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The Market Comes To Medicare: Adding Choice And Protections

Suggestions for Medicare to help its beneficiaries navigate the maze of managed care.

by Marion Ein Lewin and Stanley B. Jones

When the new Congress convenes after the November 1996 elections, strategies to restructure the thirty-one-year-old Medicare program will again be a priority legislative item, compelled by concerns about the future funding of the program, the demographic changes looming on the horizon, and the ongoing problem of rising health care costs, particularly in the public sector. Debate about reengineering the popular Medicare program will likely focus on the pros and cons of expanding beneficiaries' health plan choices, with an emphasis on managed care.

As efforts in both the public and private sectors move ahead to shift Medicare beneficiaries into managed care plans, many experts and patient advocates are concerned about whether the necessary information and consumer protections are in place to enable this population to select an appropriate health plan and to ensure that this group continues to have access to high-quality care. Unlike many employed persons, who have the help of their employers in screening and evaluating their health plan choices, most Medicare beneficiaries must rely on their own information and judgment. The potentially daunting scope and speed of the transition by elderly Americans into what for most beneficiaries remain uncharted waters make the need for high-quality, trustworthy information and accountability particularly critical.

Medicare beneficiaries have had relatively little exposure to diverse managed care models. Despite recent growth, enrollment of the Medicare population in managed care programs lags behind private-sector enrollment in such programs: About 10 percent of all Medicare beneficiaries are enrolled in managed care, compared with 70 percent of the population under age sixty-five.\(^1\) Enrollment in Medicare risk programs more than doubled between 1987 and 1995 and grew by 30 percent in 1995.\(^2\) To continue to fuel this trend, the Health Care Financing Administration’s (HCFA’s) Medicare Choices demonstration is allowing non-health maintenance organization (HMO) managed care plans, such as preferred provider organizations (PPOs) and point-of-service plans, to enroll Medicare patients for the first time, using a variety of payment mechanisms. These less restrictive managed care products constituted the fastest-growing segment of the industry in 1994.\(^3\) Another factor contributing to this growth trend is changes in employment-based health care coverage for retirees. The rising cost of retiree coverage is forcing a growing number of firms to drop or redefine this benefit in ways that make HMO enrollment more attractive to the elderly, given that a growing number of such plans offer more extensive coverage without deductibles or coinsurance.

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An IOM Initiative

These developments motivated the Institute of Medicine (IOM) to appoint a committee and undertake a study that could provide guidance on how to ensure public accountability, promote prudent purchasing, and put into place the necessary protections to help Medicare beneficiaries make informed, responsible choices. The committee’s task was not to judge the value of Medicare managed care as a vehicle for providing more appropriate care; rather, the panel was to operate under the assumption that managed care plans will continue to grow and develop and will be made available to the Medicare population.

A major focus of the committee was to see which strategies “model” purchasers such as the California Public Employees Retirement System (CalPERS), Xerox Corporation, and the state of Minnesota use to restrain costs and improve quality in a competitive marketplace. The committee also studied how these strategies might help to move Medicare beyond its current bill-paying functions to be more accountable for high-quality performance and customer service. Another important focus was to see how the Medicare managed care market differs from the market for persons under age sixty-five and what implications this has for developing standards for accountability and informed purchasing.

Distinguishing characteristics of Medicare beneficiaries. Although there is a perception that Medicare beneficiaries are relatively better off than their younger counterparts, three-quarters of older persons have annual incomes of less than $25,000. About 77 percent of Medicare spending for the elderly in 1992 was on persons in this income group. Recent reports indicate that many elderly persons may buy into managed care because of its lower price and affordability. Financially, they may not have any viable alternative, although they have credible grievances or are dissatisfied with managed care. This lends urgency to the development of public accountability parameters to ensure adequate performance and access standards.

Both aged and disabled beneficiaries have relatively high levels of education; more than half of each group graduated from high school or attended college. The median number of school years completed among the population age sixty-five and older has risen steadily in the past twenty years. Obscured in these statistics, however, is the sizable number of elders with inadequate literacy skills.

As in the rest of the population, a small proportion of Medicare beneficiaries consumes a significant share of total Medicare spending; 10 percent of beneficiaries account for 70 percent of program expenditures. Per capita spending for the elderly, however, is roughly four times that for the rest of the population. Annual per capita Medicare spending averaged about $4,000 for beneficiaries in 1993. For the 10 percent of beneficiaries with the highest health care costs, Medicare spent an average of more than $28,000 per beneficiary. Medicare paid no benefits on behalf of the healthiest 20 percent of beneficiaries. As the Medicare market becomes more competitive, protections must be put into place to ensure that plans do not engage in practices that discriminate against high-risk patients. Despite the potential advantages of managed care for elderly patients and the opportunity for controlling costs, there is concern that HMOs also may limit access to necessary care. Whereas conventional fee-for-service care is thought to promote excessive use of medical services, there is concern that HMO providers may overreact to financial incentives and limit use of services, which could reduce access to care for the elderly.

Opinions about managed care. Although Medicare beneficiaries have a wide range of experiences and beliefs about managed care, as a group they are more apprehensive than the general population is about this growing trend in health care coverage. Tom Elkin, former head of CalPERS and a member of the IOM committee, told of addressing a large meeting of retirees about CalPERS’s proposals to modify its health benefit package to encourage its members to move into risk
plans. An eighty-six-year-old man stood and announced, “Mr. Elkin, I am not interested in anything that has ‘risk’ in front of it.” Focus groups show that the elderly fear restricted choice of physicians and are particularly concerned about any restrictions that will force them to change physicians. The committee found that elderly persons whose attitudes toward managed care are most favorable tend to live in areas where HMOs have high penetration and established reputations (such as California and Florida, where more than half of current Medicare enrollees reside).

**Understanding of Insurance coverage.**

Because the elderly are less familiar with managed care, it is critical to provide Medicare beneficiaries with information that will enable them to make informed choices. Medicare beneficiaries are not that much less informed about their insurance coverage than other consumers are; such information has been shown to be not important to most people until they become sick. Older persons, however, process information differently than young adults do; they find it more difficult to understand information that is new or complicated. Surveys indicate that it takes more time to educate the elderly than it does to educate younger persons about health care choices. Elderly beneficiaries like to have information presented to them in a variety of formats and prefer face-to-face interaction. Thus, current materials and approaches used to inform the employed population about their health care, options may not be well suited to the elderly.

**IOM Recommendations**

Based on the research synthesis papers commissioned for this study and expert testimony heard at an invitational symposium in early 1996, the IOM committee developed seven primary recommendations to help guide future policy and program efforts to ensure public accountability and informed purchasing.

From the beginning, the committee decided that requirements for public accountability and informed purchasing should not be limited to risk-based managed care options but should pertain equally to the traditional fee-for-service Medicare program. While all of the recommendations sparked lively dialogue, a few of them were hammered out in the midst of active debate and considerable controversy. The more controversial items concerned the number of health plan options that should be made available to Medicare beneficiaries, whether to maintain traditional Medicare as an option, and the use of private organizations to assist beneficiaries in exercising choice.

**Number of health plan options.** During its deliberations the committee was made aware that the number of health plan options potentially available to Medicare beneficiaries would exceed the number available to most younger, employed persons. The committee heard testimony that such a broad range of choices could confuse or intimidate the elderly. Although the committee was mindful of this caution, it did not recommend setting an arbitrary limit on the number of plans offered to the elderly. Rather, it said only that all plans should meet carefully constructed benchmark conditions of participation. Allowing all plans that meet such conditions to enter the market was viewed by the committee as maximizing the likelihood that beneficiaries could find a plan that they like. In addition, the committee was mindful of the size and leverage of the Medicare enrollment and that setting arbitrary limits would have a vast and potentially negative impact on competing plans and the market as a whole.

The committee also called for the federal government to require all health care coverage options to be offered during open enrollment periods and under the same conditions of participation. Comparing the prices and benefits of the various Medicare choices is now difficult because they are not marketed at the same time or under the same ground rules.

**Keeping the traditional Medicare option.** Given how little is known about ensuring informed choice and holding plans accountable, the committee came out strongly...
for retaining traditional Medicare as an option, at least for the foreseeable future. This was seen as critical for allowing a large number and a wide range of plans to be offered to beneficiaries. There were some strong opinions, however, on how much traditional Medicare should be shored up to be maintained as a viable option. Some committee members wanted traditional Medicare to be given the authority to use some of the new purchasing and performance accountability techniques used successfully by some leading private-sector health plans to help make Medicare more competitive and prevent it from following indemnity plans that are fast becoming a relic for the market under age sixty-five. Others on the committee contended that Medicare’s size and public nature would make many private-sector techniques inappropriate. Despite these differences, the committee agreed that it was necessary to maintain traditional Medicare as an option for the foreseeable future, even if it entailed additional costs to government.

**Use of facilitating organizations.** In acknowledging the special needs and vulnerabilities of some Medicare beneficiaries, the committee recommended that nothing in law or regulation should inhibit the development of private organizations whose major purpose would be to facilitate choice for Medicare beneficiaries, including groups that would offer preselected panels of health plans. The committee came out strongly for requiring such groups to fully disclose their sources of funding and the potential biases that could result from their financial arrangements. Some committee members, however, expressed additional concerns about these kinds of entities in the absence of standards and their potential for segmenting the Medicare market.

Committee members had a broad range of backgrounds and expertise, yet every member was struck by the lack of unbiased, comparable, relevant, and clearly understandable information now available to Medicare beneficiaries, and to the entire population. Most of the information that has been developed in the areas of quality, access, and satisfaction has been targeted for other audiences such as purchasers and clinicians, not consumers. A major committee recommendation urged that special efforts be directed to building the needed consumer-oriented information infrastructure for Medicare beneficiaries, using information and customer service techniques and protocols developed in the private sector. An example cited frequently at the symposium and in the commissioned papers was the idea of customer service centers that would allow telephone access to representatives. These would be complemented by regional and local information and ombudsman programs that would provide the one-on-one communication that Medicare beneficiaries highly value.

**Other recommendations.** During its deliberations the committee heard again and again that Medicare beneficiaries place special importance on their personal and trusted relationships with their providers. The committee thus became acutely aware that physicians’ advice to beneficiaries is a quintessential part of ensuring informed choice. In that regard, the committee expressed concern about the increasing restrictions on physicians when they act as advocates for their patients. The committee was in full agreement that so-called anticriticism clauses or gag rules should be prohibited as a condition of plan participation.

Addressing management and leadership issues, the committee was impressed with many of HCFA’s current efforts to improve and broaden Medicare managed care. The committee remained concerned, however, about the challenges and complexities of ef-
Effectively managing traditional Medicare and the multiple-choice program—the former involving management of a plan or choice for beneficiaries and the other, evenhanded regulation of all plans or choices. These disparate functions require very different types of management, staff expertise, backgrounds, and knowledge. The committee concluded that HCFA's growing choice-management functions may benefit from consideration of a new organizational identity with the stature to facilitate recruitment of the needed leadership and staff to build public trust at a time of major change and new horizons.

The committee’s broad charge and short time frame for completion made it necessary to set some priorities, parameters, and caveats regarding the study's scope and agenda. For example, the committee did not focus on the issue of risk selection, although it acknowledged that risk selection was a major problem that must be addressed. Issues of fraud and abuse, estimated by the U.S. General Accounting Office to account for about 10 percent of Medicare costs, also were outside the mandate of this study.

Given the continuing and dynamic changes in the health care enterprise, the committee recognized from the outset that many of the topics addressed in the study would benefit from additional review and analysis as better data and research findings become available. Several of the important and timely themes raised by the committee will continue to be addressed by the IOM's National Roundtable on Health Care Quality. This group, established in 1995, regularly convenes nationally prominent representatives of the private and public sectors to analyze and report on a broad array of issues, including the effects of expanded managed care and integrated delivery systems on quality of care.

NOTES
1. Enrollment in managed care is growing at approximately 2 percent per year.
3. InterStudy. The InterStudy Competitive Edge 52, Part II: HMO Industry Report (Minneapolis: InterStudy Publications, September 1995).
4. The Henry J. Kaiser Family Foundation and Institute for Health Care Research and Policy, Georgetown University, Medicare Chart Book (Washington: Kaiser Family Foundation, October 1995), Figure 2.
5. GAO, Medicare HMOs.
7. Kaiser Family Foundation and Institute for Health Care Research and Policy, Medicare Chart Book, Figure 7.
8. Ibid., Figure 8.
12. Tabulations from the 1993 Robert Wood Johnson Foundation Employer Health Insurance Survey conducted by RAND indicate that the majority of private-sector employers offer only one or two health plans.