214 Massachusetts Avenue N.E.
Washington, D.C. 20002-4999
(202) 546-4400

The Heritage Foundation

F.Y.I.

August 4, 1995

A GUIDE TO MEDICARE REFORM PROPOSALS

By John C. Liu
Policy Analyst

INTRODUCTION

When Congress returns from its August recess, it will begin to consider the future of one of America's most popular entitlement programs—Medicare. Much is at stake for Americans of all ages.

The Medicare program is in dire financial trouble. According to the 1995 report of the Medicare Trustees, a seven-member federal board that includes three Clinton Administration Cabinet members and two other senior Administration officials, the Hospital Insurance (HI) Trust Fund is projected to be insolvent by the year 2002. The need and urgency for change is succinctly stated: "The Trustees believe that prompt, effective, and decisive action is necessary."[1]

To avoid the collapse of the program, Congress has only two choices:

Choice #1: Do not change significantly the way Medicare is run by the government, and assure future benefits by raising new revenues through higher payroll taxes and other taxes or by diverting money from other programs. This means Medicare survives only by draining money from the rest of the budget or by sharply raising payroll taxes.

Choice #2: Fundamentally change the way Medicare is run so that benefits are delivered more efficiently, thereby avoiding future tax increases or a diversion of money from other programs. This approach would aim to slow the rate at which costs are anticipated to grow.

Several proposals have been put forward in recent months, from outside Congress, to address the problems of Medicare. During the August recess, Members and the public can be expected to evaluate such proposals as they consider what actions should be taken regarding Medicare when Congress meets to finalize action on the budget.

To assist this evaluation, this *F.Y.I.* summarizes several of the leading reform proposals. These include plans advanced by the Clinton Administration, by "think tanks" (the Brookings Institution, Heritage Foundation, and National Center for Policy Analysis), by organizations repre-

1 *1995 Annual Report of the Board of Trustees of the Federal Hospital Insurance Trust Fund*, April 3, 1995, p.28.

Nothing written here is to be construed as necessarily reflecting the views of The Heritage Foundation or as an attempt to aid or hinder the passage of any bill before Congress.

senting the elderly (the National Committee to Preserve Social Security and Medicare and United Seniors Association), and by major organizations representing health care providers (the American Hospital Association, American Medical Association, Federation of American Health Systems, Group Health Association of America, and Healthcare Leadership Council).

This *F.Y.I.* is intended only to summarize these proposals, not to evaluate them; as far as possible, documents are quoted verbatim or paraphrased. Documents used in the summaries may be obtained from the issuing organizations.

While the proposals vary widely in detail, many share common themes. Only two (the Clinton Administration and the National Committee to Preserve Social Security and Medicare) can be described as leaving the current structure virtually unchanged. The others tend to emphasize three broad reform themes:

1) An option to pick private plans. Virtually all the reform plans would allow recipients to pick private plans as an alternative to the traditional Medicare program. Generally this is seen as a way to improve the quality of care and, by introducing a much greater degree of consumer choice within a competitive market, a way to reduce the rate of increase in Medicare spending. Some proposals would permit beneficiaries to choose plans with benefits that differ from the current Medicare package (Heritage, American Medical Association), while others would require the private plans to contain at least the standard Medicare benefits (Brookings, NCPA). Virtually all would retain the traditional Medicare program as an option.

2) A defined contribution. Virtually all the reform plans would begin to shift Medicare away from an open-ended program which pays for a set of benefits (a defined benefit) and toward a program which makes a financial contribution towards the health costs of a Medicare beneficiary. This is accomplished in several ways, such as a budgeted voucher payable to the plan chosen by the beneficiary (American Medical Association, Heritage) or a payment linked to the growth in general health care costs (Brookings, NCPA). Like the general option to pick private insurance in place of traditional Medicare, moving to a defined contribution system is intended to change fundamentally the incentives in the program, encouraging beneficiaries to seek better value for money.

3) The FEHBP as a model for reform. While virtually all the reform plans propose some form of new or revised administrative structure to organize and monitor a Medicare market of competing private health plans, several proposals (American Medical Association, Federation of American Health Systems, Heritage) adopt as an administrative model the program currently serving federal workers, retirees, and dependents. The Federal Employees Health Benefits Program (FEHBP) organizes a market of almost 400 private plans competing for the business of over nine million Americans.[2]

---

2 Robert E. Moffit, "Consumer Choice in Health: Learning from the Federal Employees Health Benefits Program," Heritage Foundation *Backgrounder* No. 878, February 6, 1992.

THE CLINTON ADMINISTRATION

The following is a summary of the Medicare proposals outlined by the Clinton Administration on June 13, 1995, when the Administration unveiled a second budget blueprint. Specific details on the proposal have not yet been made available.

The President's plan to restore the fiscal integrity of the Medicare trust fund aims to reduce the growth in spending in Medicare Part A by $79 billion over seven years to ensure the solvency of the Medicare HI Trust Fund to 2005. These savings are based on the Office of Management and Budget's projection of Medicare spending under current law. (The savings to be achieved would be higher if the Congressional Budget Office baseline is used).

The White House plan aims to achieve such savings by reducing the growth of payments to providers, not by raising beneficiary costs. In fact, the Administration's proposal reduces the same beneficiary costs by eliminating the copayment for mammograms. The White House notes that only 14 percent of eligible beneficiaries without supplemental insurance schedule mammograms. One factor, say officials, is the required 20 percent copayment. To remove financial barriers to women seeking preventive mammograms, the President's plan waives the Medicare copayment.

The President's plan would expand managed care options for retirees to include variants such as preferred provider organizations (PPOs) and point-of-service (POS) plans. The plan also seeks to improve Medicare reimbursement of managed care plans, including a competitive bidding demonstration proposal.

Finally, the Clinton proposal aims to combat fraud and abuse, in part through an "Operation Restore Trust," a five-state demonstration project targeting fraud and abuse in the home health care, nursing home, and durable medical equipment industries. The President's budget proposal increases funding for these fraud and abuse activities.

For further information, contact:
The White House
Office of Legislative Affairs
1600 Pennsylvania Ave.
Washington, D.C. 20500
(202) 456-6620

RESEARCH ORGANIZATIONS

AARON AND REISCHAUER (OF THE BROOKINGS INSTITUTION)

The following summarizes a proposal put forward on July 20, 1995, by Henry J. Aaron and Robert D. Reischauer of the Brookings Institution.[3] *Reischauer until recently was Director of the Congressional Budget Office.*

Like other policymakers, Aaron and Reischauer have defined several goals and principles around which Medicare reform should revolve.

First, Medicare reform should encompass the full package of benefits most Medicare beneficiaries use.

Second, "a reformed Medicare program should not result in the provision of health care to the elderly and disabled of a quality materially different from that available to the general population; nor should the delivery system for the elderly and disabled be segregated from that of the rest of the population (other than for definable services where medical reasons justify separate delivery, as with geriatric care)."

Third, "Medicare should create incentives for beneficiaries to seek care from efficient plans and should encourage physicians and hospitals to provide care of given quality at lowest possible costs."

Fourth, "Medicare beneficiaries should have a degree of choice among health plans similar to that enjoyed by the rest of the population."

Aaron and Reischauer believe the current Medicare program should be converted from a defined benefits program (service reimbursement system) into a form of defined contribution program (premium support system). Instead of paying for all services on a predetermined list, Medicare would pay a defined and set sum toward the purchase of an insurance policy that provides a defined set of services. "As with private insurance for the working population, plans could reimburse any provider the patient chooses on a fee-for-service basis (the current method Medicare uses for most beneficiaries), contract with a preferred provider organization, or operate through a health maintenance organization." These plans could manage care in any of the ways they currently practice or adjust as necessary for changes that may occur in the future. In short, every "Medicare beneficiary would receive a pre-determined, geographically variable amount that would be applied toward the purchase of a health plan providing defined services."

Health plans participating in the new program would be required to offer a defined set of services. While the new Medicare plan would not use the current Medicare benefits package as a model, it would add prescription drug and catastrophic coverage. Aaron and Reischauer believe that a standard benefits package is necessary because it will enable enrollees to compare the cost and quality of the various plans while reducing the risk of instability in the insurance market from plans altering benefits in an effort to attract healthier enrollees.

Marketing. Health plans choosing to participate in the new plan (commercial insurance companies, Blue Cross/Blue Shield plans, HMOs, PPOs, non-managed care networks) would be invited to submit bids on the standard benefit package for the "average" Medicare enrollee within a particular marketing area. The federal Medicare contribution to help the enrollee defray the cost of a plan in

3 Henry J. Aaron and Robert D. Reischauer, "Summary, Medicare, Where to From Here," July 20, 1995.

each market area would be the same regardless of which plan the Medicare enrollee chose. To ensure that Medicare enrollees are well-informed of their various options, local marketing organizations would be established to handle the sale of insurance and act as consumer advocates. As in the FEHBP, enrollees would choose a health plan for the upcoming year on an annual enrollment basis.

Health plans would receive risk-adjusted payments from Medicare based on age, gender, disability status, and other health indicators.

Premium Contribution. The initial federal payment would be set at 95 percent of the cost of the current Medicare package in the enrollee's market area. The size of the payment would be adjusted to exclude direct medical education, indirect medical education, and disproportionate share payments. It is projected that during a phase-in period of five to ten years, the federal payment would grow more slowly than projected budget baseline costs. Later, the federal Medicare payment would grow at the same rate as per capita spending on health care for the non-elderly population. Aaron and Reischauer contend that while this formula is somewhat rigid and will require periodic adjustments, it is more than likely that such an approach will yield appreciable savings over the projected baselines. The authors believe that as the competitive marketplace develops and enrollees become more comfortable with choosing their own health plans, the difference between the federal payment and the cost of insurance could be rebated to participants as non-taxable income or shared between the government and participants.

The authors believe that even under the most optimistic scenario, it will take several years for the necessary institutional infrastructure to develop and become operational. The authors believe that the current Medicare system should be run concurrently with the new choice-oriented proposal. But the new system would be mandatory for everyone who turns 65 and becomes eligible for Medicare at a date to be determined. Current Medicare enrollees would have the option of staying in the traditional program or moving into the new system.

Echoing the sentiments of the public trustees of the Medicare program, and like the authors of most other plans, Aaron and Reischauer call for the consolidation of Parts A and B.

For further information, contact:
The Brookings Institution
1775 Massachusetts Ave, N.W.
Washington, D.C. 20036
(202) 797-6000

THE HERITAGE FOUNDATION

The following summarizes Heritage Foundation Backgrounder *No. 1038, "What to Do About Medicare," by Stuart M. Butler, Robert E. Moffit, and John C. Liu, dated June 26, 1995.*

To control costs while improving value and choices for beneficiaries, The Heritage Foundation advocates a conversion of the Medicare program into a system in which the government provides beneficiaries with a defined contribution that may be used either to purchase a Medicare-approved private health plan or to remain within the traditional health care program. This system would be, in effect, a modified version of the Federal Employees Health Benefits Program (FEHBP), which currently makes 400 competing private plans available to nine million active and retired federal employees and their family members.

The Heritage Foundation envisions a new Medicare system structured much like the successful FEHBP, but with modifications that refine the government contribution to make the new program even less susceptible to adverse selection effects that the FEHBP is and provide beneficiaries with better information on which to make choices. The new program would have four basic elements:

First, elderly and disabled Americans would have an entitlement not to a defined set of benefits, but to a voucher worth an amount based on a number of factors. The total federal expenditure for the voucher system would be limited to a program budget, with the voucher amount adjusted each year according to the budget. To achieve the target for Medicare in the congressional budget resolution, the Heritage Plan proposes that expenditures for the voucher be permitted to grow 7 percent in the year of enactment and 5.6 percent each year thereafter.

Second, the base for the voucher amount would be budgeted Medicare expenditures (combined net expenditures for Parts A and B) divided by the eligible population. This base would be adjusted up or down according to three basic categories:

❶ Primary risk factors, including age, gender, reason for eligibility (age or disability), institutional status, and End-Stage Renal Dialysis (ESRD) status.

❷ An income adjustment applied to one-third of the voucher, to be the equivalent of means-testing today's Part B premium.

❸ A local market variance, to reflect the weighted average enrollee cost of a "basket" of typical plans in any area. This would permit adjustments to reflect the cost of approved plans available in the area. This basket would consist of "typical" plans, such as the Medicare Standard Plan (see below), a catastrophic /MSA plan, a Blue Cross standard plan, and a comprehensive HMO plan. This is a refinement of the "big six" formula used by the Office of Personnel Management to set the government contribution to the FEHBP. Since the plans would have to submit detailed information on their prices and benefits before the annual open season, this adjustment would reflect the actual future market the beneficiary would encounter in the following year.

Third, in order to be permitted to sell insurance to Medicare participants, health plans would have to meet certain threshold requirements. Beyond these, they could offer varieties of benefits and delivery systems. There would be no restriction on the number of plans. To be Medicare approved, a plan must:

✓ Have a license to issue health insurance in the state or obtain approval from the Department of Health and Human Services (HHS).

✓ Provide services in a service area acceptable to HHS.

✓ Meet minimum solvency requirements.

✓ Include a core set of basic coverage determined by legislation. The basic package would have to cover "medically necessary" acute medical services, including physician services; inpatient, outpatient, and emergency hospital services; and inpatient prescription drugs, with a catastrophic stop-loss amount for these services. A plan thus could offer a much leaner package than today's Medicare program (although it would have to provide catastrophic protection, unlike Medicare today), but it could offer a range of services beyond the base coverage. For example, some plans might offer dental benefits, or drug coverage, or an MSA. States would be preempted from mandating additional benefits for plans serving the Medicare population. The Medicare Standard Plan (see below) initially would provide the services available today under Medicare Parts A and B. This Standard Plan would not be required to add catastrophic protection unless its board chose to do so or Congress required such a change in benefits.

- ✓ File with HHS a standardized statement of benefits (exclusions, copayments); a table of rates for the same actuarial categories used to determine Medicare benefits (age, institutional status); and consumer information as determined by a consumer advisory board. This information might include the results of enrollee satisfaction questionnaires, turnover rates, average out-of-pocket costs paid in the previous year by enrollees for the treatment of certain illnesses, and perhaps ratings by certain organizations. This price, benefit, and consumer information also would be available to any Medicare beneficiary upon request.
- ✓ Accept and continue coverage for any Medicare beneficiary applying during an annual "open season," or for any newly eligible beneficiaries, unless the plan receives a waiver from HHS because of capacity concerns. This requirement would apply to plans marketed by affinity organizations, such as churches, unions, or elderly groups, not merely to plans marketed by insurers or provider organizations.

Fourth, the government's role in the new system would be kept to a minimum. Under the new program, HHS no longer would be allowed to regulate the prices charged by providers; instead it would take on "umpire" functions more like those being carried out by OPM in the FEHBP system. The government, however, would have three important roles:

1. The government would establish a federal corporation, governed by an appointed board, to run a Medicare Standard Plan similar to the current Medicare program. The Standard Plan would be available in all markets, and the board would set premium prices to meet long-term solvency requirements. Subject to congressional approval, the board could adjust benefits, out-of-pocket costs, and payment levels in the Standard Plan.
2. As an alternative, the Standard Plan could be the traditional Medicare program, without a set premium and funded directly rather than by vouchers. While this alternative might have political advantages, however, the lack of a premium would make it more difficult for beneficiaries to compare the Standard Plan with competing private plans.
3. HCFA would calculate the voucher amount for each beneficiary, setting that amount after the plans had filed their price and benefit information for the following year.
4. HHS would conduct a Medicare open season, much as OPM does for the FEHBP. Before open season, Medicare beneficiaries would receive an information kit from HHS, including the amount of their voucher and standardized information on prices, benefits, and consumer satisfaction for Medicare-approved plans in their area, including the Standard Plan. Beneficiaries also would receive a selection form on which to indicate their choice. Once the selection had been made, HCFA would send the beneficiary's voucher to the chosen plan. The beneficiary would be responsible for any difference between the voucher and the premium costs, but could elect to have the government pay that difference and reduce his or her Social Security check (similar to the Medicare Part B option today). If the voucher amount exceeded the plan's premium, the difference would be deposited by HCFA into a Medical Savings Account of the beneficiary's choice. Disbursements from MSA accounts could be used only for medical expenditures eligible for the Internal Revenue Service Schedule A tax deduction.

Under The Heritage Foundation proposal, Medicare would operate much as the FEHBP serves federal workers and retirees. Medicare beneficiaries would be able to pick a private plan which included the services they wanted (beyond the core package), delivered in the way they wanted and, if they wished, through an organization with which they were affiliated (as many FEHBP enrollees do). Or they could decide to apply their voucher to the premium of the Medicare Standard Plan. Because beneficiaries would receive a voucher for a specific amount (paid directly to the plan of their