Will Medicare reforms increase managed care enrollment?

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Will Medicare Reforms Increase Managed Care Enrollment?

"It depends," says this noted health economist. Indeed, fears of reforms herding seniors into managed care plans may be unfounded.

BY MARK V. PAULY

ALTHOUGH THERE APPEARS to be general agreement that steps eventually will have to be taken to reduce the growth of government spending on Medicare, there is considerable disagreement about the form and timing of those steps. One popular strategy is the conversion of Medicare from the present system, in which payments for alternatives to the traditional Medicare fee-for-service coverage ("classic Medicare") are tied to the cost incurred under that coverage, to a system that "breaks the link" between the level or rate of growth in spending on classic Medicare and what is paid toward the purchase of alternative forms of insurance. Under this strategy payments both for alternative forms of insurance and for classic Medicare would be linked to a politically chosen target, beginning at current levels of spending but growing at a rate specified by law, independent of what is happening to medical prices, health care use, or technology.. To reduce spending, the target for such a “fixed-payment” plan would be set at a lower level of spending than would have prevailed under current law. Such a strategy was part of the Republican Medicare reform bills that were introduced in the House and Senate in 1995. Such an approach also has been endorsed by Henry Aaron and Robert Reischauer, who proposed an “expert commission” to set the target, and by Sen. Bill Frist (R-TN).

Much of the discussion surrounding these changes assumes that managed care—or at least forms of insurance that differ from the government-managed, classic Medicare coverage—ought to be increasingly represented in the system of health care coverage for the elderly. The intent of the reforms is to make it easier for seniors to

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choose alternatives, and it is expected that they will do so. Indeed, in its lead sentence in a story on House passage of the Republican Medicare reform bill, The New York Times assured us that the law would “encourage the elderly to turn to private managed care organizations from the traditional government plan that has served them since 1965.” But in another front-page article a consultant expressed skepticism about this effect. Which will it be? Compared with what would happen if Medicare were left unchanged, will implementation of the new policy philosophy encourage or discourage managed care?

I argue here that the correct answer is, “It depends.” Unfortunately for Medicare managed care firms, much of what the answer depends on is out of their control. Fundamentally, under such reform the fortunes of Medicare managed care plans will depend to a large extent on two external influences: how the Health Care Financing Administration (HCFA) runs the classic Medicare program in the future, and how private insurers set provider payment rates for services rendered to their enrollees who are under age sixty-five. Medicare managed care firms might be able to exert some control over their own destinies, but doing so will require them to meet a serious and possibly unanswerable challenge. It may well be that the result of the Medicare reforms will be less, rather than more, use of managed care by the elderly than would have occurred in the absence of reform.

I illustrate this argument by using a numerical example based on House Republicans’ “Medicare Choice” plan, to indicate the general conditions under which adoption of a fixed-payment plan can take place. However, the argument applies to any plan that “breaks the link” to meet a budgetary target but requires that classic Medicare be available, as it is now, for only the Part B premium. I then outline the general considerations that will help us to forecast the changes that will actually occur.

**A Numerical Example**

Under current Medicare rules, beneficiaries can choose managed care as an alternative to conventional coverage. Roughly speaking, a beneficiary can direct the government to buy a conventional insurance policy from HCFA or to use the same amount of money to make payments toward the premium of an approved alternative plan. I call the alternative plan a health maintenance organization (HMO), but the analysis applies as well to other types of permitted plans that cost less than conventional Medicare. The amount to be paid to the managed care plan is supposed to be 5 percent less than HCFA’s estimate of the cost of its plan for that beneficiary; the 5 percent
differential is partly to account for costs (largely enrollment costs) that HCFA incurs even though the beneficiary chooses an HMO and partly to ensure that if a beneficiary rejects the government insurance plan, at least the government saves some money from the deal. However, some research strongly suggests that HCFA’s failure to estimate Medicare’s cost accurately for those beneficiaries who switch means that this arrangement actually increases total Medicare payments by a small amount per (healthy) beneficiary who switches to an HMO. For the purposes of my example, however, I assume that there is no such risk sorting and that the 5 percent differential is accounted for entirely by administrative costs, so that the amount received for medical care, either by classic Medicare or by an HMO, is the same.

The per person Medicare payment was estimated to be about $4,800 in 1995. For purposes of my numerical example, I assume that the average HMO is able to provide care at a lower cost than classic Medicare can. I assume that the current HMO cost for covered services (excluding cost sharing and including profit as a return to equity capital) is 12.5 percent less than the 1995 per person Medicare payment, or $4,200. (This is approximately the estimate of cost reduction cited in empirical studies.) Who gets to keep the $600 difference between what Medicare pays and what the care costs? I assume that both competition among HMOs and enforcement of Medicare’s somewhat creaky rules on HMO pricing (embodied in the rules requiring plans to charge an “adjusted community rate”) cause all of the savings to be returned to beneficiaries in the form of a reduction in the HMO premium for coverage of Medicare’s cost sharing. Compared with the cost of classic Medicare plus Medigap insurance that covers cost sharing only, we can say that the average HMO in 1995 offered a “rebate” against premiums (for supplemental coverage) of $600 per year, or $50 per month.

**Forecast for 2002.** I choose the year 2002 to describe what the future will be like. If no changes are made in Medicare payment policy, HCFA estimates that per beneficiary cost under classic Medicare will be about 70 percent higher in 2002 than in 1995, or approximately $8,000 per beneficiary. To illustrate a plausible reduction, I use the proposal in the House and Senate bills to pay about $6,700 per beneficiary in 2002 for classic Medicare, and I assume that HCFA will provide no more than that amount for those choosing alternative plans.

What should we forecast HMO costs to be in 2002? There is virtually unanimous agreement that HMOs are less costly than conventional insurance, and the 12.5 percent differential assumed above
is in line with many estimates. However, one of the longest-running controversies in health care finance is whether HMOs are or will be able to hold the future rate of growth in their costs below that which would have prevailed under fee-for-service payment. If HMO costs in the example were to grow at the same rate as classic Medicare costs, beginning at $4,200, they would rise to approximately $7,000 in 2002—more than what Medicare would pay under the proposed reduction above.

I assume, however, that managed care plans can control cost growth and would in any case have met the spending growth target envisioned in the law. That is, I assume that plans are able to hold down growth in their costs just enough so that their costs in 2002 equal the amount targeted in the proposed law ($6,700). For the present, I also assume that managed care plans would have achieved this level of cost and efficiency in any case, regardless of the level of payment Medicare had set. That is, I assume (as advocates of managed care claim) that competition and superior incentive and organizational structures mean that these plans will be able to keep cost growth to this level, and that competition among plans will cause premiums to reflect the costs they incur and be independent of the HCFA payment rate. In this scenario, managed care plans are assumed to be “ideally efficient,” regardless of the amount of revenue they collect.

What about classic Medicare? With no changes, Medicare’s payment on behalf of beneficiaries who choose HMOs would be $8,000. The HMO cost would be $6,700, so the HMO rebate would rise to $1,300 per year. In contrast, if the proposed limits are implemented, under which Medicare payment could be no higher than $6,700 by 2002, the Medicare payment would equal the HMO cost, so that the rebate would fall from $600 in 1995 to zero in 2002.

These calculations imply that after reform the premium in 2002 for either classic Medicare or competitive HMOs will be the same. Beneficiaries will have to pay the approximately $90 per month Part B premium regardless of which plan they choose. The key point, however, is that the total premium paid will become uniform across plans, and HMOs will lose their price advantage.

**Value of classic Medicare.** Will more Medicare beneficiaries choose managed care, rather than classic Medicare, when managed care’s premium is $1,300 less than that for classic Medicare (without reform), or when its premium is the same (with reform)? The answer depends on what value we assume people place on classic Medicare when it spends $8,000 per person (without reform), compared with the value they attach to it when it spends only $6,700 per person (if the hypothesized reforms are implemented). (That is, it is not only
“Cuts will negatively affect both elders’ pocketbooks and the attractiveness of managed care.”

the nominal difference in cost, but the net value to the purchaser, that matters.) If classic Medicare has about the same value to beneficiaries under reform as it would have had without reform, the conclusion is obvious: Fewer people will switch to managed care under reform (because there is no lower premium associated with doing so) than would have switched without reform (when they would have received a $1,300 per year HMO rebate). Although the reforms force classic Medicare to make do with less, they also cut the payments that can be made to managed care plans; the latter cuts will negatively affect both elders’ pocketbooks and the attractiveness of managed care.

How could it be possible that classic Medicare could have the same or nearly the same value to beneficiaries when it spends $6,700 as when it spends $8,000? The main vehicle for spending reductions in classic Medicare in current proposals is a reduction in payment rates per unit of service under a fee-for-service system. However, the value that beneficiaries attach to classic Medicare does not depend on what providers get; it depends on the quantity and quality of and access to services that beneficiaries receive. Is it possible that providers simply would accept lower payment rates and still be willing and able to provide the same services? This phenomenon seems to have occurred for physician services in Medicare Part B. In recent years payments to doctors and other health professionals for Medicare services have been lower than providers’ private-sector prices, and yet there is virtually no evidence of shortages or difficulties with access thus far. This suggests that, at least for a while, Medicare could reduce its payment rates further without diminishing the “quality” of its insurance product (in terms of access). For hospital inpatient care, hospitals have accommodated politically determined limits on the growth of Part A payments by shortening length-of-stay and perhaps by cutting back on raises paid to employees, as well as by reducing total employment. Some hospitals also claim that they can shift costs to offset government underpayment, although the theoretical and empirical evidence for this possibility is not strong.

Compared with current levels, the number of Medicare beneficiaries choosing managed care almost surely will increase without reform—in that scenario, the rebate to switch to managed care rises to $1,300, and the trend toward managed care is already positive at
the lower existing rebate of $600. However, under what circumstances would this same anticipated high rate of growth in managed care enrollment continue even after reform?

If we assume that the reduction in value associated with the lower level of spending is proportionate for every beneficiary—that is, if each beneficiary's value for classic Medicare falls by the same percentage when spending is cut—then we can get a definitive answer. Consider the person who would have been indifferent about managed care versus classic Medicare when the services provided under classic Medicare cost $8,000. We can say that this person “on the margin” attached a value to managed care that is equal to the value attached to classic Medicare ($8,000), minus the $1,300 rebate. This person will still be indifferent after the proposed reforms are implemented and the rebate falls to zero if his or her value for classic Medicare falls by just $1,300. That is, the reforms will make no difference if the value of the now less expensive classic Medicare declines by an amount equal to its decline in cost. Those who preferred classic Medicare will still do so because the additional value they attached to it will still be positive.13

When will beneficiaries’ enrollment in managed care rise more with Medicare reform than without it? That is, when will The New York Times’s expectation be fulfilled? For this to happen, classic Medicare at a cost of $6,700 must be regarded by beneficiaries who would have chosen it as much inferior to classic Medicare at a cost of $8,000. The reduction in payment rates for classic Medicare envisioned under the law must reduce perceived access, quality, or satisfaction, and it must reduce the value for the beneficiary just on the margin by more than the $1,300 cut in spending. That is, reform will encourage managed care if cutting spending for classic Medicare reduces its value by more than the amount of the spending cut.

What Is Likely?

This numerical example demonstrates that the impact of any new method of determining Medicare payment for managed care enrollees that “breaks the link” and reduces payments per beneficiary depends crucially on how (and how well) HCFA and its advisory committees (the Prospective Payment Assessment Commission [ProPAC] and the Physician Payment Review Commission [PPRC]) manage the process by which spending growth in classic Medicare is to be reduced. The value of the budget-constrained classic Medicare to beneficiaries also will depend on the response of providers to levels of payment that grow more slowly than otherwise would have been the case. To gain some insight into what is likely to happen, it
COMMENTARY

will be helpful to consider in more detail what that response might be.

**Volume of services.** For payments to health professionals under Medicare Part B, one of the key issues is the response of providers to lower Medicare reimbursement and (because of the limit on balance billing to 115 percent of the Medicare allowed charge) lower prices. It is unlikely that most of these health professionals will withdraw medical services by leaving the practice of medicine. Even if the current “long-run” return to doctors and other providers is competitive, in the short run health professionals may have few opportunities; thus, lower prices for their services may indeed eat into their net incomes but not cause them to reduce supply.

To lower the volume of services to Medicare beneficiaries appreciably, providers must render services to persons covered by other insurance whose reimbursement or price levels are now relatively more lucrative. (Providers also might decide to work fewer hours or weeks, but the work effort of physicians appears to be relatively unresponsive in the short run.) If Medicare cuts its prices, we would expect health professionals to be willing to accept somewhat lower prices from other insurers—actually a kind of negative cost shifting—as long as those prices stay above Medicare prices.14

It appears that the private-sector prices most physicians now charge, even to HMOs, are well above Medicare’s current fee schedule. What is unclear is what additional opportunities exist to sell more services in this private market. After all, even if private patients are more lucrative, if no more of them are seeking services, physicians still may be willing to supply services to Medicare beneficiaries. Opportunities for additional private patient volume at high prices may be limited even now, as many managed care insurers (and some indemnity insurers with market power) pay discounted fees and limit the quantity of services provided. Even more importantly, it is virtually certain that the downward pressure on private fees will continue, both from managed care firms and from purchasing groups. No one can know for sure, but my guess is that while some doctors may withdraw from Medicare, especially those for whom it makes up a small share of their practice, the supply of physician and other professional services under Part B would not be seriously reduced by (relatively) lower prices for fee-for-service physicians under classic Medicare over a considerable range.

**New technology.** Another aspect of provider behavior that may be affected is the types of services offered, New technology has accounted for a majority of the growth in real health care spending for persons of all ages, economists believe. It seems likely that
stronger limits on future Medicare spending may reduce access to such technologies. In response, new technologies that require less provider time and (especially) less use of physicians' office visits might be introduced. But, in general, if there is to be a decline in value of classic Medicare compared with that of managed care plans, it will come from a slowing in the rate at which beneficial but costly new technology is added. The key challenge for Medicare managed care plans is what they will do about new technology. If they can manage it more cost effectively or market it more judiciously than providers operating under classic Medicare can, Medicare managed care plans may yet increase their market share.

For the hospital and related services covered under Part A, many of the same qualitative considerations apply. Here as well (perhaps even to a greater extent) management of technology will be key. Hospitals probably will have less scope to reduce the incomes of their employees, if only because their workers have more competitive alternative jobs than physicians have.

- Efficiency in cutting spending. The key insight concerning the share of managed care in the Medicare market concerns the relative efficiency of managed care compared with that of classic Medicare in dealing with reductions in the rate of spending growth. Whichever system is able to make those cuts in the least unsatisfactory, most graceful, and most humane fashion, will succeed. Ironically, if managed care already has removed most of the "fat" from its operations, it may be less well positioned to slim down painlessly than classic Medicare is. The challenge for classic Medicare is two-fold. It must be effective in throwing its weight (buying power) around, but it must stay light on its feet and avoid fee reductions that lead to declines in access to or quality of care. If reductions in payments for Medicare coverage should cause Medicare managed care plans to successfully redouble their efforts to find greater efficiencies, their fortunes may yet be as optimistic as The New York Times envisions. But if they already are ideally efficient, they may have a more difficult time.

Conclusion

Why might the proposed Medicare budgetary limits hurt HMOs? Such limits require Medicare to at least try to further implement some of the same things that "first-generation" managed care has already implemented—provider discounts or price reductions. In effect, the proposed reforms would provide the managerial determination to get tougher with providers that Medicare is otherwise expected to lack. Indeed, one of the reasons that the market share of classic Medicare may be higher under the Republican proposal dis-
"The reforms might well be the last hope for preserving some presence of fee-for-service medicine in the United States."

cussed here than under a competitive bidding model is precisely because the proposal requires Medicare to contain its costs by lowering payments per beneficiary. In contrast, simulations that have assumed that classic Medicare’s costs and premiums will continue to rise at the higher rate its actuaries have forecast, no matter what, correctly predict a much lower market share for classic Medicare.16

Of course, if Medicare cuts what it pays doctors, and other insurers (whether HMOs or other private insurers) do not make similar cuts, then caring for patients under the classic Medicare program would become less attractive. The result could be the transformation of Medicare into a de facto preferred provider organization (PPO), with the providers “preferring” the insurer rather than the more conventional other way around. However, such reductions in access to care may not appear, even with the more dramatic spending reductions that are embodied in the proposal, precisely because other insurers also may reduce the fees they pay, or worsen the conditions of work.

The primary social goal of reforming Medicare presumably is not to encourage business for managed care plans, or, when all is said and done, to preserve the classic Medicare program. Rather, the primary objective ought to be to encourage seniors to choose a level of care that is most valuable, given its cost and the financial burden taxpayers are willing to bear. This analysis shows, however, that far from reforms “herding seniors into managed care,” quite the opposite result could occur. The irony is that the proposed budget-cutting Medicare reforms might well be the last hope for preserving some presence of fee-for-service medicine in the United States,
NOTES


4. This means that my analysis is not strictly applicable to proposals that would allow or require additional premiums for classic Medicare. Such proposals have been made by the Jackson Hole Group and by the Progressive Policy Institute.


6. The actual process for setting the relative payment rates in the final House plan is complex, and appears to set payments for alternatives to classic Medicare at per beneficiary rates that will be less than what classic Medicare will receive. Such a difference in payments obviously increases the likelihood that alternative enrollment will be low.


9. While it is plausible, and consistent with what HMOs say about themselves, to assume that HMO costs for a given benefit package will grow at the same (minimum and efficient) rate with or without reform is not the only assumption one could make. One could assume that HMOs “shadow cost” as well as shadow price, targeting their costs to be close to Medicare's (even though such behavior would be neither efficient nor profit maximizing).


11. That is, even though Medicare already pays less per unit than private payers do, it has much larger market power (monopsony), which it could use further.


13. Suppose people are ordered by the value they attach to classic Medicare. Any across-the-board reduction in value that left this preference ordering unchanged would have the same effect on classic Medicare's market share.

