



A How-to Manual for Modernizing Medicare

The Bush administration has outlined its plan to strengthen and modernize the Medicare system. The idea behind the plan is to give seniors more private sector options.

Both President Bush and Health and Human Services (HHS) Secretary Tommy Thompson have pointed to the Federal Employee Health Benefits Program (FEHBP) — which offers private insurance choices to some 8.2 million federal workers and retirees and their dependents — as a model for modernizing the Medicare system.

But Congress used the FEHBP as a model for the reforms of 1997, which created the Medicare+Choice (M+C) program. The program never reached its potential because very few private insurers joined, and many that did have since withdrawn. Before another Medicare modernization plan emerges, a very important question must be answered: What is required to induce private sector insurers to participate in Medicare over the long term? Fortunately, Congress doesn't need to reinvent the wheel to create a Medicare program that will attract insurers. The states and the National Association of Insurance Commissioners have already addressed some of the most difficult issues relating to health plan accountability, financial solvency, access and pricing, and may serve as a model for a modernized Medicare system.

The Failure of Medicare+Choice. With M+C, Congress sought to create a private sector option that would allow seniors to choose among different types of health plans, including Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), Point-of-Service (POS) plans and Medicare Medical Savings Accounts (MSAs). Because of major design flaws, M+C never worked well. Some HMOs that were already serving the Medicare population under the “Medicare Risk” program were willing to continue providing services. But insurers that could have offered PPO or POS plans or Medicare MSAs looked at the “Three Rs” of Medicare reform — restrictions, regulations and reimbursements — and decided not to participate.

Can the administration design and Congress develop a program that is attractive to many private insurers and most older Americans? They must if Medicare reform is to have any chance of succeeding. The following list of five basic principles — researched, debated and then drafted by insurers, actuaries and health policy experts — would, if incorporated, make the private sector Medicare market attractive and viable.

1. Simplify and Modernize the Current Medicare System. Before Medicare can be modernized, it must be rethought. What should the program look like and who should it serve? Here are four recommendations.

(A) Combine Medicare Part A and Part B into a single cohesive benefit plan.

Medicare is the most complicated health insurance plan in existence, and it serves the population — seniors and the disabled — least able to deal with a complicated system. Private sector Medicare options such as those proposed by the Bush administration should be structured like traditional insurance with one deductible, one copayment and a cap on total out-of-pocket expenses. Ideally, traditional Medicare should be similarly restructured.

(B) Add a prescription drug benefit. Most private sector health insurance plans provide at least some prescription drug coverage. So should Medicare. That coverage should come as part of a comprehensive insurance package. The marketplace now offers scarcely any standalone prescription drug policies because insurers who have offered such policies have found them to be a financial liability because they paid in claims more than they received in premiums.

The administration supports comprehensive prescription drug coverage for seniors who choose one of two proposed private sector programs, Enhanced Medicare and Medicare Advantage, and limited coverage for those who remain in traditional Medicare. Low-income seniors in traditional Medicare would receive an annual \$600 subsidy to purchase drugs, and high-cost users would get help with their bills.

Thus the administration's plan recognizes that prescription drug coverage must be part of a larger insurance package in the private sector, but it also finds a way to help low-income and high-cost users who remain in traditional Medicare.

(C) Subsidize low-income seniors. Currently, about 6 million low-income seniors, known as “dual-eligibles,” are also enrolled in state-based Medicaid programs. In most cases, Medicaid pays these seniors' Medicare copayments and prescription drug costs. A modernized Medicare system should provide federal assistance for these individuals, instead of relying on the states. State coverage for low-income seniors is variable and subject to state budget limitations; a nationwide program would equalize benefits for low-income seniors across the country.

(D) Permit flexibility and promote innovation in plan design. Private sector plans continually evolve in order to take advantage of new information and therapies. By contrast, only an act of Congress can change the traditional Medicare system. For example, private sector insurers covered laparoscopic surgery long before Medicare did. Medicare needs to take advantage of the technological marvels of American medicine if it is to provide seniors with the best care. Private sector plans that can change quickly with the technology are essential to a modernized Medicare system.

2. Enhance Choices for Seniors. A goal of modernizing Medicare is to give seniors more choices. In one sense, it would be hard to improve on the choice of providers that seniors had under original Medicare. Under that plan, they could go to virtually any doctor, get whatever care the doctor recommended, and rely on the government to pay the bill.

Defenders of traditional Medicare say that the choices seniors want is the same choice of doctor and treatment they used to have — plus prescription drugs.

But the original Medicare program no longer exists, has not existed for 20 years, and cannot exist again, with or without coverage for prescription drugs. Medicare spending began to explode the day the program went into effect, and Congress soon felt compelled to reduce expenditures. In the early 1980s Congress created the DRG (Diagnosis-Related Group) system, which imposed price controls on hospital charges. In the early 1990s Congress enacted the RBRVS (don't ask!) system that imposed price controls on doctors. These price controls did not control costs because they encouraged more utilization, and they created incentives that can now affect the type, quality and availability of seniors' care. Increasingly, doctors refuse to accept new Medicare patients, and they are speaking out about the payment reductions. These are just a few of the reasons why the Medicare program of 2003 is not the Medicare program of 1965, and it never will be again.

But it is the program many seniors and others remember and would like to have. If Congress and the administration are going to provide seniors with choices, it must be choices they want, choices they would rather have than the coverage offered under traditional Medicare. To achieve a modernized system that enhances choices, Medicare should include:

- (A) More private sector options.** Medicare+Choice gave seniors private sector options, but not many and virtually all were HMOs. A modernized system would provide a greater range of options — just like those available to the under-65 population.
- (B) More of the care seniors want.** The private sector is flexible and cost-conscious enough to offer more benefits and services at lower prices. If the latest breakthroughs and procedures are not covered by traditional Medicare, seniors will want to join plans that offer such benefits as:
 - (1.) Preventive services.* Medicare cannot offer a full range of preventive services unless Congress authorizes it to do so, and years can pass before such options work their way through the legislative approval process and the Medicare regulatory bureaucracy. By contrast, private sector plans can offer proven preventions immediately, and they will as new services are shown to be safe and worthwhile.
 - (2.) Prescription drugs.* The Bush administration's proposal includes comprehensive drug coverage for those choosing private sector options and limited coverage (a subsidy for low-income seniors and coverage for the highest cost users) for those who remain in traditional Medicare. This approach is fiscally prudent and relies on the private sector to find ways to provide comprehensive coverage.
 - (3.) Disease management.* According to the Disease Management Association of America (DMAA), the term refers to a system of coordinated health care interventions and communications for populations with conditions they can manage themselves. Disease management relies on the physician/patient relationship and plan of care, emphasizes patient actions to keep the condition from worsening, and continually evaluates clinical, psychological, and economic

outcomes so as to improve the patient's overall health. Many health care experts believe that disease management, especially for the major chronic diseases of hypertension, diabetes, asthma and high cholesterol, could significantly increase patient compliance and reduce treatment costs. Disease management can incorporate other health care providers in patient care and monitoring. For example, Asheville, N.C., adopted a disease management program, and the city employee who runs it reports a 4-to-1 return on the municipal investment.

"Although drug costs rose, total health care spending on diabetics fell from \$7,042 per patient in 1996 to about \$4,000 apiece each year since the program began, in 1997," according to the director of the program, as reported in the *Washington Post*.

(4.) *A restricted guaranteed access provision.* Insurers and health policy experts know that giving people a choice of plans can be tricky. People often want a less expensive plan until they need care, at which time they frequently want to switch to a more comprehensive and usually more expensive plan.

The Medicare program is "guaranteed issue," which means it accepts all qualified applicants, regardless of their health status. Supplemental policies – so-called Medigap policies – are guaranteed issue for the first six months after a senior applies for Medicare Part B. Should the new private sector options also include such a limited guaranteed issue provision? The answer is yes, primarily because private sector programs operating under the umbrella of Medicare should have similar basic entry parameters.

(C) A catastrophic coverage option. A primary reason Medicare spending is exploding is that seniors have no incentive to seek value for each health care dollar spent. One way to solve that problem is to offer consumer-directed policies – for example, policies that include a Medicare Medical Savings Account.

With an MSA policy, seniors could have a high-deductible policy to cover major medical expenses, and a tax-free MSA with funds provided by Medicare. They would draw upon the latter account to pay for such routine health care as doctors visits, preventive care and prescription drugs. Money left over at year's end could be rolled over to pay for future health care needs, including long-term care or nursing home needs.. The key to decreasing utilization is making it clear that the money in the accounts belongs to the seniors and their estates.

(D) The option of supplemental insurance. Seniors in the traditional Medicare program now turn to supplemental insurance coverage to protect themselves from financial loss. If Congress developed a simple, viable Medicare program with one deductible and copayment system, seniors likely would be less interested in purchasing Medigap insurance because they could more easily calculate their out-of-pocket exposure. However, in its effort to modernize the current system Congress may create subtle inefficiencies that expose seniors to high out-of-pocket costs for which they might want to purchase insurance coverage. Furthermore, many seniors already buy additional coverage that does not fall under the category of a Medigap policy.

Thus Congress must be careful about limiting the role of the Medicare supplemental market. While a better system may reduce the demand for supplemental coverage, insurers need to be able to provide that coverage if seniors believe they face significant financial risks and want to be protected from that loss. Of course, those who choose to remain in traditional Medicare should have access to the full range of options. If lawmakers are still concerned about the increased utilization of care – and therefore increased costs – because of Medigap’s first-dollar coverage requirement, they can abolish the first-dollar coverage requirement.

- (E) The option of remaining in the current Medicare program.** Currently, Medicare covers not only seniors but about 4 million disabled Americans, including those with end-stage renal disease. Even if every senior chose a private sector plan, some form of Medicare would need to remain available for the disabled.

Current Medicare enrollees should be able to remain in traditional Medicare and perhaps gain a prescription drug benefit. Those who leave traditional Medicare should be able to get better and more comprehensive coverage, and/or the chance to control their money with a Medicare MSA.

- 3. Ensure Consumer Protections.** Critics of private sector options – whether in modernizing Medicare or Social Security – raise concerns that private companies can mishandle funds or commit accounting fraud. While the threat is overstated, basic consumer protection standards can be required. What are some of those standards?

- (A) Provide consumers protection from plan insolvency.** A health insurance company can become insolvent for many reasons, some the company’s fault, some not. Insurers wanting to participate in Medicare should be required to follow accounting standards and practices that will allow close monitoring of the companies’ financial status. These standards already exist in state law. State-required reports should be copied to the federal government so that a federal agency is informed of the plans’ status.

- (B) Establish a guarantee fund.** Most banks are protected against failure by the Federal Deposit Insurance Corporation (FDIC), which serves as insurer to the banking system. Similarly, a guarantee fund should cover claims if a private sector Medicare insurer becomes insolvent.

The good news is Congress doesn’t have to reinvent the wheel to provide this protection. Many states have established a guarantee fund association, regulated by each state’s department of insurance. These funds have a long and successful track record. Thus, all that is needed to meet this requirement is that insurers offering private Medicare plans participate in a guarantee fund in those states where they sell Medicare policies.

- (C) Ensure a minimum benefit structure.** Critics claim that private sector options won’t cover everything that Medicare now covers. Although the goal of private sector options should be to provide more benefits for less money, private sector policies should be allowed some variation from Medicare’s basic benefit structure. The best solution may be for Medicare to identify what providers and procedures must be

included (e.g., hospital and doctor's visits, mammograms and MRIs), but leave some flexibility in the amount or coverage for different providers and procedures.

In addition, private Medicare plans should be allowed to offer a high deductible, especially when combined with an MSA, as long as the benefits are covered once the deductible is met. By allowing a variety of benefit structures, seniors will be given choices similar to what they had in the under-age 65 market.

- (D) Restrict guaranteed eligibility to a six-month sign-up period.** Proponents of an FEHBP-model for Medicare point to the annual open season during which federal employees can shift from one health plan to another. They claim it increases choice. But an open season also encourages people to seek cheaper, less comprehensive policies when they are healthy and more comprehensive policies when they are sick. Such gaming of the system can destroy a health insurance pool.

To minimize these actions and still preserve choice, seniors should be offered a one-time open enrollment when the reform legislation is passed and put into effect. Afterward, seniors should be allowed to join any participating plan for six months after they become eligible for Medicare (similar to current law regarding enrollment in Medigap policies). However, those wanting to shift from one plan to another after attaining the Medicare eligibility age should do so only with the consent of the insurer who could underwrite the policy (i.e., the insurer should be allowed to charge more to those with preexisting medical conditions). The ability to underwrite is critical because it encourages people to choose a plan at the appropriate time, rather than waiting until they are sick.

But what if a health plan decides to leave the Medicare market altogether? In that case seniors should be allowed to move to an equivalent plan without restrictions.

- (E) Require a guaranteed minimum-loss ratio.** One of the first complaints will be that insurers will charge seniors too much for the premiums. And that concern could lead Congress or HHS to consider imposing price controls on the premiums.

Fortunately, there is an easy way to guarantee that insurers are only charging what they need to cover losses, plus administrative costs: a minimum-loss ratio. That model is supported by the National Association of Insurance Commissioners and is already working in many states.

Some states require a minimum-loss ratio that says that the claims paid by the company must be equal to a certain percentage of the premium taken in (e.g., the claims paid must be at least 65 percent of premium received). Medicare reform should use a similar provision based upon the current required Medigap loss ratios. If insurers are required to maintain loss ratios similar to those required by the states, there would be no need for insurers to file for approval rates. A minimum-loss ratio assures consumer protection that claims will be paid by the insurer, and equity in the level of premium charged compared to the claims paid. If the insurer does not meet the minimum-loss ratio requirement, it would have to adjust its premium intake in order to maintain it for consumer protection and equity purposes.

(F) Increase fraud and abuse protections and enforcement. Today, in order to receive payment for Medicare-covered services, some individuals game the system. This practice burdens the entire Medicare program. The U.S. General Accounting Office (GAO) estimates that \$1 out of every \$7 spent on Medicare is lost to fraud and abuse. Such fraud and abuse affects all Americans by diminishing the quality of care and the quantity of programs available to Medicare beneficiaries. While many Medicare payment errors are simple mistakes, a few individuals are intent on abusing or defrauding Medicare or the beneficiary. Thus continuing antifraud outreach campaigns is important. HHS's "Who Pays? You Pay" campaign fights health care fraud and abuse, using several agencies within the department and promoting partnerships with other federal, state and local groups. The campaign encourages Medicare beneficiaries who have concerns or questions about their Medicare bills to contact the HHS Inspector General.

4. Commit to a Fully Funded Program for Providers

- (A) Develop a method to eliminate rampant overutilization.** The Centers for Medicare and Medicaid Services (CMS) reports that even though physician reimbursements were reduced by 5.4 percent last year, payments to doctors rose by 7 percent because of higher volume. Since two decades of restrictive HMOs have demonstrated that neither patients nor doctors want top-down utilization control, the only option remaining is bottom-up control, in which patients and their doctors make value-conscious decisions in the health care marketplace. That option requires giving patients more control over their health care expenditures through mechanisms such as Medical Savings Accounts and the educational tools to decide what is best.
- (B) Establish a system that will ensure appropriate provider reimbursements.** The best way to guarantee health care providers and insurers participate is to make payment schedules adequate. Both the American Medical Association and the American College of Physicians have reported that the percentage of primary care physicians accepting new Medicare patients has declined steadily due to cuts in provider payments over the past several years. The AMA predicts that without program changes Medicare reimbursement rates will be lower in 2005 than they were in 1991. When Medicare reimbursements do not reflect the costs for treating Medicare patients, physicians tend to reduce their percentage of Medicare patients, eliminate beneficial services and technologies, discontinue charitable care, or close their practice to Medicare patients. Further, physicians may shift some of the cost of treating Medicare patients onto other patients who are privately insured. Only physicians offered appropriate and reasonable compensation can be expected to participate over time.
- (C) Create an automatic fee index to take politics out of funding.** Several factors influence the current Medicare fee schedule: some are national, some are regional and some defy explanation. What is needed is a mechanism that eliminates incentives to game the system by, for example, unbundling Medicare services. Providers need to be reasonably reimbursed for services provided. Implementing an automatic fee index/schedule or allowing only one fee for both traditional and private Medicare could assure consistent and equal payment and remove funding issues from the political arena.

(D) Establish safeguards for those companies accepting Medicare disabled beneficiaries. Under some state and the federal Health Insurance Portability and Accountability Act (HIPAA) enforcement laws, most companies are required to accept eligible individuals with a preexisting medical condition, up to a certain percentage of the insurers' covered lives. The same policy could apply to the private Medicare option. This protection prevents one company from accepting an excessive amount of high-cost applicants and therefore absorbing a disproportionate share of the costs of providing coverage. It spreads the risk of covering high-cost individuals to all participating carriers.

5. Enhance Long-Term Solvency of the Medicare Program

(A) Slow the rate of growth below the Medicare Trustees trend line. We must slow Medicare's growth rate. M+C tried to do that by paying HMOs 95 percent of the average annual per person Medicare outlay. However, some health policy experts claim that seniors choosing the private sector HMOs were disproportionately healthy and therefore cost the system much less than 95 percent of the average per person amount. Thus, they contend, Medicare actually spent more money under M+C because it was paying more than it should for the healthier seniors who chose HMOs while still paying the full cost of the sicker seniors who remained in the traditional program. While the Bush administration boasts that it isn't cutting Medicare spending but increasing it, Congress and the administration are going to have to come to grips with Medicare spending. The current trend is unsustainable, as the Medicare trustees attest.

However, by incorporating many of the proposals presented in this paper — and especially by encouraging and rewarding more consumer involvement — Medicare costs will begin to slow over time, thereby strengthening the program's financial condition in the long run.

(B) Ensure that the private Medicare market is a fiscally responsible environment. In the states the departments of insurance set and oversee health insurance rates and provide rate increases for the under-65 health insurance market. They can handle private Medicare policies in a similar fashion. In order to maintain proper premiums, the ability to receive timely and adequate premium adjustments will be vital to the financial solvency of the private market. And by requiring the minimum-loss ratio discussed above, consumers can be assured that premium increases are justified, based on the amount of claims paid.

(C) Reduce utilization through personal responsibility. One way to slow the growth of Medicare is to give patients more control over their money through personal MSAs or Health Reimbursement Arrangements (HRAs). Such cost-sharing options can make private Medicare plans viable over the long term.

(D) Enact medical malpractice reforms. Currently, American tort law encourages doctors to prescribe unnecessary tests and treatments, but often the legal system punishes them for administering reasonable care. Such systemic problems drive up the cost of health care and discourage appropriate treatment regimens. The medical liability system — as it now operates — disadvantages patients by increasing the cost

and decreasing the availability of the health care services they need most. Probably the best solution is to impose a cap on non-economic damages, thereby eliminating outrageously high awards.

(E) Increase the enrollment age. The retirement age for Social Security is gradually rising from age 65 to 67, reflecting Americans' longer life spans, as well as Social Security's future financial troubles. Congress should act promptly to link the Medicare enrollment age to that of Social Security.

Conclusion. Giving seniors more private sector options in Medicare is a good idea – but it won't work unless insurers are willing to participate in the program. Congress must learn from Medicare+Choice and not make the mistakes it did in 1997. Insurers and the states know how to create viable plans that ensure good health coverage while instituting consumer protections that would protect seniors. This "manual" has tried to identify and inform lawmakers about which issues should be addressed and the best way to approach them.

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