premium everywhere for the same benefit package. In fact, only one plan in each region is likely to have only the statutory premium attached. Higher bidding plans will have to charge a premium, and lower bidding plans can offer beneficiaries rebates off their statutory amount. This should encourage health plans to become more efficient, but it is not what some analysts and advocates mean when they talk about Medicare being available to all at one nationwide premium for all beneficiaries. Now there are regional disparities today for both availability and price of extra benefits beyond the current parsimonious (excluding drugs) Medicare benefit package, and at least one plan in each area will be available at the statutory price. But if regional disparities in premium payments for most Medicare health plans become too large, then a reevaluation of the definition of the Medicare “entitlement” may be demanded and appropriate.

The second major risk of an almost ideal Medicare health plan pricing system is that it does depend completely on local competition to engender efficient bids. If that local competition is not forthcoming (in rural areas, for example) or not sustainable (if health plan consolidation leaves oligopoly or monopoly health plans in certain areas), then some other way to generate pressures for efficiency must be found.

CONSTRAINTS ON MEDICARE

Even if the almost ideal health plan pricing system could be implemented and made to work well everywhere, Medicare is not and cannot ever be exactly like a large multistate employer. A private employer can strive for efficiency with no worries about spillover consequences, such as provider availability for 39 million beneficiaries, many of whom are very vulnerable and some of whom are chronically ill or disabled, both of which are fairly rare occurrences among working families that employers usually cover.

First, precisely because of these chronically ill and disabled, as well as rural beneficiaries, Medicare cannot ignore FFS providers the way large employers can now if they so choose. Only about 15 percent of beneficiaries are in Medicare + Choice plans today, thus managed care capacity will have to be expanded quite a bit before FFS can be allowed to fade away. Given the preponderance of FFS enrollees today, Medicare simply has to modernize this part of the program as well, rather than just focus on health plan payment policy and wait to achieve efficiency gains until all beneficiaries choose the new and improved managed care plans. Modernization will require selective contracting, performance requirements, and locally negotiated payment discounts with doctors and hospitals, none of which are features of the Medicare program today, and all of which are features of organized private purchasers who do a credible job of managing more or less FFS delivery systems (e.g., preferred-provider organizations).

Medicare must also worry about this problematic geographic equity because it is a national program. There is no simple scientific test to decide if having the same benefits everywhere or charging the same premium everywhere is the better definition of geographic equity. The very idea of geographic equity may be a bit problematic in a country with the heterogeneous health care systems that the United States has. Given that some form of geographic adjustment in payment rates is necessary, it is also difficult to come up with factors that are truly exogenous to local health care system demand. For example, nurses' wages are clearly input prices to both hospitals and doctors' offices, so a geographic adjustment factor including their wages makes intuitive sense. But nursing wages are higher where the demand for health care

is greater, so they are hardly a purely exogenous reflection of the relative costs of providing medical care in different places around the country.

The Medicare program must also worry about income equity more intensely than private employer purchasers of health insurance. Low-income Medicare enrollees cannot be expected to bear high out-of-pocket costs, either for health plans or for health services. Since approximately 30 percent of Medicare beneficiaries have incomes below poverty (Moon, Waidmann, and Storeygard 2000), payment provisions for protections that may impede the pursuit of efficiency must be made.

Similarly, differential health risks, while present in relative terms in all insurable populations, may be more of a problem in Medicare than in other settings. For health plans, the absolute financial consequences of being saddled with a disproportionate share of the highest risks are more severe, and thus provisions for risk adjustment of premium dollars received by plans are essential. Equally essential is absolute guaranteed open enrollment and the absence of risk-related beneficiary premiums and co-pays so that no one with chronic or serious illness is prevented from getting medically necessary care.

ALTERNATIVE REFORM PROPOSALS

Since 1995 there have been quite a few proposals to restructure Medicare,³ and in 1999 two major proposals emerged to galvanize the debate and to act as magnets or centers of gravity for rather different perspectives around which to coalesce. I label these the Breaux-Frist and Clinton proposals, respectively, after the leading politicians who have sponsored them. Breaux-Frist grew out of the Bi-Partisan Commission's plan, which was released in March.⁴ President Clinton's plan was developed as a response to the Bi-Partisan Commission plan and was released in July.⁵ Specific legislation has now been drafted and some details have been changed, though no formal bill has been marked up in committee and actually voted on in either chamber. Still, the key contours I will outline have not changed, and they will serve to

clarify these alternative approaches to long-term structural reform of the Medicare program.

First, I will highlight the important principles that the proposals share. To begin with, they both have competitive price incentives for beneficiaries, plans, and FFS Medicare. This is one essential key for long-run Medicare reform to promote efficiency and thus to reduce the long-run real rate of growth of cost per beneficiary. Second, both proposals make prescription drugs an optional part of the Medicare benefit package. The acknowledgment that prescription drugs are central to modern medical practice is important, even though neither drug provision is as generous as those made outside the context of structural Medicare reform in the bidding wars for the 2000 presidential election campaign. Finally, each major proposal has provisions that would protect low-income and high-risk individuals, as well as address the thorny issue of geographic cost differences. These are important areas of agreement, and they suggest that a compromise is possible within this broad outline.

But the Breaux-Frist and Clinton proposals differ in their treatment of three key features: the reference price, or the amount of the government contribution toward health plan enrollment choices by beneficiaries; use of national averages to influence local competition; and adjustment for geographic differences in price and utilization or patterns of delivery of health care services to Medicare beneficiaries.

The Reference Price

Each reference price is best understood in the context of each proposal's specific and unique bidding process. For Breaux-Frist, there are two benefit packages: core and high-option. Core includes only current law benefits, and high-option adds (at least) an \$800 (actuarial value) drug benefit and (at most) a \$2,000 stop loss (maximum beneficiary out-of-pocket payment). Health plans must submit a high-option bid, and they may submit a core bid as well if they are willing to sell a package with just current law benefits (all bids in all proposals are presumed to be for the average risk enrollee, and both proposals assume risk adjustments will be made before payments are made to plans). HCFA, as the manager of FFS Medicare, must offer a core bid everywhere in the United States. This bid must be set to break even, i.e.,

finance itself, over the year. HCFA must also partner with any willing private insurer to offer a high-option plan wherever firms are willing to sell the supplemental policy to go along with its core package of FFS services.

The Medicare board computes the core bid for each plan that did not submit one on its own, and then computes the national weighted average (NWA), an enrollment-weighted average of all bids for the core plan nationwide. For the NWA calculation, each bid is also deflated by its geographic adjuster, as determined by the board. (The geographic adjuster will be explained in some detail later, for this is the third key element wherein Breaux-Frist differs from Clinton).

The Breaux-Frist reference price is 88 percent of the NWA for core plans and $0.88 \times \text{NWA} + 25$ percent of the statutory minimum cost of the drug benefit (\$800) for high-option plans, or $0.88 \times \text{NWA} + 200$. If a core plan bid exactly the NWA, the beneficiary would have to pay $0.12 \times \text{NWA}$ to enroll in it. If a high-option plan bid exactly the NWA + 1,000, the beneficiary who chooses it would pay $0.12 \times \text{NWA} + 1000 - 0.25 \times \text{Drugcost} = 0.12 \times \text{NWA} + 800$. (This paragraph assumes the geographic adjuster and the risk adjuster for that beneficiary are each 1.0 for simplicity of exposition).

The larger point is that this type of reference price builds in both carrots and sticks; high-bidding plans must charge more than these reference amounts, and plans that bid less could offer beneficiaries discounts. Thus, this kind of pricing structure imparts strong incentives for plans to become efficient or lose market share.

Clinton also has core and high-option benefit packages, but they are structured somewhat differently than in Breaux-Frist. The core defined benefit is the current law package plus zero cost sharing on a specific set of prevention benefits. The high-option package adds a specific outpatient prescription drug benefit (no deductible, 50 percent co-insurance up to \$5,000 in drug spending) to the Clinton core. HCFA would add the prescription drug benefit to the "high-option" FFS plan. Private plans must bid a price at which they are willing to supply each package. Plans could also add the cost of reducing regular Medicare cost sharing, as long as this does not increase the actuarial value and cost by more than 15 percent.

HCFA and/or FFS Medicare do not bid, per se. Yet the reference prices for the Clinton proposal are pegged at 96 percent of the local

FFS cost for the core package and at 96 percent of the FFS cost of the core package plus the cost of HCFA-administered drug benefit. This has the effect of insulating beneficiaries who choose FFS from ever paying more than the statutory part B premium amount, i.e., beneficiaries under Clinton's plan will always be able to select FFS without a financial penalty for FFS's inherent inefficiency at controlling costs. However, low-bidding plans will be able to offer premium rebates to beneficiaries, with beneficiaries getting 75 percent of the savings and the government getting 25 percent of the savings. In this way, the Clinton reference price structure is all carrots: since FFS is expected to usually be the highest-cost plan, private health plans have incentives to bid low to gain market share but no stick forcing them to bid low to be competitive as the NWA provides under Breaux-Frist.

Use of National Averages to Affect Local Competition

Breaux-Frist uses the NWA as a check on local plans and on FFS Medicare. Breaux-Frist also uses the local bids to force FFS Medicare to become more efficient or lose market share. (This will become a bit more clear in the examples I present below). Clinton uses the FFS premium guarantee to protect beneficiaries while still offering plans the reward of higher market share for competing successfully (at lower cost) against FFS Medicare. Clinton's proposal also has plans to modernize FFS, i.e., make it more like a preferred-provider organization.

Adjustment for Geographic Differences

The third major difference between the proposals for long-term Medicare reform is treatment of geographic cost differences. Breaux-Frist would adjust bids only for local input price differences. This approach is consistent with a particular view of utilization differences: that they are clinically unjustified and mostly driven by ignorance of best medical practice or pursuit of economic gain by providers. Clinton's original proposal called for "full" geographic adjustment, which seemed to promise to adjust for all FFS utilization differences as well as price differences among different areas. But the final proposal as specified in the FY2001 budget documents defined the geographic adjuster as an enrollment-weighted average of FFS and managed care

costs, locally as compared to national averages, which at least allows for managed care utilization to dampen slightly the degree for which utilization differences are adjusted. The Clinton approach is consistent with a view that most, if not all, utilization differences among areas are legitimate—more or less the opposite of the Breaux-Frist view.

The significance of these divergent views is made clear in Table 1, which decomposes Medicare + Choice payment rate deviations from the national average into input price and utilization sources in eight different metropolitan statistical areas. I used the simple hospital wage index to proxy input prices. The table shows that areas that cost more than the national average, from Trenton to Miami, could mostly have high utilization (the Florida locations), high prices (Los Angeles and Flint), or just slightly elevated utilization (Trenton). Areas with below average costs (Tacoma and South Bend) have substantially lower utilization, even sufficiently low enough to more than counter the effect of higher prices (Tacoma). The point of this table is to suggest, however, that the Breaux-Frist geographic adjuster will have very different effects and be much more popular in Los Angeles and Tacoma than in Miami. Clinton's adjuster, on the other hand, is likely to be the most popular of the two adjusters everywhere, which is no doubt why it was designed precisely the way it was.

Table 1 Geographic Disparity in Medicare Managed Care Plan Costs

	2000 Medicare + Choice payment (\$)	% above U.S. avg. ^a	% due to price HWI ^b - 1	% due to utilization
Miami	724.23	43.4	2.3	40.2
Ft. Lauderdale	623.63	23.5	1.7	21.4
Palm Beach	564.73	11.8	-0.5	12.4
Los Angeles	627.76	24.3	20.9	2.9
Flint	576.49	14.2	10.2	3.6
Trenton	521.93	3.4	-0.4	3.8
Tacoma	439.62	-12.9	16.3	-25.1
South Bend	415.86	-17.6	-2.1	-15.9

SOURCE: Author's analysis of Health Care Finance Administration data. Price deflator is the hospital wage index.

^a The U.S. average is \$504.96.

^b Hospital wage index.

EXAMPLES TO HIGHLIGHT THE DIFFERENCES IN THE BREAUX-FRIST AND CLINTON PLANS

The following hypothetical examples are designed to illustrate how the competing proposals would translate a given set of “facts,” i.e., private health plan bids and FFS costs, into marginal prices that beneficiaries would pay, and thus, ultimately, into incentives for long run efficiency. It is not simple to construct an example that permits an “apples to apples” comparison across reform proposals because they have different benefits in their “high-option” plans and because their treatments of FFS Medicare are so dissimilar—Clinton does not force HCFA to bid per se, whereas Breaux-Frist requires it to break even with its premium collections. Nevertheless, the following is offered as a first order approximation of an example that permits a fair comparison, and while I have made some simplifications compared to the “actual” proposal throughout (these proposals are moving targets in any event), I have been careful to preserve the rank order of beneficiary premiums that would actually occur among plans and geographic areas.

I use four “plans”: two private HMOs (Plans 1 and 2), FFS Medicare, and FFS Medicare with a high-option supplement (FFS + D), where D = prescription drugs. Both private plans offer each proposal’s high-option package: the implicit assumption to keep the premium bids identical under both Breaux-Frist and Clinton is that the more expansive drug benefit under Clinton has the same actuarial value as the drug benefit plus stop loss in the Breaux-Frist high-option package. Table 2 lists the bids by each plan in a low-cost and a high-cost area. (A high-

Table 2 Bids of Sample Plans (\$)

	Low-cost area	High-cost area
Plan 1	6,100	8,300
Plan 2	6,710	8,930
FFS	6,200	6,200
FFS+D	7,300	7,400
NWA	6,000	6,000

cost area is presumed to have 10 percent higher prices and 20 percent higher utilization than the national average. A low-cost area is presumed to have 5 percent lower prices and utilization). NWA is the national weighted average computed under the Breaux-Frist rules.⁶

Table 3 shows the reference prices in the low-cost and the high-cost areas (for the Clinton plan, the reference prices are relevant to plans 1 and 2 since this reference price includes drugs for the high-option plan). Note that the Clinton reference prices are uniformly higher in the same geographic area. This shows the protection Clinton gives to FFS, while Breaux-Frist provides stronger incentives for health plans to become more efficient.

Table 4 shows what beneficiaries would pay out of pocket on the margin for each of the specific health plan choices in the example. Recall that, under the Clinton plan, beneficiaries pay the Part B premium for FFS without drugs. I proxied this amount by making it equal to 10 percent of the nationwide FFS average cost in my example, or \$620 per year. Note that the Clinton plan would charge beneficiaries less for all plans in the low-cost area, and considerably less for private plans in the high-cost area, because the Clinton reference price is so high. However, and perhaps surprisingly, Breaux-Frist would charge beneficiaries less for standard FFS than Clinton.

Table 3 Reference Prices, Given Example Bids (\$)

	Low-cost area	High-cost area
Breaux-Frist	5,700	6,600
Clinton	6,642	8,943

Table 4 Beneficiary Payments, per Year, per Beneficiary (\$)

	Low-cost area		High-cost area	
	Breaux-Frist	Clinton	Breaux-Frist	Clinton
Plan 1	920	863	2,220	638
Plan 2	1,530	1,388	2,850	1,107
FFS	1,220	620	320	620
FFS+D	2,120	1,120	1,320	1,120

This result illustrates the power of the NWA versus the Clinton reference price. In high-cost areas, FFS is relatively cheap under Breaux-Frist since it is forced to bid the national average everywhere, and by definition the national average FFS is lower than the average cost in high-cost areas. The NWA formula makes FFS even more attractive. The Clinton proposal, on the other hand, keeps the absolute price of FFS the same everywhere, and the surprising result is that because of the way the Clinton reference price is computed (with geographic adjusters, not shown but available from the author on request), the private health plans are actually cheaper in high-cost areas—to beneficiaries—than they are in low-cost areas. This is in some ways an artifact of this particular example, wherein excess utilization is more important in defining the high-cost areas than excess prices, but as Table 1 showed, this is also a fair representation of Florida's high-cost Medicare markets in real life.

The upshot of this example is that because Clinton adjusts area-specific reference prices for utilization differences and input prices, whereas Breaux-Frist only adjusts for input prices, Breaux-Frist imparts in high-cost areas much stronger incentives on high-cost private health plans to become more efficient, or they will be hard pressed to survive in high-cost areas. Now high-cost areas—which are, after all, high-cost because of their historical FFS utilization and pricing patterns—are where the greatest potential for new savings lie, as efficiencies are sought. Thus, Breaux-Frist imparts the strongest incentives for private plans to become efficient in the areas where it is likely to do the most good from a program-wide efficiency perspective. Clinton, by contrast, ends up protecting the excess utilization in high-cost areas by making private plans here relatively inexpensive compared to FFS + D, until this protection is eroded by the slightly declining geographic adjuster over time as costs elsewhere (note the low cost area's private premium bids) reduce the geographic adjustment factor over time. It is clear from Table 4 that health plans in high-cost areas would greatly prefer the Clinton approach. In absolute terms, they would prefer Clinton in low-cost areas as well, though relative to FFS, private plans under Breaux-Frist are better off than under Clinton.

IMPLICATIONS OF THE EXAMPLE

In general, Breaux-Frist imparts stronger incentives for health plan efficiency. Private plans in high-cost areas—especially if utilization is the main reason they are high-cost now—would have to become much more efficient very quickly or charge such high premiums they would likely lose business to FFS. Indeed, the NWA calculation works in such a way that FFS Medicare seems relatively cheap in high-cost areas. Beneficiaries would pay more on the margin for all private plans under Breaux-Frist, and for HCFA's FFS plan with prescription drug coverage. In the example, the NWA also works to make the out-of-pocket cost of FFS exceed the price of the lowest-cost plan in low-cost areas, which implies that managed care plans might be encouraged to enter here, since they could likely compete against the national average-priced FFS plan.

As advertised, the Clinton plan protects FFS beneficiaries well, in that FFS Medicare, offered to them for the usual Part B premium, is the lowest-cost plan in each type of area. In the example, no private plan bid lower than the Clinton FFS plan, but private plans were cheaper than Clinton's FFS plan that includes prescription drugs. Thus, beneficiaries who wanted prescription drugs and were price conscious in both high-cost and low-cost areas would be able to find non-HCFA alternatives to their liking. In a surprising reflection of the implications of "almost full" geographic adjustment, the out-of-pocket premium for the private plans with drugs is lower in the high-cost areas under Clinton than in the low-cost areas. From the point of view of encouraging beneficiaries to migrate to managed care in high-cost areas, this is good. But the Clinton approach, relative to Breaux-Frist, is clearly going to discourage managed care growth in low-cost areas. It also may stall significant growth in high-cost areas as well, since it will be hard to provide the extra benefits beneficiaries want (e.g., outpatient prescription drugs) and also to price below FFS Medicare, especially if FFS Medicare modernizes along the lines of the Clinton proposal. Of course, if managed care cannot control cost growth better in the long run, then it should not—and would not—grow relative to FFS. The Clinton plan does a better job overall of hedging the bet that managed care is destined to win this competition.

Each plan has both potential and obvious flaws. In my judgment, the Clinton plan's incentives are potentially weak in high-cost areas. Especially to the degree that norms of excess utilization are responsible for historically higher than average costs in these areas (as in Miami, etc.), there may be much more inefficiency to wring out of the system than the Part B premium allows room. Recall, the Clinton plan is all carrots. Thus, plans can price lower than FFS but they can't go below zero, and FFS doesn't have to charge more when it's more expensive than the reference price, as in Breaux-Frist. Thus, a potential private plan premium discount relative to FFS costs—the Part B premium, or roughly 10 percent of national average FFS costs in the example—is constrained to be no more than \$620 in 2000.

The Breaux-Frist plan, by contrast, may have too harsh an incentive structure. It would clearly be disruptive in the short run in high-cost areas, precisely where managed care enrollment within Medicare is highest today. Ironically, if imposed without a transition phase as the plan was originally drafted, it would likely kill off Medicare managed care plans in precisely the areas where Medicare needs managed care to help it save resources in the long run. The complement to this effect is that the NWA protects FFS in these high-cost areas, which is unlikely to be wise for long run Medicare payment policy.

OUTLINE OF A COMPROMISE

These implications, relative strengths, and flaws of each Medicare reform proposal all point to a fairly obvious compromise that might actually make decent long-run policy sense: start with the Clinton plan and gradually wean FFS from this much protection by lowering the reference price over time to something closer to the Breaux-Frist concept. The wisdom of reforming Medicare deliberately as opposed to precipitously should be obvious.

In the long run, a locally defined contribution based on competitive bidding makes perfect sense, as does making FFS Medicare compete. But FFS Medicare must be given time to modernize, and payment reform should not kill off any options in year one, or there will be precious little competition and reform in the long run. It seems likely that

Medicare will need both sticks and carrots in its ultimate pricing arsenal—as Breaux-Frist has—to achieve the lowest possible c (real growth in per beneficiary costs). It would be wise to reevaluate the Clinton concept of more or less full utilization adjustment, though recent work by Cutler and Sheiner (1999) suggests that zero utilization adjustment is probably not appropriate either, and truth may be closer to two-thirds than some people now think. Finally, to make all Medicare health plan pricing reforms palatable, Medicare must work hard on quality measures and plan accountability. Ultimately, the limit to how aggressive pricing reforms can be will be set by how much the people in the United States trust the health care delivery systems we allow Medicare to pay for.

LIMITS OF ECONOMIC ANALYSIS OF MEDICARE REFORM

To conclude, it is important to remember that Medicare is not just an abstract set of incentives that may be oddly structured for economists' tastes. Economists can best serve the Medicare debate by identifying the trade-offs inherent in competing policy objectives and real world conditions, and in analyzing the likely outcomes of alternative incentive structures. That is, at best, economics merely clarifies the choices real policymakers face. If we have learned anything in Washington during the eight years of the Clinton Administration, it is that major health policy changes, as structural Medicare reform would be, can only be achieved with a broad bipartisan consensus. Only with this consensus can entrenched interests—which will always oppose reform—be overcome. However, the other lesson that economic analysis can offer Medicare reformers is that the cost of delay is higher future pain (in tax rates) and hasty, ill-considered implementation snafus and unintended consequences. That is surely a poor enough bargain to keep minds in Washington concentrated on Medicare reform.

Notes

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1. This algebra section is taken from Nichols (2000). I simplify a bit by assuming there are no non-elderly disabled beneficiaries, no elderly workers, and that all public funds are financed with a payroll tax. Including the precise details would complicate the algebra without changing the essential point at all, since the general fund financing that reduces the actual required payroll tax rate also increases the fraction of income tax revenue that must be dedicated to Medicare. Nevertheless, the stylized “ r ” that is calculated in this simplified example is higher than is actually required because of current income tax financing and because of the payroll and income generated by elderly workers.
2. Author's calculations; details available on request.
3. Reischauer, Butler, and Lave (1998); Moon (2000); Helms (2000). See also the papers by McClellan, Cutler, Fuchs, Reinhardt, and Saving in the Spring 2000 issue of the *Journal of Economic Perspectives*.
4. The bipartisan commission's proposal can be found at <http://medicare.commission.gov/medicare/index.html>. Breaux-Frist was introduced in the U.S. Senate as S. 1895 in November of 1999.
5. The Clinton plan can be found in the FY2001 budget documents. Contact the author for further details.
6. Under Clinton, the FFS plans do not bid, per se, but under Breaux-Frist they do.

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