Medicare Competition

THE WHITE HOUSE

WASHINGTON

April 6, 1999

BACKGROUND MEMORANDUM ON COMPETITION IN MEDICARE

FROM: Chris J. and Jeanne L.

This memo briefly summarizes the issues and options associated with competition in Medicare. It does not include cost estimates; instead, it provides background information to facilitate an informed discussion of policy options that will be presented at the next principal's meeting.

I. Competition in the Current Medicare Program and Premium Support

Medicare Today. Medicare spending in 1998 and the first part of 1999 has been very low, and the outlook for Medicare's solvency has improved significantly. In 1993, the Medicare Hospital Insurance Trust Fund was projected to be insolvent in 1999; today, it is projected to become exhausted in 2015. The positive news regarding the trust fund can be attributed in large part to three major factors: the enactment of Medicare reforms and over $100 billion in savings in the 1997 Balanced Budget Act (BBA); the strong economy that has increased revenues and decreased inflation, and success in combating Medicare fraud. The BBA added prospective payment systems to several services and reduced Medicare overpayment.

Despite these successes, Medicare faces the retiring baby boom without many of the tools and competitive incentives that could make the program more capable of meeting this demographic challenge. Under current law, the traditional Medicare program cannot use negotiation, competitive bidding, and other market-oriented approaches to reduce costs. And, although CBO has traditionally not estimated significant savings from these types of policies, our actuaries have estimated that Medicare costs could be reduced by $15 to 20 billion over 10 years if we did.

Medicare managed care payments are also not set competitively. Managed care plans are paid according to a rate schedule (Medicare pays all plans about 96 percent of traditional program costs in the county -- regardless of the plan's premium). Because of the historic overpayments to managed care and the lack of risk adjustment, it is not clear that Medicare saves money from managed care enrollment today. Because of the flat payment rate, the government gets no additional savings if beneficiaries in the traditional program join a lower-cost plan or if they switch from a higher-cost private plan to a lower-cost private plan. However, beneficiaries have an incentive to choose lower cost plans, since they can get 100 percent of the savings back in the form of supplemental benefits (e.g., prescription drug benefit, lower cost sharing). Although the extra benefits offered by managed care are attractive to beneficiaries, the Medicare program does not share in the savings. Competition under the current system, therefore, is based on benefits

rather than price. These extra benefits can be designed to be more attractive to healthier populations, which results in further segmentation of healthy from sick beneficiaries.

Premium Support. Recognizing the limits of competitive incentives in Medicare, Robert Reischauer and Henry Aaron developed a concept called premium support. They described premium support as when "Medicare pays a defined sum toward the purchase of an insurance policy that provided a defined set of services" -- in other words, it maintains the guarantee of a defined set of benefits, but limits the government contribution to create an incentive for beneficiaries to seek care from efficient plans. They suggested that plans, including traditional Medicare, develop premiums for how much it costs to provide the defined benefits and the government sets its contribution based on the average (or median) premium. Beneficiaries choosing plans, including the traditional program, whose premiums are higher than average would pay more -- those choosing lower-cost plans would pay less than under current law.

Premium support comes closer to a traditional voucher program than the current Medicare program since payments for the traditional program would be limited to the government maximum contribution -- beneficiaries would bear the risk of underfinancing of the traditional program. However, there are some critical differences between premium support and a traditional voucher proposal. Premium support includes a guarantee of defined benefits; even if the government contribution is limited, health plans must provide the statutorily-set of Medicare benefits. Also, the government shares with beneficiaries the risk of unexpected health care cost inflation. This is because the maximum government contribution is set as a percent of actual Medicare spending, either for the traditional program, managed care, or both. If Medicare costs go up, so does the maximum government contribution (similar to what happens in Medicare Part B, where the government pays 75 percent of costs). Even though this provides some built-in protection against risk to the beneficiary, the extent of that protection depends on its design.

Savings in premium support are generated in several ways. First, there are direct savings because the government is paying less for lower-cost plans rather than the flat dollar amount under current law. Second, to the extent that the national average premium is reduced over time as people move to managed care, the payment schedule also is reduced and the Federal government saves. And third, increased revenues result from higher premiums for traditional Medicare. Under virtually all premium support models, the traditional plan premium would be higher than the national average, defining it as a "high-cost plan" and resulting in higher premiums. However, the Reischauer-Aaron concept of premium support would provide a richer, better benefits package which would make the inefficient and expensive Medigap market that supplements Medicare either unnecessary or significantly less expensive. The savings that beneficiaries reap would make them more able and willing to finance the choice of a higher-cost traditional program that includes additional benefits.

Breaux-Thomas Proposal. The Breaux-Thomas proposal included a premium support model that loosely resembles a Reischauer-Aaron concept since the government would pay health plans a percent of plan costs up to a limit -- a percent of the national average premium (a dollar amount

based on the per capita costs of the traditional program and the premiums for private plan, adjusted for enrollment). Beneficiaries would pay more for plans above the national average -- including the traditional program -- and less for lower-cost plans (see chart 1). However, it does not explicitly improve the Medicare package and it does not provide a clear guarantee of defined benefits, both of which are central to the concept of premium support.

Of greatest concern is the use of increased premiums for the traditional program as a mechanism to implicitly, financially coerce beneficiaries into managed care options. Our actuaries estimated that the premiums for traditional Medicare would be 18 to 30 percent higher than current law (10 to 20 percent if traditional program savings are included). To fend off the concerns about this premium hike, the final version of the Breaux-Thomas plan allowed beneficiaries in areas without private plan options to pay current-law premiums for traditional Medicare. However, this fix is not given to beneficiaries for whom managed care is not a good option (the very old, beneficiaries with special health need), and those in areas with one limited or substandard plan.

II. Options for Managed Care Competition

The Breaux-Thomas premium support proposal is clearly a politically and policy-flawed design. However, there are options for reforming Medicare managed care payments that reduce Federal costs, improve efficiency, and protect the premium for the traditional program. Most analysts agree that our current system for paying managed care plans is inefficient, with little savings accruing to the government. More importantly, it is harder for beneficiaries to compare choices based on extra benefits than on premiums. Allowing plans to compete on lower premiums would raise the cost consciousness of beneficiaries about their plan choices, creating incentives for them to help reduce program costs. At the same time, it represents a major change from the current system, in which all beneficiaries pay the same, Part B premium.

This section describes assumptions and the key policy parameters in designing a competitive approach to managed care payments. All options are structured to prevent the premium for beneficiaries choosing the traditional program from rising. These options also assume that Medicare benefits are guaranteed and explicitly defined; that plan payments are fully adjusted for risk of the beneficiary and local costs; and that private plans have some flexibility in reducing beneficiary cost sharing. Since risk adjustment under current law will not be fully phased in until 2004, this would probably be the earliest implementation date.

Under these options, the current law premium is $720 per year or 12 percent of total costs which is equivalent to 25 percent of Part B costs. The goal of protecting the traditional program premium is unanimously shared within the Administration because any approach that we adopt should produce savings through competition, not implicitly raising the Medicare premium. However, it should be noted that by protecting the traditional program's premium, it probably would not be considered premium support by those who advocate for it. Not withstanding its potential similarities to the Breuax-Thomas concept, managed care plans will likely oppose since

they are, in most options, but at a competitive disadvantage relative to the traditional program. Additionally, there will be both less private plan enrollment and less savings as a result.

Another major assumption in the options is that the government splits the savings with beneficiaries when they choose lower-cost plans. This does not occur under current law, since the government pays a flat rate for all plans and the beneficiaries gets 100 percent of the savings in the form of extra benefits. It is possible under these options to give beneficiaries 100 percent of the savings back in the form of lower premiums. However, to ensure some direct savings to the government for beneficiaries, the options assume that both the government and beneficiaries pay less for lower-cost plans. Additionally, since we have not yet had any experience with beneficiaries and price competition, there is some concern about providing such large financial incentives to go to managed care. Our actuaries suggest that the government cannot take more than 25 percent of the savings from choosing a lower-cost plan, since taking a higher cut would discourage beneficiaries from choosing private plans.

Setting the Maximum Government Contribution. As stated earlier, the difference between premium support and a voucher proposal is that the maximum government payment is set as a percent of actual Medicare spending, not some arbitrary budget-driven factor that could shift greater risk to beneficiaries. However, exactly how this maximum is designed determines the extent to which competition occurs, beneficiaries choose private plan options, and the government saves. There are three major options for the setting the government contribution, described below.

Option 1: Premium Support-Like Payment Methodology with Explicit Premium Protection for Traditional Program. The first option would set the maximum government contribution based on the national weighted average premium (see chart 2). This is the same basis for payments in the Breaux-Thomas plan with one exception. There would be a special rule that would ensure that the traditional plan premium does not rise above current levels for all beneficiaries, not just those in counties with no private plans.

Pros

- Maintains the savings that result from increased private plan enrollment, but assures that Medicare beneficiaries are not financially coerced into HMOs.

- Assures that private plan premiums are related to traditional Medicare, since traditional Medicare will dominate the national average which serves as the anchor for payments.

Cons

- Because it is the closest to the original Breaux-Thomas model, it is the most vulnerable to being modified into an unacceptable premium support plan.

- Creates odd incentives since a beneficiary would pay more for a private plan that costs the same as the traditional plan because of the special exception.

- Could be perceived as a double standard -- payments to managed care plans are set using competition but the traditional program is exempted from competition.

Option 2: Nationalized Competitive Pricing for Private Plans. The second option would set the maximum government contribution regionally, based on the local weighted average of private plan premiums (see chart 3). This approach not only excludes the traditional premium from being set under the new system, but excludes it from affecting the maximum government contribution. Thus, managed care payments would essentially be de-linked from traditional Medicare, whose premium would be set as under current law.

Pros

- Most straightforward way of protecting the traditional program's premium since it is totally separate from the competition

- This is the one competitive option that even the most liberal of Democrats in Congress could support.

- Would likely pay private plans less than other options because excluding the traditional program, which is usually higher, from the average premium lowers the average.

Cons

- Could create instability in premiums in private plans and has less of an incentive for beneficiaries to join private plans. As such, it has no supporters in the Administration.

- Most likely to result in lowest participation by managed care plans, thus reducing plan options, beneficiary migration to plans, and overall government savings.

- Would likely not be viewed as "real" competition in Medicare since the traditional program would be totally excluded.

- Could be perceived as a double standard. The private payments are set based on competition but the traditional plan is paid separately, and a beneficiary could pay more for a private plan that costs the same as the traditional plan because of the special exception for traditional Medicare.

Option 3: Modified Current Payment Methodology to Assure Savings for Government and Beneficiaries. The third option would set the maximum government contribution based on the traditional program's premium, similar to current law (see chart 4). Rather than basing private plan payment schedule on private plan premiums, it would link them to the traditional program. Specifically, the maximum government payment to the private plans would be set as a percent of the traditional program, guaranteeing the premium for traditional Medicare will be 12 percent. Beneficiaries who choose private plans with premiums below that amount would get a large proportion of the savings as a reduced Part B-like premium -- the government would save by paying the plan less. This is similar to our current managed care payment methodology, that pays for private plans based on traditional program costs, but differs since it allows price, not benefits, competition.

Pros

- Provides financial incentives for beneficiaries to opt for low-cost plans without putting private plans at a competitive disadvantage relative to the traditional program (since there is no special exception for the traditional program).

- Could be described as a next step in our current policy, maintaining the link to the traditional program but rewarding beneficiaries for opting for low-cost plans.

- While it uses the traditional program premium as a benchmark, it does not require special rules to protect the traditional premium, making it less vulnerable to movement towards a voucher proposal.

Cons

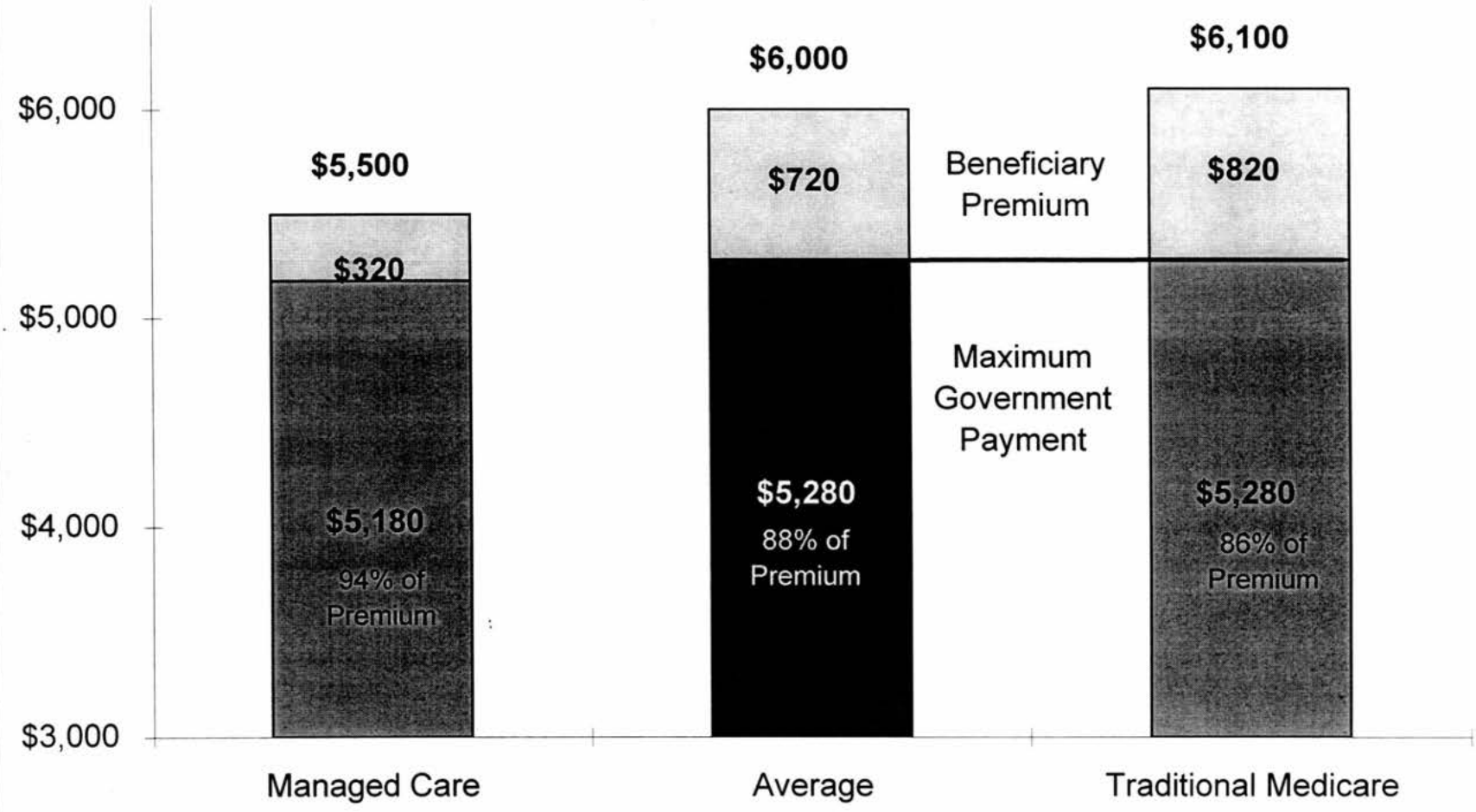
- Maintaining the traditional program at the center of private plan payments could lead to criticism about how efficient this option is -- if traditional program costs skyrocket, private plans are automatically paid more.

- Could be viewed as too incremental and would be most disliked by the managed care industry that has argued for including the traditional program in the competition and against linking payments to the traditional program.

Chart 1.

Breaux-Thomas Plan: Base Payments on Average

Traditional Medicare Premium Not Protected

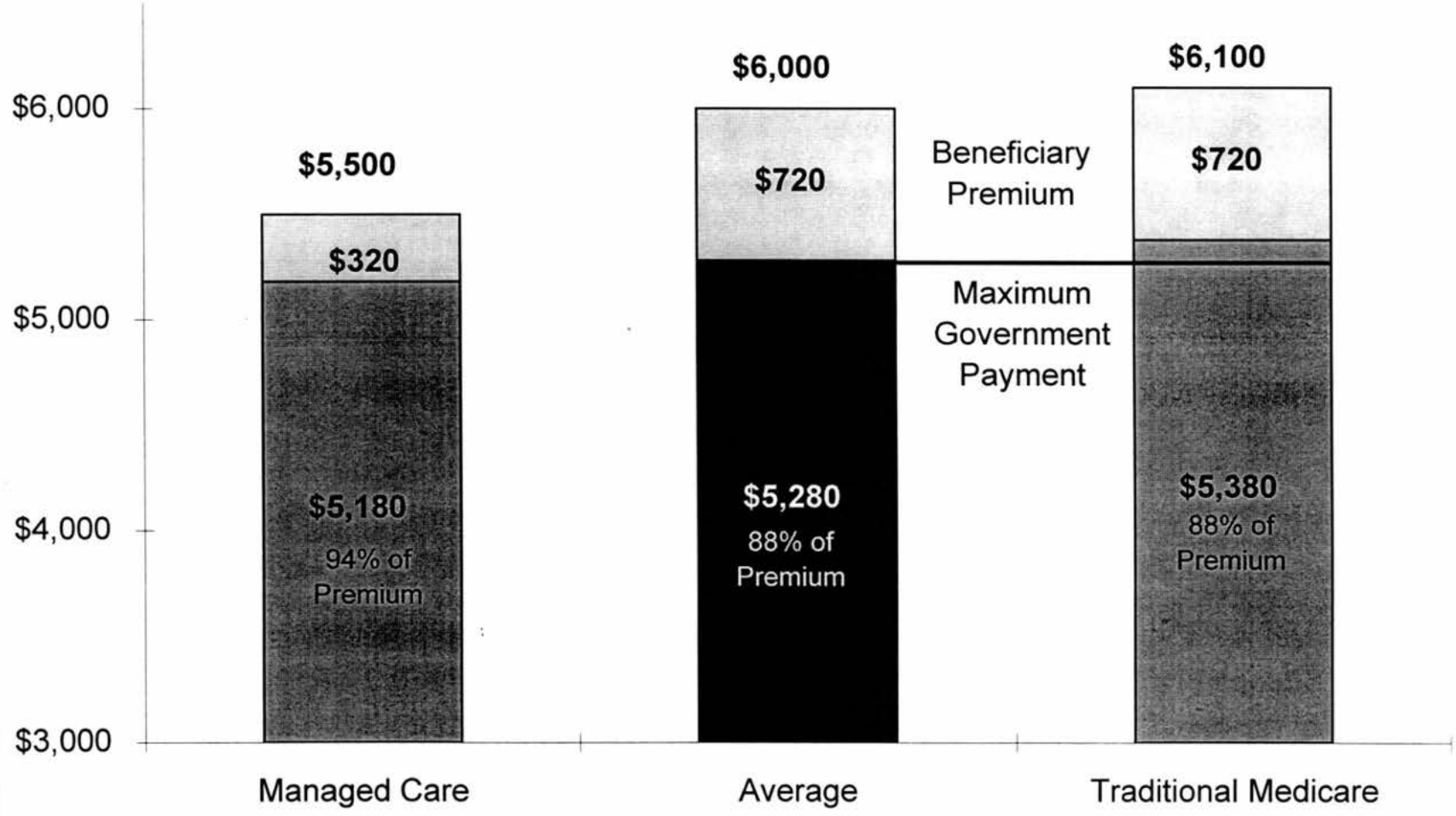


Note: $720 is approximately current law

Chart 2.

Option 1: Base Payments on Average

Traditional Medicare Premium Protected / Private Plans Not

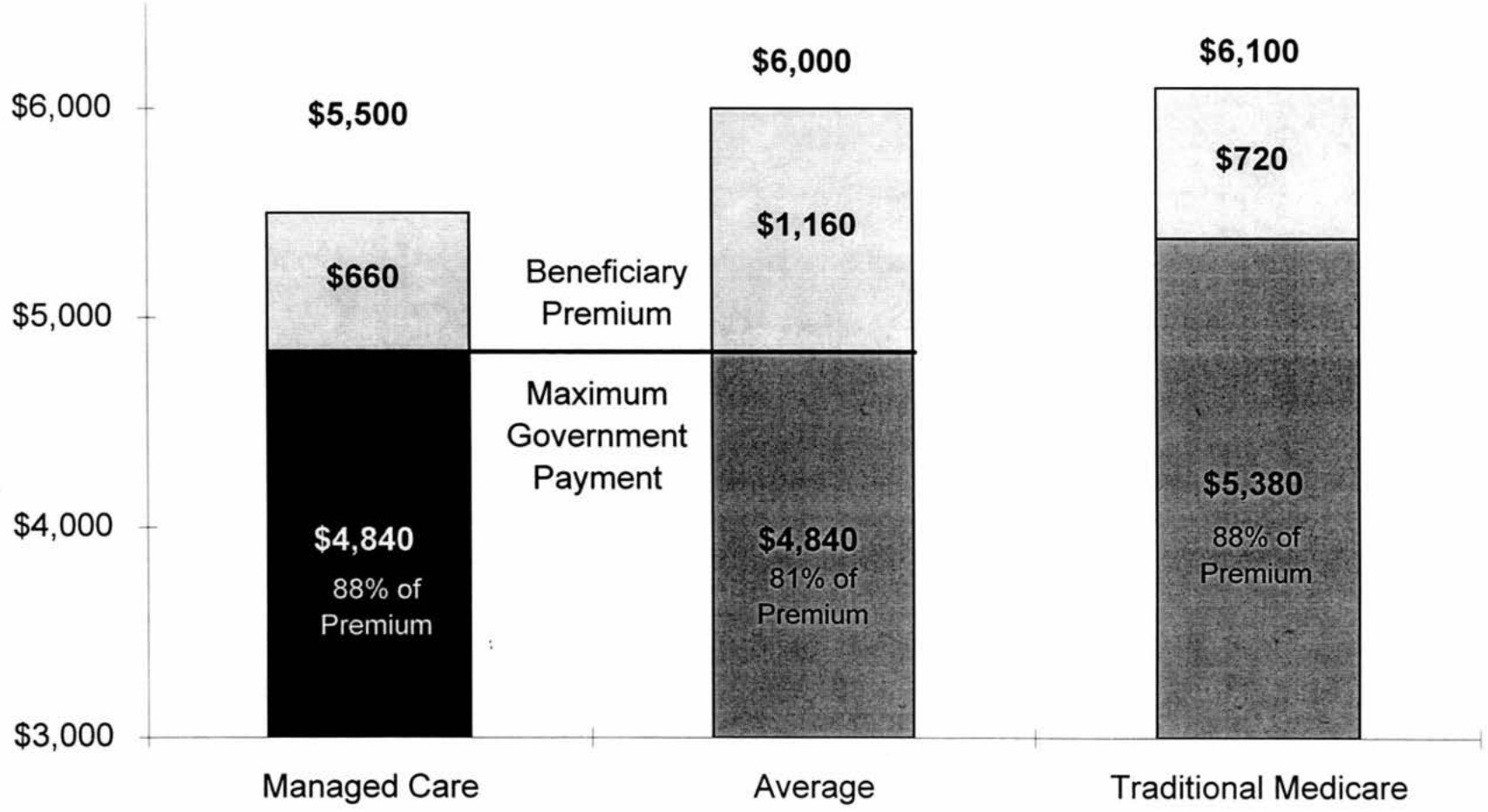


Note: $720 is approximately current law

Chart 3.

Option 2: Base Payments on Managed Care Only

Traditional Medicare Premium Set Separately

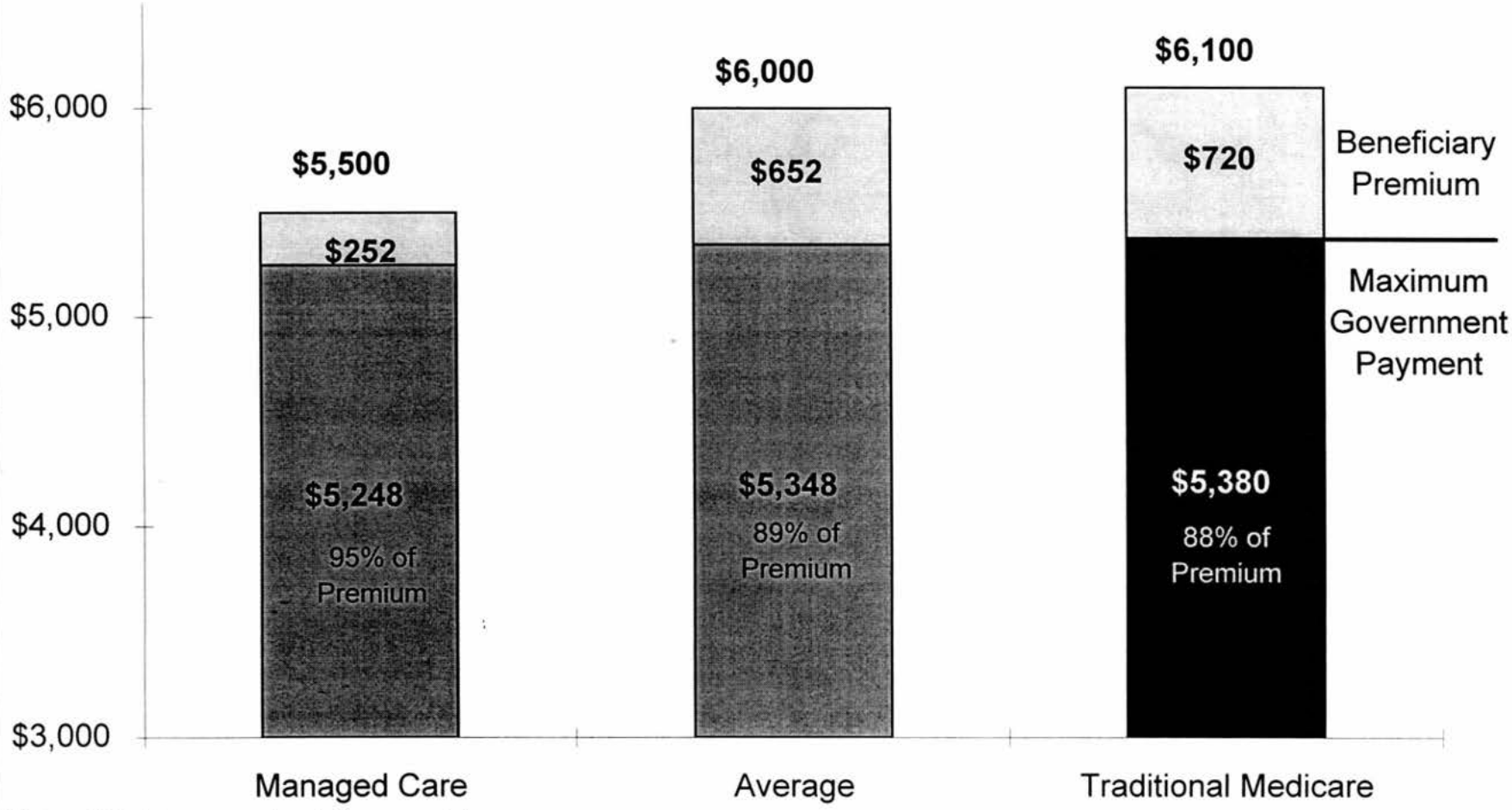


Note: $720 is approximately current law

Chart 4.

Option 3: Base Payments on Traditional Medicare

Traditional Medicare Premium Automatically Protected



Note: $720 is approximately current law

Stephanie

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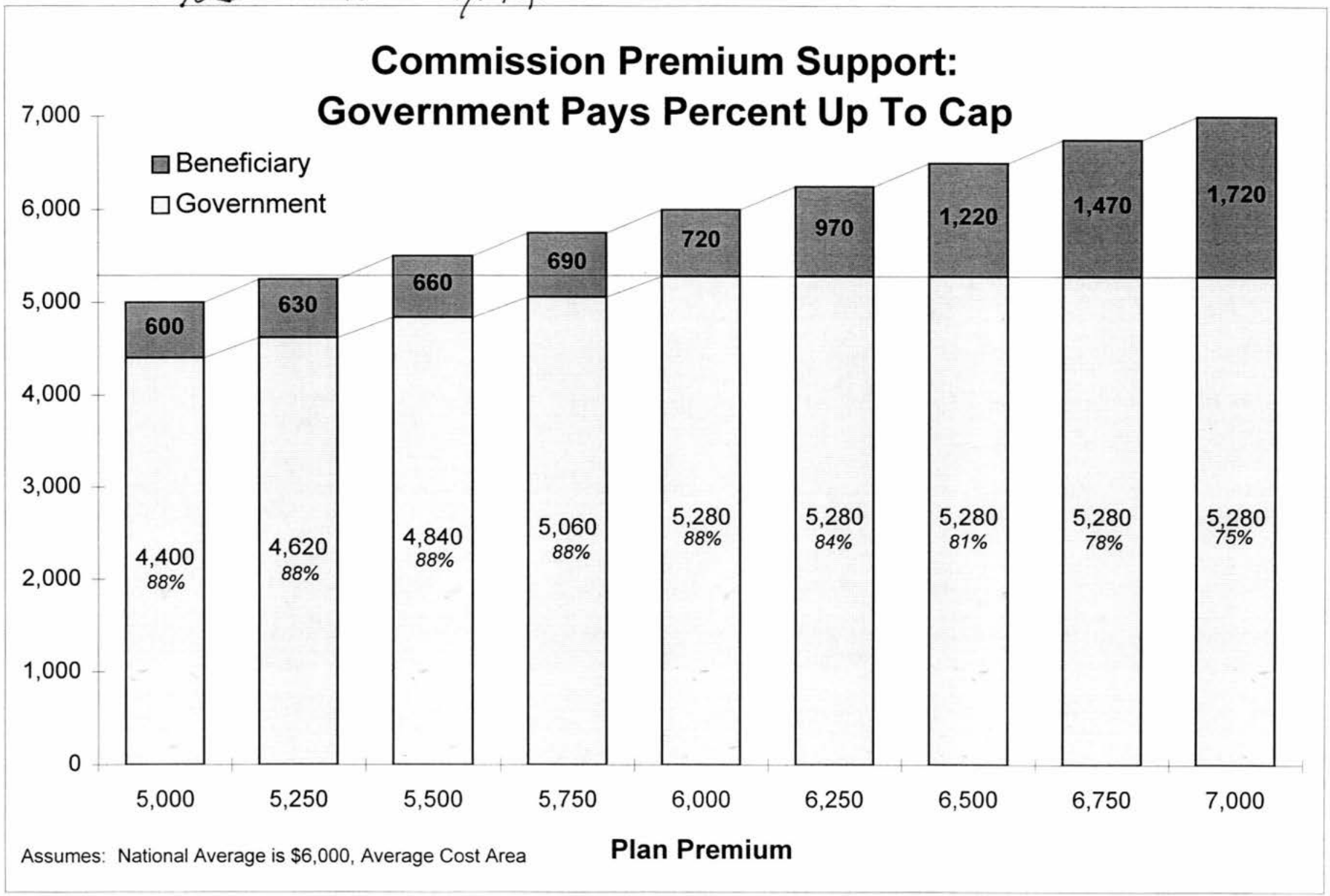
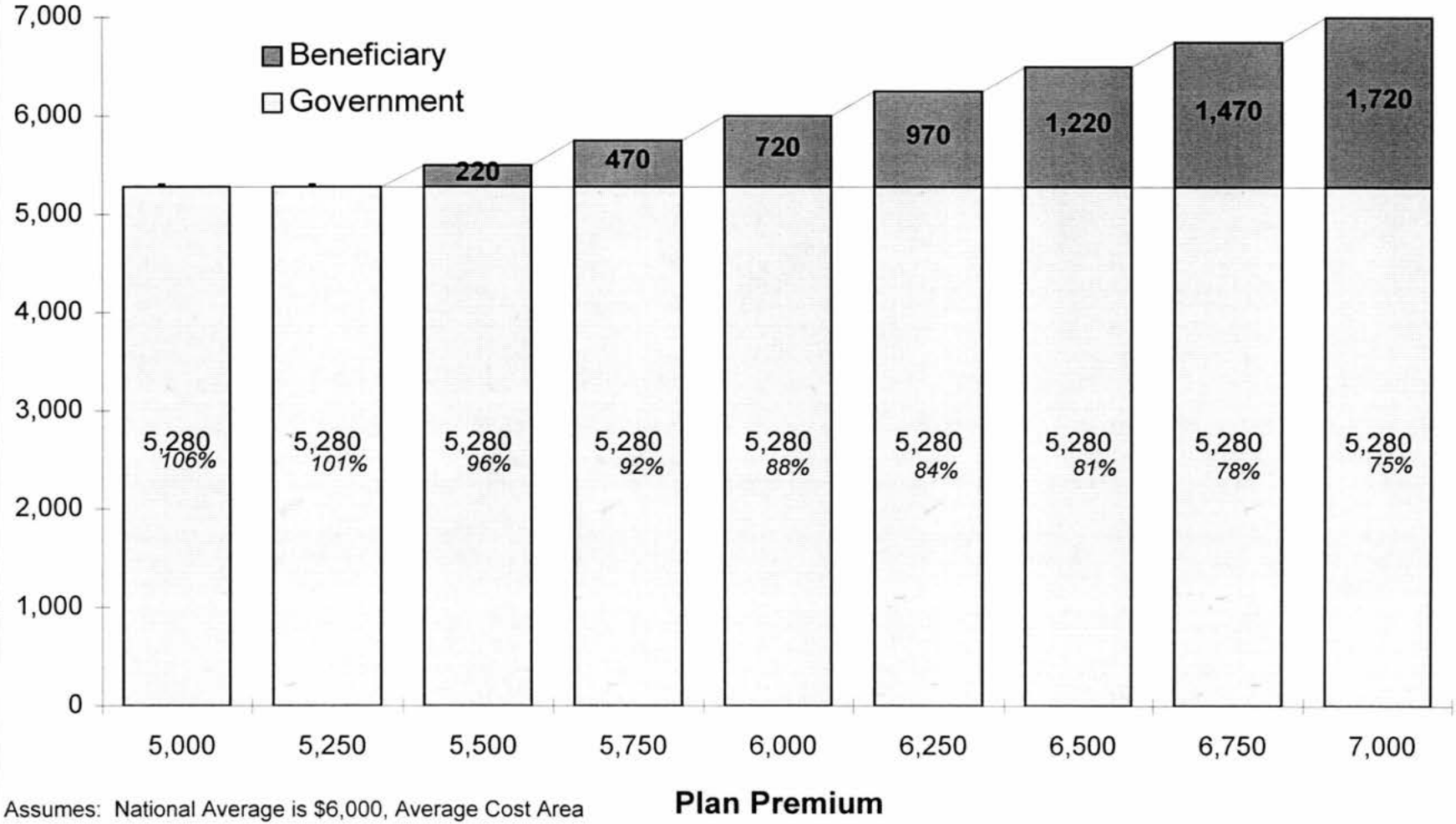
1. NATIONAL - MODEL / Region
2. Full Geographic / Partial - Res
3. Benefits : - Do you Allow Donation to Offset
4. % CAP % CAP/Avg.



Alternative Premium Support: Government Pays Flat Amount



Assumes: National Average is $6,000, Average Cost Area

PREMIUM SUPPORT: FEHBP MODEL

MODEL 1. Full Geographic Adjustment; 88% Up to the National Average

HEALTH PLANS			FEHBP PLAN						
Region	% of Avg	Cost of Basic Benefits	Government Payment				Bene Payment		Total Payment
			Bid: Cost / Geo Adj	100% Geo Adj	Bid x Geo Adj	Adj Bid - Bene $	12% Up to Cap	% Total	
Average:	**100%**	**6,000**	**6,000**	**100%**	**6,000**	**5,280**	**720**	**12%**	**6,000**
Low Cost Area:	**90%**								
+10%		5,940	6,600	90%	5,940	4,620	1,320	22%	5,940
Median		5,400	6,000	90%	5,400	4,680	720	13%	5,400
-10%		4,860	5,400	90%	4,860	4,212	648	13%	4,860
High Cost Area:	**110%**								
+10%		7,260	6,600	110%	7,260	5,940	1,320	18%	7,260
Median		6,600	6,000	110%	6,600	5,880	720	11%	6,600
-10%		5,940	5,400	110%	5,940	5,292	648	11%	5,940

MODEL 2. Full Geographic Adjustment; 88% Of the National Average

HEALTH PLANS			FEHBP PLAN						
Region	% of Avg	Cost of Basic Benefits	Government Payment				Bene Payment		Total Payment
			Bid: Cost / Geo Adj	100% Geo Adj	Bid x Geo Adj	Avg x 88% + Geo Adj	Bid - 88% Avg	% Total	
Average:	**100%**	**6,000**	**6,000**	**100%**	**6,000**	**5,280**	**720**	**12%**	**6,000**
Low Cost Area:	**90%**								
+10%		5,940	6,600	90%	5,940	4,680	1,320	22%	6,000
Median		5,400	6,000	90%	5,400	4,680	720	13%	5,400
-10%		4,860	5,400	90%	4,860	4,680	120	3%	4,800
High Cost Area:	**110%**								
+10%		7,260	6,600	110%	7,260	5,880	1,320	18%	7,200
Median		6,600	6,000	110%	6,600	5,880	720	11%	6,600
-10%		5,940	5,400	110%	5,940	5,880	120	2%	6,000

PREMIUM SUPPORT

CONCEPT OF PREMIUM SUPPORT Combines elements of defined benefit and defined contribution to improve Medicare's efficiency.

- **Guaranteed benefits:** Beneficiaries would be guaranteed a defined set of benefits. Regardless of plan payments, they would be obligated to provide those benefits.

- **Total premium**: Medicare fee-for-service and private managed care plans would set a premium based on how much it costs to provide those services.

- **Government payment**: The government contribution toward that premium would be limited (e.g., a percent of the premium and/or as a flat dollar amount).

- **Beneficiary payment**: Beneficiaries' premium payments would depend on their plan choices. In general, they pay more for a high-cost plan, and less for a low-cost plan.

- **Savings**: Overall Medicare costs would be reduced because beneficiaries would tend to choose lower cost plans, reducing the national average spending and growth over time.

COMMISSION PREMIUM SUPPORT MODEL

- **Beneficiary payment**: This amount depends on the relationship between the plan's premium and the national average premium. (Note: amounts would be geographically adjusted)

  - Below average plans: 12 percent of the premium
  - Above average plans: 12 percent of the national average plus every dollar that the premium is above the national average.

- **Government payment**: 88 percent of the premium up to 88 percent of the national average.

- **Issues**:
  - Benefits: The Commission would allow private plans to include the costs of additional benefits in their premiums. If a plan's premium is below average, Medicare will subsidize 88 percent of the cost of the extra benefits (only in private plans). Today's Medicare's benefits are less generous than 4 out of 5 private plans.

  - No incentive for plans to set premiums below average: A plan that can provide Medicare's benefits below average has two choices for attracting beneficiaries: reducing its premium or adding extra benefits. If it offers extra benefits, the beneficiary not only get the benefits but gets a government subsidy for them (88 percent up to the cap). In contrast, if the plan reduces its premium, the beneficiary does not get every dollar that the premium is below average. This is because government payment will drop to 88 percent of the lower premium. For this reason, plans have strong incentives to offer extra benefits up to the cap rather than reduce their premiums below average to attract beneficiaries. This also means that this model will not reduce Medicare costs.

January 28, 1999

$100M Sought for Child Health Care

A.P. INDEXES: TOP STORIES | NEWS | SPORTS | BUSINESS | TECHNOLOGY | ENTERTAINMENT

Filed at 2:39 a.m. EST

By The Associated Press

WASHINGTON (AP) -- The Clinton administration wants to spend more than $100 million helping children's hospitals and fighting childhood asthma.

Both initiatives will be included in the budget President Clinton submits to Congress next week for the fiscal year starting Oct. 1, said a White House official, speaking on the condition of anonymity.

The $68 million asthma plan, which first lady Hillary Rodham Clinton is announcing this afternoon at the White House, was billed as the ``first-ever comprehensive, administration-wide strategy'' to fight the disease. Most of the money -- $50 million -- would be used for competitive state grants to identify and treat poor children served by Medicaid who have asthma.

Mrs. Clinton also was scheduled to unveil proposed new subsidies for training pediatricians in speech at the National Press Club.

The government now helps pay for training doctors by reimbursing hospitals through the Medicare program for the elderly. But that system is based on the number of Medicare patients a hospital sees, which creates a disadvantage for hospitals that treat mainly children.

Children's hospitals lose money each year, more than other teaching hospitals, partly because of this inequity, the administration contends. The $40 million would come through an existing grant programs and amount to about $9,380 per resident. The average hospital would see $689,000.

The asthma initiative would help schools educate children and parents on how to avoid attacks, support research into environmental hazards and pay for a public information campaign. It would be administered by the Department of Health and Human Services and the Environmental Protection Agency and was developed in part by Vice President Al Gore.

Over the last 15 years, the number of children with asthma has doubled to about 6 million, with an even steeper increase -- about 160 percent -- among children under age 5. More than 100,000 children are hospitalized with the ailment each year.

Black children suffer the most. Their risk of contracting the disease is only slightly higher than it is for other children, but they are more than four times as likely to die from it.

The initiative would provide:

--$8.4 million for schools to teach parents and children the importance of asthma medication and how to identify and avoid materials that trigger attacks. The administration estimates this initiative will reach more than 2 million children.

--$2 million for new research into the role chemicals, pesticides and cigarette smoke play in the onset of asthma. Another $1 million would be used by EPA to monitor air pollution in two communities to examine its relation to asthma.

--$5.2 million for a public information campaign, including posters, flyers and brochures, to reduce children's exposure to tobacco smoke and other asthma triggers.
